

Wakely
Consulting Group



Health Benefit Exchange Planning and Implementation (Requisition Number: 03410-103-12)

Wakely Consulting Group, Inc.

November 30th, 2011

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Letter of Submittal

November 30, 2011

Jason Elledge
Grants Management Specialist
Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, VT 05495

Dear Mr. Elledge:

On behalf of Wakely Consulting Group, Inc. (Wakely), I want to express my appreciation for the opportunity to submit a proposal to the Department of Vermont Health Access. Wakely has assembled a team of seasoned experts to assist the State of Vermont in response to Requisition # 03410-103-12, "Health Benefits Exchange Planning and Implementation."

Wakely in combination with the other members of the team of subcontractors listed below have the experience and commitment to provide a complete solution to Vermont's request in seven of the eight sections set forth in Chapter 3, A Specification of the Work to be Performed. Wakely is proposing on all sections other than **Section 4: Stakeholder Involvement and Outreach/Education**. Based on our experience with exchange planning and development in over a half-dozen states, Wakely recognizes the advantage to the client of close coordination among vendors for related projects. We therefore propose a "full-service" team to deliver the entire scope of requests, with the one exception (Section 4) noted above. We address each of the RFP's four criteria in four large segments of our proposal, each segment covering the entire seven sections on which we are proposing.

With respect to any section for which Wakely is not awarded a contract, this team will strive for close coordination with the other successful bidders. Toward that end, Wakely has communicated with GMMB – with which Wakely teams already as part of Robert Wood Johnson's State Health Reform Assistance Network. As we understand GMMB intends to propose on Section 4, we reached out in order to better understand how to coordinate our deliverables for the other seven sections with GMMB activities under Section 4.

Below please find the requested information about our organization and sub-contractors.

1.) Organizational Information:

Name of Organization: Wakely Consulting Group, Inc.
Address: One Constitution Plaza, Suite 100, Boston, MA 02129
Telephone Number: (617) 939-2006
Principal Officers: Patrick Holland, Managing Director & Jon Kingsdale, Managing Director
Project/Program Leaders: Patrick Holland & Jon Kingsdale, Managing Directors
Staff Names: Ross Winkelman, Managing Director & Senior Consulting Actuary
Julia Lambert, Principal
Mary Hegemann, Senior Consulting Actuary
Julie Pepper, Senior Consulting Actuary
Kathie Mazza, Sr. Consultant
Ann Hwang, Sr. Consultant
James Woolman, Sr. Consultant
Kerry Connolly, Analyst
Description of Organization: Founded over 30 years ago, Wakely is a mid-sized consulting firm that specializes in health care financing, working directly with government and commercial health insurance carriers on public and private program offerings. Wakely has considerable experience in carrying out complex projects, yet its size and structure allow it to be nimbler and more responsive than larger, national firms. Its corporate headquarters are in Clearwater, Florida, with additional offices in Denver, Louisville, and Boston. Over the past 18 months, Wakely has built a network of professionals in its Boston office that have first-hand experience managing health insurance/benefit exchanges and focus almost entirely on exchange planning and development.

Sub-Contractors:

Name of Organization: KPMG LLP
Address: 60 South Street, Boston, MA 02111
Address Local: 356 Mountain View Drive, Colchester, VT 05446
Telephone Numbers: (617) 988-1000, (802) 651-5600
Principal Officers: Lorna Stark, Partner
Project/Program Leaders: Dave Gmelich, Director; Lou Tarricone, Senior Manager
Staff Names: Ian Gilmour, Associate Partner
Peter Blessing, Director
Michelle Miller, Senior Manager
Roger Abbott, Senior Manager
Arun Iyer, Manager
Erica Heintz, Senior Associate
Description of Organization: KPMG has experience managing large projects, and

providing a variety of professional consultative services to government clients, including audit and IT advisory services. The latter include transition planning and execution, business process reengineering, enterprise architecture, program management, requirements definition, acceptance testing and reporting, implementation management, and other relevant disciplines on many large and mission-critical initiatives. KPMG is a leader in providing IT advisory services in the HHS arena, providing these services to New York State, New York City, the Commonwealth of Massachusetts, the States of New Jersey, Indiana, and California, and others. KPMG assisted the Commonwealth of Massachusetts in its efforts to build and operate its health benefits Exchange on multiple projects over the 2007-2010 timeframe, and is currently assisting the states of Missouri and Rhode Island to do the same.

Name of Organization: Freedman HealthCare, LLC
Address: 29 Crafts Street, Suite 470, Newton, MA 02458
Telephone Number: (617) 243-9509
Principal Officer: John Freedman, Principal
Project/Program Leader: John Freedman, Principal
Staff Names: John Freedman, Principal
 Alison Glastein, Vice President
 Ellie Soeffing, Affiliate Consultant
 Ben Stewart, Analyst

Description of Organization: Established in 2005, Freedman HealthCare assists diverse stakeholder groups in adopting policies and programmatic changes that can drive cost containment and quality improvement. Through its work with provider organizations, payers and policy makers, Freedman HealthCare is committed to creating a more efficient health care system and ensuring broad community buy-in to a future vision of health care delivery. Freedman HealthCare understands both the clinical and business aspects of a more transparent system of care, and has demonstrated expertise with process facilitation, measurement methodology, claims databases, IT strategy, analytics, public reporting, and health insurance exchange design. Freedman HealthCare offers a range of services related to health policy development and implementation, including our All Payer Claims Database Services available to states

across the country. Freedman HealthCare’s team is also expert at healthcare strategic planning and market research, as well as health-related content development.

Name of Consultant: Jon Gruber, PhD
Address: 83 Pleasant St., Lexington MA 02421
Telephone Number: 781-862-0112
Principal Officers: Jon Gruber, PhD
Project/Program Leaders: Jon Gruber, PhD
Staff Names: Dylan Bannon, Research Assistant
Description of Organization: Jonathan Gruber, PhD, is a Professor of Economics at the Massachusetts Institute of Technology and a nationally renowned economist. During 2009-2010 he served as a technical consultant to the Obama Administration and helped craft what would become the ACA. Jon also co-authored the report on Vermont’s single-payer vision, “Act 128: Health System Design Reform” and helped design and currently sits as a board member on the Massachusetts Health Connector. Jon will serve as a special advisor to the team on population flows and econometric modeling.

Name of Organization: RKM Research and Communications, Inc.
Address: 1039 Islington Street, Portsmouth, NH 03801
Telephone Number: 306-433-3982 (x1035)
Principal Officers: R. Kelly Myers, President and Chief Analyst
Project/Program Leaders: R. Kelly Myers, President and Chief Analyst
Staff Names: NA
Description of Organization: RKM Research and Communications is a full-service marketing and communications research firm specializing in custom-designed quantitative and qualitative research services. RKM has extensive experience in healthcare, working with health insurance companies, health systems, hospitals, provider groups and health insurance brokers. RKM also has experience working with the Commonwealth Connector in Massachusetts and the State of Rhode Island researching consumer and small business awareness and preference for Exchanges, and testing options for expanding coverage for the uninsured.

Name of Organization: Policy Integrity LLC
Address: 1855 North Street, Montpelier, VT 05602
Telephone Number: 802-522-0986

Principal Officers: Steven Kappel

Project/Program Leaders: Steven Kappel

Staff Names: NA

Description of Organization: Policy Integrity was founded by Steve Kappel in 2007 to provide support for organizations developing or evaluating health policy. Primary areas of expertise include health data management, financial modeling, and statistical analysis.

2.) List of Materials and Enclosures: Nothing to disclose.

3.) Additional Statements: Nothing to disclose.

If you should have any questions or need further information during your review of this proposal and wish to discuss them, please contact Patrick Holland or Jon Kingsdale, both Managing Directors at Wakely Consulting Group, at 617-939-2006.

We look forward to the opportunity to work on this important project with you.

Sincerely,

Patrick Holland
Managing Director

Information from the Bidder

Quality of Bidder Experience

Wakely and its teaming partners are uniquely qualified to provide the technical assistance sought by Vermont for seven sections of the RFP. Wakely will provide much of the technical assistance for the Exchange planning and implementation activities on which it is proposing -- sections 1-3 and 5-8 of Chapter 3, "Technical Proposal/Program Specifications" -- and will coordinate all other work performed by its teaming partners. Wakely and its teaming partners have experience performing many of the specific tasks requested by Vermont for other states, and we will provide references specific to our relevant experience. Wakely and its teaming partners are also familiar with the unique features of the insurance market in Vermont, plans for ultimately moving toward single-payer and a universal exchange, and much of the planning that has already been done by Vermont for its Exchange. Wakely recognizes the importance of close collaboration with the Department of Vermont Health Access (DVHA) and other state agencies, as well as coordination with other consultants selected through this RFP in order to develop a plan that is in line with Vermont's particular goals and priorities.

At the same time, Wakely's own depth of experience starting exchange programs in Massachusetts, working since enactment of the ACA with other states and with the federal Center for Consumer Information and Insurance Oversight (CCIIO) provides unparalleled expertise in exchange design, operation and implementation. Wakely's expertise will build on Vermont's unique vision and accelerate its exchange development.

Staff and Consultant Qualifications & Experience

Founded over 30 years ago, Wakely is a mid-sized consulting firm that specializes in health care financing, working directly with government and commercial health insurance carriers on public and private programs. Wakely has considerable experience in carrying out complex projects, yet its size and structure allow it to be nimbler and more responsive than larger, national firms. Its corporate headquarters are in Clearwater, Florida, with additional offices in Denver, Louisville, and Boston. Wakely's gross revenue in 2010 was more than \$7 million dollars, having doubled in size since 2008.

Wakely has assembled a broad, experienced team of consultants specializing in health reform under the Affordable Care Act to deliver strategic and technical advice, conduct research and data analysis, perform actuarial and financial modeling and provide project management services. Jon Kingsdale and Patrick Holland, Managing Directors of Wakely's Boston office will lead the project in Vermont and will ensure that the entire project team provides the appropriate analytic and support services to DVHA. Beginning even before enactment of the Affordable Care Act (ACA), and increasingly since its passage, Jon and

Patrick have consulted to numerous states and to CCIIO on developing state-based insurance exchanges and a federal fallback exchange.

Patrick Holland, with over 25 years of experience in the health care industry, brings a broad background, including accounting, finance, strategy and analytics, with direct leadership experience at several health insurance and provider organizations. Prior to starting Wakely's Boston office, Patrick was the Chief Financial Officer of the Commonwealth Health Insurance Connector Authority (Health Connector), an independent authority established in 2006 to implement key provisions of Massachusetts' landmark health reform law and a model for national health care reform. At the Health Connector, Patrick was primarily responsible for the development of the financial operations, eligibility, enrollment integrity and reconciliation, and the analytical support, planning, and implementation of carrier procurements for the Exchange. Since leaving the Connector, Patrick has led Wakely's consulting engagements in Oregon, Washington, Missouri, Wisconsin, Maryland, and Colorado, and has advised another half-dozen states in developing exchanges.

Jon Kingsdale, PhD, led a Washington, D.C.-based health policy consulting practice for three years, taught and conducted research at the Harvard School of Public Health, helped manage the Massachusetts, all-payer, prospective hospital rate-setting system, and led strategic planning, product development and public affairs for New England's third largest health plan. After 25 years of experience at two health plans, Jon served as the Massachusetts Health Connector's founding Executive Director for four years. In this role, he led key initiatives to make health insurance universally available and to reform health care financing in Massachusetts. Since leaving the Health Connector, Jon has led Wakely's consulting engagements in California, Illinois, New York, and Rhode Island, and has advised a half-dozen other states on developing their insurance Exchanges.

A number of key individuals from Wakely will lead or support the efforts outlined in our proposal. James Woolman worked in progressively more responsible financial analytic positions at the Massachusetts Division of Health Care Finance and Policy, the Health Connector and Tufts Health Plan, prior to joining Wakely. At Wakely, he has worked on exchange self-sustainability models, business plans and various other exchange planning analyses for Washington, Missouri, Rhode Island, and Maryland. Kathie Mazza is a licensed broker with some 25 years of experience in sales & marketing, product development, project management, member service and account management for several health plans and, since joining Wakely in March 2011, has led analytic projects on exchange development for CCIIO, Illinois, Missouri and New York. Her work included developing a plan of operations for the New York exchange. Ann Hwang, MD, will provide strategic and policy analysis, and brings a unique set of credentials as someone who works in both the policy and clinical worlds. She was a senior policy advisor at the Health Connector, has led Wakely's engagement in Rhode Island, and is a practicing internist. Kerry Connolly helped build the Connector as one of its first employees, and since joining Wakely in June 2011 has coordinated Wakely's support for Rhode Island's Level II Establishment grant application, developed numerous work plans for state projects, and contributed to various exchange

analyses, including resource assessments and business plans, for several states. Steve McStay was Senior Project Manager at the Health Connector responsible for implementing the operational policies and procedures of the Commonwealth Care program. His most recent accomplishments include working with internal and external customers in requirements definition and implementation of open enrollment activities, Customer Relationship Management Systems, Premium Billing and Enrollment Systems, and Medicaid Management Information Systems in support of health care reform.

Ross Winkelman, FSA, MAAA, will serve as the lead actuary for this engagement. He has over 17 years of experience as a healthcare actuary and has been involved in pricing for both commercial and government programs. He currently leads Wakely's actuarial efforts to support the Massachusetts Health Connector on rating, risk adjustment, and procurement strategy. He has developed a number of pricing models for government programs, including the Connector, Medicaid, Medicare, and Tricare, in addition to Medicaid expansion programs in Colorado and Missouri, and financial models for high risk pools offered under the ACA. He is a national expert on risk adjustment, reinsurance and risk corridors (the "3R's"), having led development of a summary of the proposed rules¹ and development of a work plan² for states to implement the reinsurance and risk adjustment provisions of the ACA. He is currently assisting several states in the implementation of the risk adjustment and reinsurance provisions of the ACA. Ross and the core Wakely actuarial team have worked on modeling population movements and price effects under the ACA in Colorado, Illinois, Oregon, Missouri, Rhode Island, Delaware, and others. Wakely has already collaborated on such work with Jon Gruber in Colorado and to a lesser degree in Rhode Island.

Ross will work with Julie Peper, Mary Hegemann, and Julia Lambert, who are fully credentialed actuaries as well, on this project. Julie and Mary have worked on modeling population movements, small group – individual market mergers, the impacts of subsidies by income, pricing of essential benefits, the impact of minimum loss ratio (MLR) and actuarial value requirements, Basic Health Plan (BHP) modeling, and other potential changes to the insurance markets under the ACA in several states such as Rhode Island, Illinois, Delaware, and Colorado. This same team of actuaries is also assisting Missouri with provider contracting reform efforts associated with the ACA as it pertains to transformation of the Medicaid program.

While the focus for Julie and Mary has been more concentrated on the individual insurance market and the expanded Medicaid population, Julia Lambert has focused on the group insurance market and has assisted states with decisions around employee choice, adverse selection, expansion of the small group market from 50 to 100 lives, and pricing considerations in the group market regarding essential benefit, MLR requirements, and actuarial value tiers.

¹ "Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment", funded by a grant from the Robert Wood Johnson Foundation (RWJ), <http://www.rwjf.org/coverage/product.jsp?id=72682>

² The work plan was also funded by RWJ, although it has not been publicly released yet.

Wakely has also engaged four other sets of consultants with specific expertise relevant to Vermont's RFP, and with whom Wakely has excellent past experience: Lou Tarricone and Ian Gilmour (KPMG), John Freedman and Ellie Soeffing (Freedman HealthCare), Kelly Myers (RKM Research and Communications) and Professor Jon Gruber of MIT will serve as task leaders and provide important input throughout the project. Steven Kappel will also assist our team with data analysis.

KPMG will work under Wakely's lead primarily on call center, business process, and (if needed) IT consulting for this project. KPMG will also lead the effort for section 5 on Program Integration. KPMG has experience managing large projects and providing a variety of professional advisory services to government clients, including business process reengineering and program integration. KPMG is a leader in providing business process and IT advisory services in the HHS arena, providing these services to New York State, New York City, the Commonwealth of Massachusetts, the States of New Jersey, Indiana, and California, and others. KPMG assisted the Commonwealth of Massachusetts in its efforts to build and operate its health benefits Exchange on multiple projects over the 2007-2010 timeframe, and is currently assisting the states of Missouri and Rhode Island to do the same. Lou Tarricone and Ian Gilmour of KPMG currently lead an effort to integrate business and systems requirements for RItCare, RItShare and the Rhode Island exchange. KPMG has built a team of experts on exchanges, whom Lou Tarricone will coordinate for the Vermont work.

Jonathan Gruber, PhD, is a Professor of Economics at the Massachusetts Institute of Technology and a nationally renowned economist. During 2009-2010 he served as a technical consultant to the Obama Administration and helped craft what would become the ACA. Jon also co-authored the report on Vermont's single-payer vision, "Act 128: Health System Design Reform" and helped design and currently sits as a board member on the Massachusetts Health Connector. Jon Gruber will serve as a special advisor to the team on population flows and econometric modeling, and will co-lead our work on section 8, the Universal Exchange.

RKM Research and Communications (RKM) has extensive experience in healthcare, working with health insurance companies, health systems, hospitals, provider groups and health insurance brokers. RKM also has experience working with the Commonwealth Connector in Massachusetts and the State of Rhode Island researching consumer and small business awareness and preference for Exchanges, and testing options for expanding coverage for the uninsured.

Freedman HealthCare, established in 2005, specializes in performance measurement and improvement in healthcare, focusing on both quality and efficiency. John Freedman, MD, MBA Principal at Freedman HealthCare has 20 years' experience in quality program development and reporting, performance incentives and managed care. Dr. Freedman served as Medical Director for Quality at Kaiser Permanente in Colorado, and subsequently as Medical Director for Specialty Services at one of the Northeast's largest neighborhood

health centers, overseeing 40 physicians in 16 specialties. He also held a leadership role at Tufts Health Plan, where he helped them climb to a #2 national NCQA ranking with market-leading efforts in pay-for-performance contracting, tiered network products, public reporting, disease management and innovative member outreach programs.

Ellie Soeffing, Affiliate Consultant at Freedman HealthCare, will develop the wellness components of the proposed engagement. Ms. Soeffing is a senior healthcare executive with over 25 years of diverse healthcare experience developing businesses, building and marketing products and managing large scale projects and interdisciplinary project teams. She served as a Senior Director at Health Dialog where she developed evidenced based wellness program, and also held senior roles at two Boston area hospitals and at Harvard Pilgrim Health Care.

Steven Kappel helped develop the Vermont Uniform Hospital Discharge Data Set (VUHHDS) and is an expert in health care policy and data analytics related to the health care market in Vermont. Steven's experience and analytical expertise will be an invaluable contribution to our project team.

References

Deb Faulkner, State of Rhode Island
Faulkner Consulting Group
12 Vialls Drive
Barrington, RI 02806
dtfaulkner@gmail.com
401-245-1653

Dwight Fine, State of Missouri
ACA Coordinator
Missouri Health Net
Broadway State Office Building
221 West High St, 2nd Floor
Jefferson City, MO 65101
Dwight.fine@dss.mo.gov
573-526-3288

Beth Walter, State of Washington
WA State Health Care Authority
676 Woodland Square Loop SE
Lacey, WA 98503
beth.walter@hca.wa.gov
360-923-2942

Section-by-Section Experience

Vermont is requesting technical assistance to provide in-depth analysis of key strategy and operational decisions that the state faces in designing its exchange. These tasks focus on eight distinct areas, and Wakely (and subcontractors) are proposing on seven of the eight. As a team, we have substantial prior experience and qualifications on all seven sections, including sub-sections, as detailed below:

1. **Exchange Operations/Business Functions**: Having run an exchange for Massachusetts, including call centers, financial systems, monitoring for fraud, waste and abuse, and various evaluative and other related functions, the key personnel at Wakely are intimately familiar with these issues. In addition, Wakely has begun many of the business planning tasks described below for the states of Missouri, Oregon, Washington, New York, Illinois, Maryland, and Rhode Island.
 - a. **Call Center**: Based on experience at the Massachusetts Health Connector (“the Connector”) and advising CCHIO on business functions for a federal fallback exchange, Wakely is fully conversant with the requirements of an exchange call center. Wakely personnel have even dealt in Massachusetts with the special kinds of call center issues that arise prior to opening the exchange itself, such as press inquiries, legislators’ calls, and premature efforts by consumers to enroll for coverage. For its subsidized program (Commonwealth Care), the Connector went through an intense learning process, after two years of overseeing one call center, of evaluating several vendors and then switching out its first call center operator for a new vendor. Steven McStay, who worked on this project at the Connector and later worked for the new call center vendor to the Connector, will lead this sub-section.
 - b. **Financial Management**: As CFO of the Connector, Patrick Holland has first-hand experience with the full range of relevant issues; Patrick and James Woolman have now done (or are doing) 5-year financial projections and sustainability modeling for California, Washington, Illinois, Colorado, Maryland, Missouri, New York, and Rhode Island, and have developed a proprietary exchange financial model (ExFIM) specifically for this purpose. Patrick will lead this effort for Vermont.
 - c. **Program Integrity**: Having just completed a project on the prevention of fraud, waste and abuse for the Maryland exchange, Wakely is well qualified to undertake this effort for Vermont. Again, the principal analysts of the Maryland effort – Patrick Holland and James Woolman – will lead this effort for Vermont, with input and assistance from financial management staff at KPMG.
 - d. **Exchange Staffing**: as part of its 5-year financial modeling for a half-dozen other state exchanges, Wakely has developed recommendations on how to cost-

effectively sequence hiring consultants and staff, has provided job descriptions and organization charts for higher-level staff, and has developed staffing budgets, year-by-year through 2015 and beyond. This effort for Vermont will be led by James Woolman.

- e. Exchange Evaluation: The Connector undertook both internal and external evaluation efforts during the tenure of Wakely staff who will work on this subtask for Vermont. While at the Health Connector, Ann Hwang developed and oversaw a survey of the Commonwealth Care program and collaborated with the Massachusetts Department of Revenue to evaluate the implementation of the individual mandate. Ann Hwang, MD also created a data and evaluation plan for the Rhode Island Exchange, including reform goals and selected indicators appropriate for assessing progress toward these goals. Wakely also assessed which of these indicators were available from existing data sources, including how up-to-date the baseline data were and whether the data could be used to provide state-level estimates. For recommended indicators that are not currently being collected, Wakely described strategies that could be used to obtain this data. This data and evaluation plan was submitted by the state in support of its federal grant application. Dr. Hwang will lead this effort for Vermont.
 - f. Level II Establishment Grant Application: Wakely provided significant support to Missouri in its successful Level I grant application – originally intended as a Level II proposal, had exchange authorizing legislation passed in Missouri -- and Wakely provided comprehensive support to Rhode Island in its recent Level II grant application (submitted September 30, 2011). While a number of individuals at Wakely worked on Rhode Island’s level II proposal, Kerry Connolly took primary responsibility for this project, and she will lead Wakely’s effort to support Vermont’s level II application.
2. SHOP Exchange, Individual and Employer Responsibility, and Enrollment: These issues require a broad array of expertise, as they span the business development challenges of improving service and value for employers and determining obligations, exemptions and appeals of regulatory requirements to purchase coverage. (From a customer perspective, there is considerable tension between these missions.) For example, how does an exchange attract employers and individuals, while also enforcing requirements, imposing penalties and hearing appeals and grievances? Wakely’s staff has had the unique experience of balancing these conflicting requirements in Massachusetts.
- a. SHOP Exchange: Wakely is working on SHOP design issues for Missouri, Illinois, New York and Rhode Island, through competitively bid state contracts and under special Robert Wood Johnson funding for its State Health Reform Assistance Network (SHRAN). SHOP presents a particular challenge both because employers may expect that health plans in the SHOP exchange will be less expensive than private insurance purchased otherwise, and a philosophical

- resistance from some employers and brokers to government's role in "selling" group insurance. Our research conducted in close coordination with RKM in Rhode Island included focus groups with small employers and employees of small firms, plus interviews with employers, employees, brokers and general agents to test four different models for a SHOP exchange. The focus of this research was on ways for the SHOP exchange to add value for employers and employees. Ann Hwang, MD and Jon Kingsdale, Ph.D. have worked together on Rhode Island's SHOP development research and design work, and Dr. Kingsdale will take the lead for Vermont as well.
- b. Individual and Employer Responsibility Determinations: Wakely is also working with KPMG in Missouri and Rhode Island to specify business processes that can be built into an eligibility determination system serving individuals, small group, Medicaid, CHIP and premium assistance programs. The aim of these design efforts is to maximize savings to employers and employees by ensuring accurate, timely and highly automated administration of affordability tests, tax credit eligibility calculations (for employers and individuals), etc. Ann Hwang, Kathie Mazza and Jon Kingsdale have been heavily involved in the Missouri and Rhode Island work. Ann Hwang will take the lead for Vermont.
 - c. Enrollment in QHPs: Patrick Holland helped design and oversee premium billing and collection systems for the Connector; he and James Woolman worked on preliminary development of specifications for this function in Missouri and Washington as well. James will take the lead in evaluating existing enrollment and premium payment processes for Catamount and other publicly-funded programs in Vermont, best practices in other states, and developing enrollment, billing and payment business processes for Vermont's Exchange. Wakely will work with KPMG's Lou Tarricone to coordinate this activity with the analyses in section 5 (Program Integration) and translate business processes into systems design specifications.
3. Health Insurance Market Reform: Wakely has performed comprehensive analyses of health insurance market reforms for Illinois and Rhode Island, and has or is performing analyses of aspects of market reform and risk adjustment in New York, Maryland, Colorado, and Wisconsin. Ross Winkelman, Julie Peper, Mary Hegemann, Julia Lambert and Patrick Holland have led these analyses and will take the lead for Vermont.
 - a. Impact of Exchange on Outside Market: In addition to the work completed by Ross Winkelman and Marry Hegemann on the ACA's impact on the outside markets in Illinois and Rhode Island, Julia Lambert and Patrick Holland are currently leading a study for Vermont, funded by the Robert Wood Johnson Foundation, on the impact of state policy for the sale of small group health insurance. They are assessing: (1) requiring the sale of small group, fully insured health insurance products exclusively through the state-based health benefit

exchange, (2) allowing only “qualified” small group health plans to be sold outside the exchange, or (3) allowing both “qualified” and “non-qualified” small group health plans to be sold outside the exchange. The study will also analyze the premium impact on employer groups that are currently purchasing through the Association pool, but may be required to purchase in the small or large group risk pool, depending on the employer group size, in 2014. Depending on the nature of the actuarial analyses requested by the State, Ross Winkelman, Mary Hegemann and Julia Lambert will each be available to lead Wakely’s effort for this subsection.

- b. Risk-Leveling Programs: Wakely employs nationally recognized experts in the reinsurance, risk corridor and risk adjustment programs under the ACA. Ross Winkelman, Mary Hegemann, and Syed Mehmud are providing ongoing consulting work to a number of states both directly and through a broad grant from the Robert Wood Johnson Foundation (RWJF).

An analysis of the reinsurance, risk corridor and risk adjustment programs developed under the RWJF grant³ has been widely cited. The consultants assigned to this subsection are completing (or have already done so) the following projects related to the reinsurance, risk corridor and risk adjustment programs:

- New York stakeholder meetings on risk adjustment under ACA, jointly funded by RWJ and the NY Health Plan Association
- General work plan on risk adjustment under ACA for 10 RWJ states (40+ pages listing considerations and timing for states to implement risk adjustment and reinsurance)
- Report to CCIIO on states’ APCDs
- Report to CCIIO on reinsurance market
- Update to Massachusetts Commonwealth Care risk adjustment
- Update to Arizona Medicaid risk adjustment
- Health reform planning for insurer in Indiana, including education and strategy on risk adjustment
- Two research reports for the Society of Actuaries (SoA), on a) uncertainty and b) such non-traditional variables in risk adjustment as income
- Leading a committee of SoA that is finalizing an Actuarial Standard of Practice on risk adjustment

- c. Certification of QHPs: Patrick Holland and James Woolman have assessed QHP certification requirements for Maryland and are doing a similar project for Illinois currently. They will lead Wakely’s effort in Vermont, including the range

³ “Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment”
<http://www.rwjf.org/coverage/product.jsp?id=72682>

of criteria to consider; recommendations for criteria that meet federal requirements and state objectives, especially those related to Vermont's initiatives on quality improvement, payment reform, the PCMH, and continuity of care for chronic illness; processes and procedures for certifying QHPs, recertifying and decertifying them; and development of a "data book" and model contract for soliciting QHP bids.

- d. Consumer Satisfaction Surveys: RKM has extensive experience in Massachusetts and elsewhere with consumer satisfaction surveys and measuring health plan performance, including HEDIS and other measures. RKM has also worked closely with personnel at Wakely -- Jon Kingsdale in particular, at the Tufts Health Plan, the Connector, and Rhode Island. John Freedman, M.D. also has extensive experience in measuring health plan quality, and his expertise will inform our work in the sub-section. Building on a close working relationship with Wakely, Kelly Myers, CEO of RKM, will take the lead in proposing consumer satisfaction standards and measures, designing a survey approach and instrument, developing the instrument, and recommending procedures for administering it, and reporting results in ways that purchasers can readily understand and use.
 - e. QHP Plan Design: Most states have not yet designed specifications for QHPs, including requested benefits, cost-sharing, product-type, etc. However, Wakely has done so for the Connector, both for individual and small-group offerings, and is thoroughly familiar with federal requirements spelled out in the ACA and subsequent guidance. Based on current plan availability in Vermont and consumer/employer feedback, Wakely will recommend standardized benefit designs for Vermont's consideration. Kathie Mazza is leading a research initiative for New York State to inventory the most widely used plan designs in the non-group and small-group markets there. Kathie, who has a broad background in both sales & marketing and product development, will lead this effort for Vermont, with actuarial input from other Wakely offices.
4. Stakeholder Involvement and Education/Outreach: Intentionally left blank
 5. Program Integration: Vermont's vision is to align and integrate all the constituent coverage programs under Green Mountain Care, private insurance and State and municipal employee coverage into a single pipeline for provider payment purposes and an aligned benefits structure. Aligning these disparate programs to the extent possible under the ACA will require a strategy for ultimately integrating them, as well as detailed specification of the operating systems for eligibility determination, enrollment, billing and collections, customer service and provider payment to support integration. Dr. Jon Gruber and Steve Kappel have worked with Dr. William Hsaio to develop a single-payer vision for Vermont, and KPMG is working with Wakely in Rhode Island to create the business design and IT specifications for a fully integrated offering of RItCare, premium assisted RItShare, and a unified non-group and SHOP exchange.

- a. Integration of Existing Coverage Groups: Wakely and KPMG have worked together on integration strategies for eligibility determination, alignment of QHPs with Medicaid MCOs, and business design processes for Missouri and Rhode Island. Working closely together, our teams have conducted multiple, detailed planning sessions to integrate Rhode Island's Medicaid and exchange processes, and we expect to use a similar process, working closely with staff from DVHA, BISHCA and the Catamount plan to identify integration opportunities and obstacles, design systems solutions, "work-arounds," and the necessary statutory changes to support such integration. Ian Gilmour will lead KPMG's team on this subsection, with input from (Wakely's) Ann Hwang and Jon Kingsdale.
 - b. Administrative Simplification: Kathie Mazza and Jon Kingsdale recently completed an assessment of options for simplifying employer reporting and data collection under ACA, based on best practices in nine states. We will work with the KPMG team to review current simplification projects in Vermont and other states, and to research federal law to determine other opportunities. We will design and field an expedited process for polling providers to determine their priorities for simplification. KPMG will incorporate this input into an administrative simplification plan for the state, including specific tasks and timeline. Lou Tarricone will lead this effort in Vermont.
6. Quality and Wellness: Wakely is teaming with Freedman HealthCare to develop quality improvement plans, measure and rate QHPs on quality, and design wellness program components for Vermont's exchange. Wakely brings to this engagement full understanding of exchange-specific requirements under ACA, such as the need to certify QHP's and to help enrollees shop for coverage. Freedman HealthCare brings deep experience in quality measurement and wellness programs. Key personnel from Wakely and Freedman HealthCare previously worked together at the Tufts Health Plan.

Established in 2005, Freedman HealthCare specializes in performance measurement and improvement in healthcare. Freedman HealthCare brings an innovative perspective to its client engagements, and is committed to creating a more efficient health care system and ensuring broad community buy-in to a future vision of health care delivery. Freedman HealthCare has helped clients develop provider profiling reporting, focusing on both quality and cost and exploring both inpatient and outpatient data; develop new and/or evaluate existing pay-for-performance, tiered and limited network development initiatives; and create a public reporting plan as a component of incentive-based programs for contracting and compensation purposes. Additionally, Freedman HealthCare has extensive experience designing and implementing wellness and population health programs at payer and provider organizations in addition to helping clients develop disease and pharmacy management initiatives.

- a. Quality program & rating system: Freedman HealthCare's team has extensive experience with quality program and rating development. Dr. Freedman helped

- develop the Massachusetts Healthcare Quality and Cost Council's website, the first in the nation to display hospital-specific quality and cost information simultaneously derived from data from the All Payer Claims Database. For this engagement, Dr. Freedman researched quality measures; drafted recommendations; facilitated discussions in public meetings to select measures, as well as statistical methodologies and reporting options; and helped design the display of the results. He also assisted the Massachusetts Attorney General's Office (AGO), providing quality analysis for the AGO's annual (2010, 2011) examinations of health care cost and market trends. Most recently, Freedman HealthCare was hired by the Massachusetts Division of Health Care Finance and Policy to facilitate the selection of standardized clinical quality measures to be used by the state under the small business health reform law. John Freedman will lead the effort under this subsection
- b. Wellness programs: Freedman HealthCare has extensive experience designing and implementing population health programs at payer and provider organization. This includes creating disease management programs in which we help clients focus on high risk case identification and high risk specialized case management. Freedman HealthCare also brings expertise on evidence-based wellness programs. Affiliate Consultant Ellie Soeffing oversaw the building and implementation of "Healthy Living Support for Seniors" an evidenced based wellness program for Health Dialog based on the research of the Foundation for Informed Medical Decision Making. Using advanced analytics, sophisticated engagement methods, and effective behavior change techniques, the program focused on finding the right individuals at the right time, and providing them with the right tools. Ellie Soeffing will lead the effort under this subsection.
7. Payment Reform: Patrick Holland has over 25 years of experience with provider payment, working on both the plan and provider side in negotiating payment terms that include FFS, global budgets, and bundled payments. He recently developed budgets and sub-capitations for several PHOs and POs in Eastern Massachusetts. Patrick, James Woolman and Ross Winkelman have worked closely together to develop risk adjustment methods and capitation rates for the Connector. Julie Peper has provided contracting expertise to the Massachusetts Connector by leading analyses involving provider contract comparisons for administrative services bidding related to the unemployed population covered by State programs. Jon Kingsdale helped implement Massachusetts' all-payer, hospital rate-setting system in the mid-1980's (premised on Blue Cross's global budget contracts with each of nearly 100 acute-care hospitals) and recently developed an all-payer reimbursement model for Massachusetts, which formed the basis of legislation introduced and promoted in 2011 by the Massachusetts Association of Health Plans (MAHP). Patrick Holland will lead this section of the engagement, working with Jon Kingsdale, James Woolman, Julie Peper, Ross Winkelman and Steve Kappel.

8. Universal Exchange: Dr. Jon Gruber contributed to the original study of a single-payer model for Vermont, has been a Board member of the Massachusetts Health Connector since it started in 2006, and is familiar with the universal vision for Vermont's exchange. Jon Kingsdale led the development of the Connector from legislation into a functioning exchange, including much of the visioning for health reform that was delegated to the Connector's Board by Massachusetts health reform legislation. Jon Kingsdale and Jon Gruber will lead this section of the engagement, and will work with Patrick Holland, Julia Lambert and Steve Kappel on modeling specific elements, such as scale economies for a universal exchange and combining separate risk pools in Vermont.

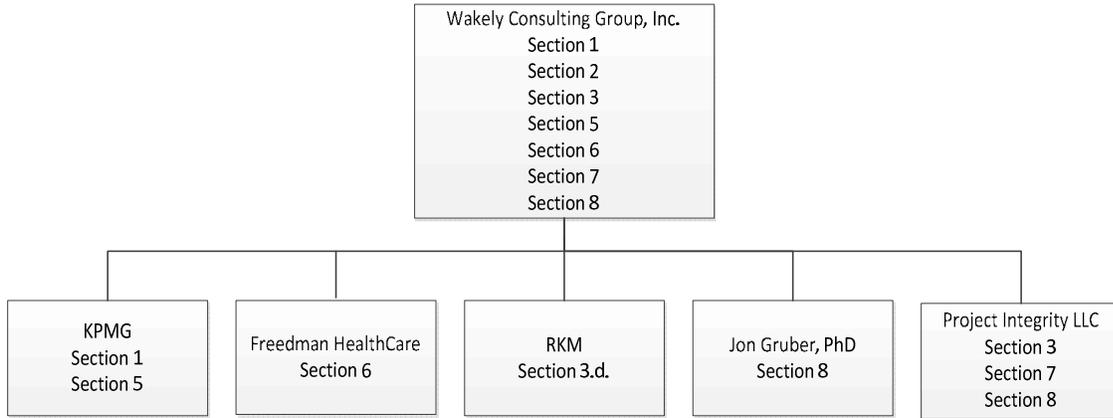
We recognize Vermont's goal of developing an exchange that will meet HHS requirements under the ACA, and simultaneously help Vermont move toward a single-payer system. Our approach emphasizes collaboration to help Vermont articulate and prioritize its objectives, a deep dive into analytics to help inform state-decision making, the use of a proprietary financial simulation model to deliver detailed budget projections, and econometric and actuarial modeling to understand the likely impact of policy decisions on different segments of the insurance markets.

Wakely's project team provides an unparalleled level of expertise in Exchange implementation and operations, actuarial and financial analysis, and state health reform policies, plus the close coordination that comes from having previously worked together. Wakely and its partners are fully committed to working with DVHA to ensure the success of Vermont's Exchange planning activities.

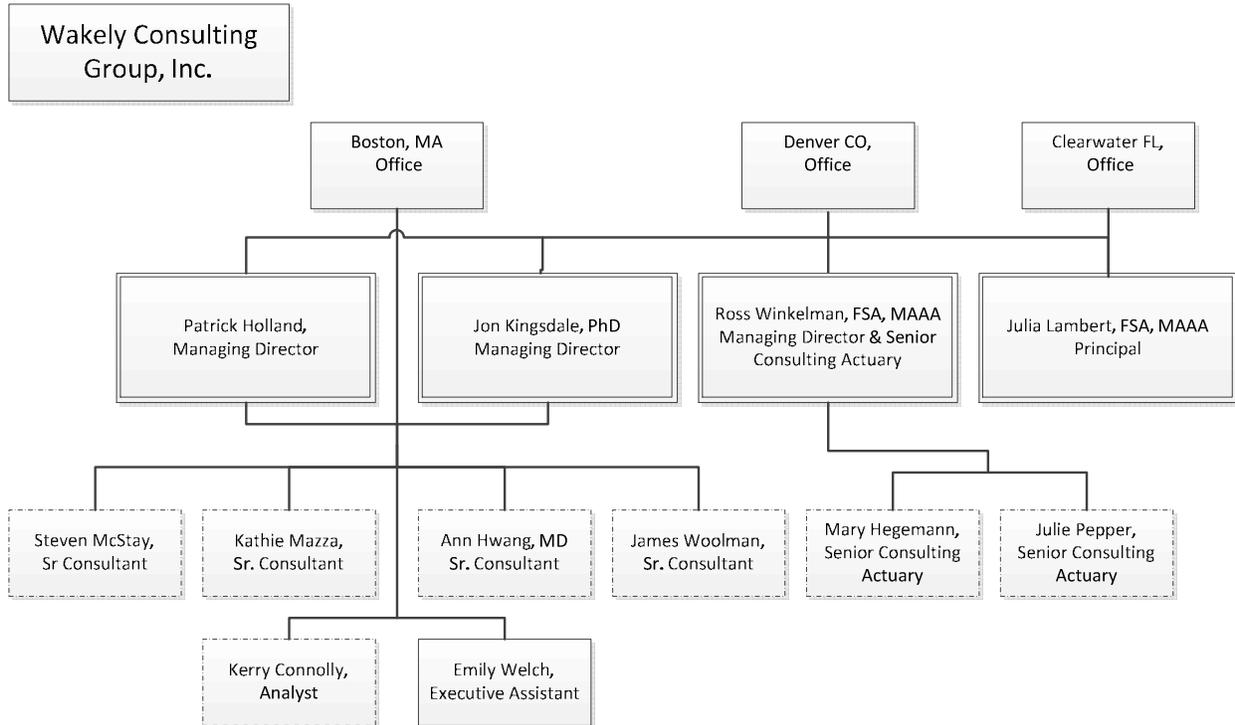
Bidder Capacity

Organizational Capacity & Charts

PROJECT ORGANIZATIONAL CHART



WAKELY CONSULTING ORGANIZATIONAL CHART



Descriptions of Organizational Size & Backup

Wakely has over 40 professionals in four offices across the country that can provide Vermont with a unique blend of highly skilled professionals with deep experience in government and commercial health insurance, including health benefit exchanges and the ACA. Additionally, as evidenced in the qualification section, Wakely has developed a close professional relationship with a handful of consulting firms ranging from the boutique to international in size that can provide a broad range of services at cost effective rates.

Wakely and its partners have been involved, individually and collectively, in large projects for government and commercial clients, and understand the need to manage this project within budget and on-time. Wakely will work closely with the state to ensure project deliverables are met, and has the ability to bring on additional resources should the need arise.

Resumes of Key Project Staff

WAKELY CONSULTING GROUP, INC.

Patrick M. Holland

One Constitution Way, Suite 100, Boston MA 02129
patrickh@wakely.com • 617.939.2002 (C) 617.633.9959

Profile

Mr. Holland has extensive insurance and provider health care experience with an emphasis in payer, hospital and physician contract negotiation, finance, provider reimbursement strategy, risk modeling, financial reporting, budgeting and managed care operations. He has excellent leadership abilities complemented with strong organizational, interpersonal, and communication skills. As part of a small senior executive team, he was responsible for implementing landmark healthcare reform legislation in Massachusetts, developed innovative program designs to lower the monthly premium for healthcare services, in addition to leading the organization to profitability within 24 months of operation. Developed and executed reimbursement strategies for a national PPO entity as well as regional Managed Care Organizations. Mr. Holland has proven abilities in negotiation, contracting strategy and analysis, estimation and forecasting, financial accounting, project management, team building, information systems, and operational policies and procedures.

Professional Experience

Wakely Consulting Group, Inc.

Boston, MA
Managing Director
5/2010 – Present

Lead executive responsible for all aspects of a new office for a national health care consulting and actuarial firm.

- Responsibilities include business development, office operations, hiring and training of staff, and working with other geographic locations to develop synergistic products offerings to the health care industry.
- Primary business line includes strategic, managerial, and financial consulting to hospitals, physicians, accountable care organizations, commercial health insurance companies, state government and private organizations offering services to the health care market.
- Responsible for the development of new relationships with partner vendors and consultants and working with managing directors of other Wakely Consulting offices regarding improvements to standards and protocol across all of Wakely Consulting locations.

Milliman

Windsor, CT

Healthcare Strategy Consultant

3/2010 – 4/2010

Responsible for the development and financial performance of a new profit center focused on strategic and financial consulting in the health care market.

- Focus was primarily in the areas of providers and commercial health insurance payers, as well as state governments administering Medicaid managed care programs and preparing for the implementation of health care reform.
- Architect of a strategic business plan to expand the client base of the practice, as well as the development of business alliances with organizations offering complementary services to our core offering of health care services and products.

Commonwealth Health Insurance Connector Authority

Boston, MA

Chief Financial Officer

2006 – 2/2010

Primary duties included supervision of banking and accounting functions, oversight of programmatic and administrative budgets which included preparation of annual enrollment and financial projections, management of administrative expenses, as well as advising and assisting on all matters financial including rate negotiations with health plans, intermediaries and vendors.

- Developed the financial infrastructure of a start-up organization. Assembled the necessary financial accounting, reporting, budgeting, and operational infrastructure, while simultaneously supporting policy development and analytical needs to meet the tight timelines established by the healthcare reform legislation.
- Negotiated contracts with five managed care organizations to provide subsidized health insurance to low-income adult residents of Massachusetts.
- Negotiated annualized premium trend under 5% over four years for Commonwealth Care.
- Developed all necessary analytical and financial reporting systems to provide capitation payments in excess of \$800 Million annually to health plans participating in Commonwealth Care.
- Developed and implemented the Authority's accounting and financial reporting systems including payroll and accounts payable functions.
- Developed and monitored projections of administrative cost and report financial performance quarterly to key legislative (House and Senate) leaders.
- Developed programmatic financial budgets and enrollment projections of uninsured and private program take-up of health care coverage.
- Worked with financial institutions to secure a line of credit for the Authority.

Private Healthcare Systems

Waltham, MA

Vice President, Network Strategy

2005 – 2006

- Developed and executed a national physician and ancillary reimbursement strategy aimed at improving client access as well as the overall competitiveness of provider discounts.
- Created a new, centralized corporate department to support fifteen territory offices in contract analytics, proposal development, comparative analysis, and provider negotiations.
- Developed specific strategic initiatives regarding physician and ancillary services that were adopted by the organization and widely endorsed by customer constituents.
- Participated in a senior-level team to create an innovative contract incentive model linking provider contract negotiations to performance.
- Created and developed the necessary infrastructure and analytical expertise to facilitate the improvement of PHCS provider discounts for both physicians and national vendor arrangements.
- Worked closely with clients to ensure that emerging benefit design trends are aligned with provider contracts and reimbursement methodologies.
- Primarily responsible for elevating corporate and territory awareness about the increasing trend of physician cost and developed specific organizational and reporting changes to address such cost escalation.
- Developed a national vendor strategy to improve the level of discounts, service types offered to customers, and analytical approach to contract negotiation.
- Developed an innovative initiative in twenty-four key markets to significantly improve the level of provider discounts while maintaining access goals.
- Developed a “best practices” approach to contract negotiations that standardized the application of data analysis, which resulted in a more quantitative approach to physician and ancillary provider contracting.
- Supported regional leadership in the development of the business case for competitive contract proposals to large physician groups, IPA and PHO entities.

Tufts Health Plan

Waltham, MA

Assistant Vice President, Network Contracting & Performance Management

1997 – 2005

- Developed strategy and directed staff in all aspects of provider contracting initiatives with Hospitals and Physicians, including Integrated Delivery Networks (IDN's), throughout Massachusetts and parts of New Hampshire

and Rhode Island, for all commercial products lines (HMO/POS/PPO) including Medicare Advantage.

- Led the development of the plan-wide Medical Budget process and recommended approaches to benchmarking data and medical cost trend analysis.
- Worked closely with underwriting, actuarial and finance to develop necessary controls in the areas of financial reporting, contractual accruals, and the implementation of negotiated arrangements.
- Led staff in the successful negotiation of Commercial and Medicare Advantage risk contracts within Network budget parameters.
- Created various enhanced risk models that aligned specific incentives between providers and the Plan for certain negotiations. Responsible for educating internal staff on specifics of such models.
- Led the analytical work regarding medical cost trend, price point comparisons and expense accruals.
- Displayed creativity in analyzing data and presenting the position of the Plan during the successful negotiation of approximately 700,000 Commercial and 100,000 Medicare Advantage risk lives, representing over 175 unique contracts.
- Successfully challenged staff to “think differently” in the areas of data analysis, information presentation, and the development of internal workflows when engaged in provider negotiations.
- Presented to various committees, board of directors, employer groups, and other interested parties concerning the state of the provider network and plan strategy concerning various negotiations.
- Selected to participate during 2002/2003 in the AHIP (formerly the American Association of Health Plans) executive leadership program. The program is a one-year intensive study in which participants from health care companies across the country learn leadership skills, study best practices, and participate in various classroom and case study analysis.

EDUCATION

MBA, Health Care Administration, Suffolk University, Boston, MA, 1997

BS, Business Administration, University of Lowell, Lowell, MA, 1984

Jon M. Kingsdale, PhD

One Constitution Way, Suite 100, Boston, MA 02129

jonk@wakely.com • 339.927.1138

Profile

Executive, policymaker and strategist with extensive experience in health care financing, provider reimbursement, insurance product development and marketing, public affairs and general management. Worked in health insurance, government, consulting, academia and journalism.

Jon Kingsdale, Ph.D., is Managing Director and co-founder of the Boston office of Wakely Consulting Group. Prior to his current position, Jon was the founding Executive Director of the Commonwealth Health Insurance Connector Authority, an independent authority established in 2006 under Massachusetts' landmark health reform legislation. As the Executive Director for the first four years of reform, he led key initiatives to make health insurance universally available and to reform health care financing in Massachusetts. The Massachusetts experience was fundamental to national reform and the model for insurance reform and exchanges under the federal Patient Protection and Affordable Care Act of 2010.

Since leaving the Health Connector, Jon has consulted to various government agencies, non-profit and for-profit organizations on implementation of PPACA generally, and American Health Benefit Exchanges in particular. His clients include: USHHS, the California Health Care Foundation (CHCF), Academy Health, and the states of California, Illinois, Missouri, New York, Oregon, Rhode Island and Wisconsin. Through various foundations, Academy Health and the National Academy on State Health Policy, he has also worked with policymakers in Maryland, Minnesota, Ohio, Pennsylvania, Texas and Washington. He also provides strategy consulting to private-sector clients interested in health reform and insurance.

As a senior executive at the Tufts Health Plans for twenty years, Jon was responsible for strategic planning, product development, public affairs and government relations. Prior to Tufts Health Plan, he worked in strategic planning and reimbursement at Blue Cross of Massachusetts, researched hospital finances at the Harvard School of Public Health, consulted on health policy issues in Washington, D.C., and worked as a reporter for Forbes Magazine.

He received a doctorate in economic history from the University of Michigan and his bachelors' degree from the University of Pennsylvania. He has taught at the Harvard School of Public Health, the Boston University School of Public Health, Tufts University School of Medicine, and is currently a Lecturer in the Department of Health Care Policy at the Harvard Medical School.

Professional Experience

Commonwealth Health Insurance Connector Authority

Boston, MA

Executive Director

6/2006 – 6/2010

Responsible for starting and managing the state agency that played a central role in achieving near-universal insurance coverage in Massachusetts, and which became the model for national healthcare reform, enacted in 2010.

- Launched a health insurance exchange for publicly-subsidized enrollees, which went live four months after the authority began, per a very aggressive legislative schedule.
- Launched a second, web-based insurance exchange for unsubsidized individual and small-group purchasers in the authority's first year, per a very aggressive legislative schedule.
- Recruited a superb senior staff from the public and private sectors, and integrated them into a high-performing team, overseeing \$1 billion in annual funds flow.
- Oversaw development of a multi-faceted statewide outreach campaign, "Connect to Health," to promote awareness and understanding of the state's comprehensive health care reforms.
- Oversaw development of highly controversial health policy and of major procurements and achieved unanimous Board support for virtually all of them.
- Effectively managed relationships with Republican and Democratic Governors, the state legislature, multiple state agencies, dozens of interest groups, and nine private health plans.
- Achieved near-universal coverage in Massachusetts (over 97%) and a rate of increase in the private health insurance premiums that the Connector negotiated of less than 5% per year.
- Recognized in 2009 by Harvard's Kennedy School with its prestigious "Innovations in Government" award.

Tufts Associated Health Plans

Boston, MA

Senior Vice President for Planning and Development (1994-2006)

1986-2006

Responsible for strategic planning, corporate development, new product development and public affairs.

Vice President for Planning (1986-1994)

Responsible for strategy, corporate and product development.

As a member of the eight-person corporate leadership team, participated in most major decisions, represented the organization externally in various settings, and led the development of major initiatives.

- Negotiated and implemented strategic alliance with a network of 17 hospitals in MA and NH, thus doubling the provider network and positioning the Plan for 300% growth.
- Initiated a Medicaid contract and a customized network and product for the state Medicaid program (MassHealth) as part of the Plan's commitment to serving the broad community.
- Engineered entry into the Medicare market with a customized product that became the Plan's most profitable line of business and New England's leading Medicare HMO.
- Led senior management and the Board through a comprehensive reassessment of strategy in response to the "merger mania" of the mid-1990s, and developed a differentiated and highly successful growth strategy and supporting public relations campaign.
- Helped lead a successful, come-from-behind campaign to defeat a statewide ballot initiative in 2002 aimed at outlawing managed care.
- Developed two distinct and successful tiered-network products, including one which received an "Innovator of the Year" award from AHIP.
- Negotiated and managed strategic partnership with a South African insurer to create the market-leading, consumer-driven health plan in Massachusetts.

Blue Cross of Massachusetts, Inc.

Boston, MA

Assistant Director, Health Care Reimbursement (1984-1986)

1981-1986

Responsible for day-to-day management of 50 professionals in the design, administration and evaluation of approximately 30 reimbursement contracts, totaling over \$4 billion per year.

Manager, Health Care Planning (1981-1984)

Supervised professional staff of seven in benefits design, health care planning, corporate strategy, and contract development for home, hospice, and clinic-based health care services.

Harvard School of Public Health

Boston, MA

1981

Instructor and Project Coordinator for a detailed analysis of hospital cost accounting and cost trends.

Government Research Corporation

Washington, DC

Senior Health Policy Analyst

1976-1980

Responsible for consulting services to seven large health insurance companies.

Education

PhD, Economic History, University of Michigan, Ann Arbor, MI (1981)
BA, History, cum laude, University of Pennsylvania, Philadelphia, PA (1970)

Adjunct Faculty Appointments

Instructor, Harvard School of Public Health (1980-1981)
Adjunct Assistant Professor, Boston University School of Public Health (1983-1985)
Lecturer, Harvard Medical School (2010)

Boards & Commissions

Director, Mass. Association of Health Plans, Boston, MA (1994-2005); Vice Chairman (2001-2005)
Director, Ethos, Jamaica Plain, MA (2002-2007); President (2003-2006)
Director, Destiny Health, Inc., Chicago, IL (2004-2005)
Director, Network Health (2004-2006); Chair, Strategy and Development Committee (2004-2006)
Member, The Commonwealth Fund's Commission on a High Performance Health System (2010)

Publications

"The Poor Man's Club: Social Functions of the Urban Working-Class Saloon," *American Quarterly*, October 1973; reprinted in Joseph and Elizabeth Pleck (eds), *The American Man* (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1979)
"Labor and Management Sponsored Innovations in Controlling the Cost of Employee Health Care Benefits," in *The Complex Puzzle of Rising Health Care Costs: Can the Private Sector Fit It Together?* (Washington, D.C.: President's Council on Wage and Price Stability, 1976)
"Consumer Control over Medical Care," *Journal of Health Politics, Policy, and Law*, 1977
"Marrying Regulatory and Competitive Approaches to Health Care Cost Containment," *Journal of Health Politics, Policy, and Law*, Spring 1978
An Economic History of Hospitals in Baltimore, (New York: Garland Press, 1986)
"Implementing Health Care Reform in Massachusetts: Strategic Lessons Learned," *Health Affairs* web exclusives, May 2009
"Health Insurance Exchanges: A Typology and Guide to Key Design Issues," The Health Industry Forum, July 20, 2009
"Insurance Exchanges under Health Reform: Six Design Issues for the States," *Health Affairs*, June 8, 2010
"Health Insurance Exchanges: Key Link in a Better Value Chain," *New England Journal of Medicine* web posting May 12, 2010, publication June 24, 2010

Ross A. Winkelman FSA, MAAA
9777 Pyramid Ct., Suite 260, Englewood, CO 80112
rossw@wakely.com • 720.226.9801

Profile

Mr. Winkelman is a Senior Consulting Actuary and the Managing Director of the Denver office of Wakely Consulting Group. He joined the firm in January of 2007 to open the Denver office and has worked as a health actuary for 16 years.

Current Responsibility

Ross is a Senior Consulting Actuary and the Managing Director of the Denver office of Wakely Consulting Group. He joined the firm in January of 2007 to open the Denver office and has worked as a health actuary for over 15 years.

Experience

Prior to joining Wakely, Ross worked at two different insurance companies, an audit firm and was a Principal at Milliman. He specializes in risk adjustment and pricing for government sponsored managed care programs including Health Exchange, Medicaid, Medicare, and CHAMPUS.

Risk Adjustment Expertise

1. Led development of analysis of HHS proposed rules on risk corridors, reinsurance and risk adjustment and led development of a detailed work plan for
2. Committee Chair for development of Risk Adjustment Actuarial Standard of Practice (ASOP) for the American Academy of Actuaries' Actuarial Standards Board (ASB). ASOPs are binding guidance for actuarial practice. An exposure draft of this ASOP is pending.
3. Led the Society of Actuaries study on claim based risk adjustment methodologies (<http://www.soa.org/research/research-projects/health/hlth-risk-asement.aspx>)
4. Led actuarial development of the risk adjustment methodology for the Massachusetts Commonwealth Care (health reform) program
5. Led development of the risk adjustment methodology for the Arizona Medicaid program.
6. Published article on Medicaid risk adjustment methodologies in Health Watch, the SOA Health Section's publication (January 2008)
7. Worked on risk adjustment in other Medicaid programs, including South Carolina, Ohio, Illinois, Florida, Pennsylvania, Missouri, Illinois, Hawaii, Colorado and others
8. Advises Medicare Advantage health plan clients on Medicare HCC risk adjustment methodology

9. Led Milliman study on optimal methods for risk adjustment for renewal rating and published article in Health Watch related to the study
10. Use of risk adjustment tools in premium comparisons for large national health insurance carrier and use of risk adjustment tools in other analyses for the individual, small group and employer group markets
11. Worked with non-standard, consumer based risk adjustment methods and variables for health plans
12. Advised Congressional Budget Office (CBO) on risk adjustment models and methods for policy development
13. Worked with the American Academy of Actuaries to educate and advise policy makers on risk adjustment through policy brief and Webex presentation
14. Speaker including keynote at conferences on risk adjustment including several SOA conferences, risk adjustment vendor user conference, predictive modeling and others
15. Involved in SOA sponsored project on uncertainty in risk adjustment and on the project oversight group (POG) for other SOA risk adjustment studies

Health Reform Expertise

1. Lead actuary for rating and rate certification for the Massachusetts Commonwealth Care (CommCare) program
2. Lead actuary for procurement strategy and rating for the Massachusetts Commonwealth Choice (commercial health reform) program
3. Risk adjustment advisory role to CBO and other policy makers
4. Development of rating models and benefit design support for other reform programs including Colorado Medicaid expansion under DRA and the Massachusetts Medical Security Program (unemployed)
5. Health reform strategy consulting to several health plans, including Medicare Advantage, Medicaid, exchange and commercial markets
6. SOA's payment reform workgroup member

Ross is the lead actuary for the South Carolina Alliance of Health Plans (SCAHP) and the Indiana Association of Health Plans (IAHP) in their Medicaid rate negotiations with the State and has worked on Medicaid program rating in other states including Arizona, California, Colorado, Florida, Hawaii, Indiana, Mississippi, Nebraska, New Mexico, Ohio, and Pennsylvania. He is the certifying actuary for the Massachusetts Connector (health reform) program. Ross has filed Medicare bids on behalf of Medicare Advantage managed care companies for the last five years. He has experience on litigation projects and also has experience working on mergers and acquisitions, including several projects in Brazil. Ross led a team of actuaries and accountants in auditing Medicare filings for the Center for

Medicare and Medicaid Services (CMS). He has worked on triennial examinations of insurance companies on behalf of state insurance departments and has experience estimating liabilities in support of financial statement audits and litigation cases. Ross led two separate research projects for the Society of Actuaries (SOA), one on the commercially available risk adjustment software tools, and one on provider network risk.

Ross has advised CMS, states, insurance companies, military health services companies, PHOs, HMOs, PPOs, and other managed care organizations. He has developed rating models for many health plans, including developing the rating structures for the Chilean ISAPRE system.

Ross is an elected member of the Society of Actuaries Health Section Council, the former Editor for the SOA Health Section's newsletter (Health Watch), a contributing editor for Actuary magazine, former vice-chair of the SOA's Communications and Publications sub-committee, and a former member of the Society of Actuaries managed care exam committee. Ross was a contributing author for the book, "True Group Long Term Care". He is currently leading a committee that is developing a Risk Adjustment Actuarial Standard of Practice (ASOP) for the American Academy of Actuaries' Actuarial Standards Board (ASB).

Publications

- SOA Health Section News, January 2008 – Risk Adjustment in State Medicaid Programs
- SOA Research Project, 2007 – A Comparative Analysis of Claims Based Tools for Health Risk Assessment
- SOA Research Project, 2006 – Health Plan Provider Network Risk
- SOA Health Section News, August 2005 – Optimal Renewal Guidelines for Small Group Rating and Underwriting
- SOA Health Section News, August 2005 – Coverage of Spring SOA Meeting in New Orleans

Presentations

- "Medicaid Rating and State Budgets", SOA Spring Meeting 2010, Orlando
- Keynote Address, NAPEO meeting, 2009, Orlando
- Keynote Address, WRG Predictive Modeling, 2008, Las Vegas
- "SOA Risk Adjuster Research Project", WRG Predictive Modeling, 2007, Orlando
- "SOA Risk Adjuster Research Project", SOA Spring Meeting 2007, Seattle
- "SOA Risk Adjuster Research Project", SOA / DMAA Predictive Modeling Conference, 2006, Orlando, FL
- "SOA Risk Adjuster Research Project", SOA / DMAA Webinar, 2006 (Webinar)
- "Health Network Risk", SOA Spring Meeting, 2006, Hollywood, FL
- "Small Group Renewal Rating", LOMA Health Underwriting Study Group, 2005, New Orleans, LA
- "Optimal Renewal Guidelines for Small Group Rating", Milliman Health Forum, 2005, Tucson, AZ
- "Optimal Renewal Guidelines for Small Group Rating", Web Seminar, 2005, Denver, CO
- "Chile Health Cost Guidelines", Milliman Health Forum, 2003, Phoenix, AZ

- “Issues in Employer Health Insurance”, SOA Spring Meeting, 2002, Colorado Springs, CO
- “Health Insurance Valuation”, Mexican Actuarial Association, 2001, Mexico City, Mexico
- “Prescription Drug Rating”, Milliman Health Forum, 2001, Orlando, FL

Professional Designations

- Fellow, Society of Actuaries
- Member, American Academy of Actuaries

Education

BA, Mathematics and Statistics with Actuarial Science minor, Purdue University

Julia Lambert FSA, MAAA
17757 US Hwy 19 N, Clearwater, FL 33764
julial@wakely.com • 727.259.7474

Profile

Julia Lambert is a Principal in the Clearwater, Florida office and is Vice President of Wakely Consulting Group. She joined the firm in April of 2008 and has worked as a health actuary for 18 years.

Professional Experience

Wakely Consulting Group

Clearwater, FL

Principal

2008 – Current

- Lead actuary for SHOP exchange analyses for Illinois, Vermont, Delaware and Rhode Island.
- Lead actuary for several HMOs in various states, including CareMore Health Plans, HealthSun Health Plans, and Vantage Health Plans where responsibilities include product design and rating, feasibility studies, rate certification, and valuation for Medicare, Medicaid, commercial group, and commercial individual products.
- Responsible for firm's model development and training related to Medicare bid work.
- Modeling impact of Medicaid eligibility expansion and pharmacy Carve-in/Carve-out analyses in Ohio on behalf of Association.
- Performed expert witness work for various health care related practice areas, including pharmacy programs, risk adjustment, and Medicare Advantage.

Reden & Anders/Ingenix Consulting/now Optum Insight, Denver, CO

Managing Principal

2000 – 2008

- Appointed Medicare Actuarial Practice Leader responsible for the actuarial bidding process and Medicare strategy for the entire Reden & Anders actuarial practice.
- Provided strategic assistance on proposed and passed legislation. Advised client lobbyist on Medicare payment reform and been involved in discussions with MedPAC. This drove critical business decisions that had a significant impact on profitability.
- Developed feasibility studies for diverse products and services including Medicare, Medicaid, large group, and small group populations.
- Evaluated health care liabilities and complete actuarial opinions for financial statements

- Actuarially certified large group and small group rate filings, Medicare bids, and small group rating methodologies.
- Forecasted revenues, costs, and financial profitability for diverse products and services
- Established required rates and project costs for various products with emphasis on Medicare Advantage plans.
- Determined risk targets, incentives, and capitation rates for provider contracts.
- Performed reimbursement analyses used for contract negotiations and establishing unit cost trends.
- Provider contracting analyses and negotiations: By comparing the differences in underlying demographics, health risks, unit costs, and utilization for the members associated with providers, carrier clients have been able to improve provider contracts through negotiations.
- Unit cost and utilization trend analyses: Created service reports that analyze unit cost and utilization by provider group, service category, and time period, allowing the improvement of forecasts and expected outcomes.
- Underwriting and group pricing: Quantifying costs for large employers or carriers using detailed claims experience. Group renewals and new quotes, taking into account changes in plan designs, including high-deductible health plans, member cost-sharing, benefit maximums, and mandates.
- Facilitated the introduction of a new individual line of business by investigating competitor products, researching state regulations, generating scenario testing, integrating expected underwriting results, and establishing models to convey outcomes easily to the client.
- Reserve-setting: Oversee IBNR and lag adjustment expense reserve analyses for several clients.
- Forecasting and budgeting for health plans, implementing changes in risk scores. Deliver results to management determining participation in a particular line of business.

Leif Associates, Inc., Denver, CO

Consulting Actuary

1997-2000

- Provided large group underwriting assistance to HMOs
- Prepared Colorado Annual Reports for HMOs, insurance companies, and dental carriers. These reports require that the rates/capitation amounts for all lines of business (including Medicaid and Medicare) be examined for appropriateness and adequacy in relation to the claims experience, risk contracts, reinsurance, and administrative expenses of the company.
- Evaluated carrier compliance with applicable state and federal small group law and regulations.
- Completed rate filings for HMOs, insurance companies, dental carriers, and mental health providers in various states.

- Completed reserve valuations for HMOs, self-funded employer health plans, employer trusts, mental health agencies, and state agencies.
- Studied the therapy needs of children with developmental delay and established projected costs of coverage.
- Established beginning claim costs used for establishing FAS 106 valuations for self-funded retiree medical plans.

Great-West Life, Englewood, CO

Assistant Actuarial Manager

1996 – 1997

- Supervised initial HMO rate filings in multiple states including pricing benefits and plan designs.
- Created and tested computer rating models for national health products
- Responded to field questions regarding plan design, benefits, and pricing on newly released copay plans.
- Priced and coordinated release of PPO copay plans in hospital only networks.
- Set POS targets for risk-sharing medical groups.

Physicians Mutual, Omaha, NE

Senior Actuarial Associate

1993 – 1996

- Designed and programmed the Agency Profitability Measurement System for life and health products
- Designed and priced new 10 year life product
- Modeled profitability of all life policies for five years
- Collected data and compiled information for the annual persistency study
- Priced various optional health benefits

University of Nebraska-Omaha, Omaha, NE

Mathematics Lecturer

1993 – 1996

- Taught Discrete Mathematics (logic, probability, statistics) and Linear Algebra to mathematics and computer science students

Education

Masters of Science, Mathematics, University of Colorado-Boulder, (1992)

Bachelor of Science, Magna Cum Laude, Secondary Education, University of Nebraska-Lincoln, (1989)

Professional Designations

Fellow, Society of Actuaries (FSA)

Member, American Academy of Actuaries (MAAA)

Professional Affiliations

Participant of Medicaid Certification Workgroup of the American Academy of Actuaries

Publications

SOA Health Section News, January 2009 – Full Coverage through the Gap – An Endangered Benefit?

Presentations

“SOA Bootcamp”, Speaker and Panelist for various Medicare related presentations at the SOA sponsored meeting, November 2011, Nashville

“Is the Humana \$14.80 PDP plan sustainable?”, Prime Therapeutics’ Government Programs Symposium, June 2011, Vegas

“Impact of Medicare Advantage Payment Reform”, Coventry Actuarial Meeting, November 2010

“Medicare Part D 2010 and Beyond”, SOA Spring Meeting, June 2010, Toronto

“Public Programs for Medical Risk Adjustment in the United States”, SOA Annual Meeting, October 2009, Orlando

“SEAC Health Topics: Follow-up to Health Concurrent Sessions”, Moderator, SEAC Fall Meeting, November 2009

“Validating Revenue and Financial Reconciliation”, FRALL Webinar Series, Fall 2009

“Part D”, SOA Spring Meeting, June 2009, Boston

“Whats Whys and Hows of Coding Audits”, FRALL, March 2009, Phoenix, AZ

“Key Considerations for Estimating Final Payment Reconciliation Amounts”, FRALL, June 2008

“Closing the Books”, Financial Management April 2008, Washington DC

Mary Hegemann FSA, MAAA
9777 Pyramid Ct., Suite 260, Englewood, CO 80112
maryh@wakely.com • 720.226.9802

Profile

Mary Hegemann is a Senior Consulting Actuary in the Denver office of Wakely Consulting Group.

Professional Experience

Wakely Consulting Group

Denver, CO

Senior Consulting Actuary

2008 – Current

Responsible for managing client projects:

- Lead actuary for exchange planning for Colorado, Illinois, and Rhode Island. Also support actuarial analyses for exchange planning related to work funded by Robert Wood Johnson Foundation grant and analyses specific to Delaware, Missouri, and New York.
- Lead actuary for St. Louis Regional Health Commission “Gateway to Better Health” Demonstration Program.
- Co-lead actuary for the Massachusetts Connector rate certification and development of the CommCare risk adjustment methodology.
- Lead actuary for CareOregon Medicare and Medicaid programs. Responsible for CareOregon’s rate certification, signing year-end actuarial opinions for financial statements, and help with provider contract work.

Reden & Anders (Ingenix Consulting), Denver, CO

Consulting Actuary

2006 – 2008

- Public sector work / Medicaid: Actuarial certification of rates for the New York HIV/AIDS special needs plans and the West Virginia TANF and SSI populations. This involved using claims, eligibility, and other financial data provided by states and carriers to establish projections of actuarially sound capitation rates for participating managed care organizations. Public sector work / High-risk pools: Actuarial certification of the standard health questionnaire for the Washington State Health Insurance Pool (WSHIP). Led team in analyzing claims data provided for over 95% of people in Washington covered by individual health policies and calculated the prospective risk for all medical conditions using risk score technologies in order to develop a health questionnaire that will identify the 8% highest cost individuals in that State. Presented results to and worked collectively with carrier, consumer, and division of insurance representatives.
- Actuarial attestations: actuarial memorandums, actuarial opinions, small group certifications, and rate filings. Have submitted actuarial documents to

state regulators for large group, small group, and individual lines of business in Louisiana, Florida, and New York.

- Actuarial certification for Medicare MA and Part D Bids: Led team of consultants and analysts in analyzing Medicare revenue, expenses, and benefit packages in four service areas. Produced a quality product in a timely manner under strenuous CMS-imposed guidelines and timeframes resulting in a very satisfied client. Work involved analyzing new products, and with the success of several existing products, the client was able to expand into three new service areas.
- Provider contracting analyses and negotiations: By comparing the differences in underlying demographics, health risks, unit costs, and utilization for the members associated with providers, carrier clients have been able to improve provider contracts through negotiations.
- Unit cost and utilization trend analyses: Created service reports that analyze unit cost and utilization by provider group, service category, and time period, allowing the improvement of forecasts and expected outcomes.
- Underwriting and group pricing: Quantifying costs for large employers or carriers using detailed claims experience. Group renewals and new quotes, taking into account changes in plan designs, including high-deductible health plans, member cost-sharing, benefit maximums, and mandates.
- Facilitated the introduction of a new individual line of business by investigating competitor products, researching state regulations, generating scenario testing, integrating expected underwriting results, and establishing models to convey outcomes easily to the client.
- Reserve-setting: Oversee IBNR and lag adjustment expense reserve analyses for several clients.
- Forecasting and budgeting for health plans, implementing changes in risk scores. Deliver results to management determining participation in a particular line of business.

Leif Associates, Inc., Denver, CO

Consulting Actuary

2000 – 2006

- Performed SCHIP rate development each year for the Department of Health Care Policy and Financing at the State of Colorado. Assisted in establishing the State appropriation for the program and the capitation rates paid to participating health plans. This involved an intimate knowledge of the inner workings of Medicaid and the Colorado SCHIP program. Establishing rates: forecasting of premiums necessary to meet projections of claims and expenses, with consideration of provider contracting changes and underlying unit cost and utilization trends.
- Public sector work/High-risk pools: Reserve-setting, fund projections, establishing carrier assessments, working directly with state legislators in drafting Bills, establishing premium rates and plan designs for the high-risk pool in Colorado. Performing audits related to the TPA's and PBM's

processing of claims, including pre-existing conditions, application of member cost-sharing, pre-certification penalties, and premium billing. Also performed feasibility study for the State of Ohio to ascertain the state's capability to incorporate a high-risk pool. Product pricing: Quantified costs for large employers or carriers using detailed claims experience. Took into account changes in plan designs, including high-deductible health plans, member cost-sharing, benefit maximums, and mandates. Group renewals and new quotes: Developed rate models used by underwriters and brokers for small and large groups, as well as individual products. Reserve-setting: Developed IBNR and lag adjustment expense reserve estimates for public and private clients. Actuarial attestations: Actuarial memorandums, actuarial opinions, annual rate reports, small group certifications, and rate filings in Colorado and Wyoming.

Great-West Life, Englewood, CO

Actuarial Assistant

1996 – 2000

Product pricing for HMO, PPO, and indemnity products.

Conducted studies of asset-liability relationships using cashflow testing models.

Relevant Project Experience

Exchange Planning – Actuarial Analyses

Colorado, Illinois, Rhode Island, Missouri, Delaware, and New York

May 2011 – ongoing

Exchange Planning: For several states, Wakely has led the actuarial analysis regarding the impact of the Affordable Care Act (ACA) on individual and small group markets, including premium impacts due to morbidity changes, the predicted prevalence of premium and cost-sharing subsidies, changes to benefit designs to meet actuarial value requirements, changes in premiums due to minimum loss ratio (MLR) requirements, and pricing incorporating essential benefits. Analyses have typically incorporated working with carriers to accumulate their data in conjunction with using publicly available data sources. Wakely is also subject matter experts for states evaluating needs around risk adjustment and reinsurance under the ACA.

St. Louis Regional Health Commission

St. Louis, Missouri

September 2010 – ongoing

“Gateway to Better Health” Demonstration Program: The St. Louis Health Commission (Commission), “Gateway to Better Health” demonstration program transitions Federal block funding for Federally Qualified Health Centers (FQHCs) to a coverage plan model. Wakely has been providing the Commission with actuarial and strategic support in the development of benefits, provider contracting approaches, network development, administration service costs, target funding and other areas. Wakely has participated in many meetings with the Federally Qualified Health Centers (FQHCs) and other interested safety net providers. We developed health benefit pricing and structural framework to be

submitted with the follow up application / progress report that needs to be delivered to CMS on January 1, 2011. While we have performed the typical actuarial analysis on this program with data from the safety net providers and the CommCare data through a data use agreement with the Massachusetts Health Connector, we have also provided significant strategic advice in designing the financial incentives and rewards for the providers and members.

MA Health Connector

Commonwealth of Massachusetts

2008 – ongoing

Benefit Plan Modeling and Pricing, and the Implementation of Risk Adjustment to the Commonwealth Care Program: The Commonwealth Care program is a state and federally subsidized health insurance program for low income adult residents without access to employer-sponsored insurance. We are assisting or have assisted the MA Health Connector in the following areas: selection of assumptions; capitation rate build-up; RFP development; MCO rate negotiations; selection and calibration of risk adjustment model; impact of benefit changes; financial and MCO impact of eligibility rule changes, including the Aliens with Special Status (AWSS) population; consideration of risk adjustment model implementation into rating approach; anticipating and developing responses to health plan questions; identifying risks with the risk adjustment model, data and implementation; on-site presentations to MCO contractors; and other strategic advice and support.

We are also assisting the MA Health Connector on the Commonwealth Choice program, a private insurance exchange for individuals and small business, in the following areas: minimum credible coverage rules and impacts of changes; benefit, provider contracting and procurement modeling for the Medical Security Program (subsidized health insurance for the low-income unemployed); selecting standardized benefit designs; procurement development and proposal evaluation; evaluating proposed rates from carriers; report development and contractor monitoring; and strategic advice and support.

State of Colorado

Department of Health Care Policy and Financing

2009 – 2010

Analysis of Benchmark Plans for Medicaid Expansion: Analyzed various benchmark plans allowed for Medicaid expansion populations under the Deficit Reduction Act (DRA). Analysis focused on the review of claim cost projections associated with the benchmark plans and a population largely concentrated toward adults without dependent children, and a population who falls below 100% of the federal poverty limit (FPL). The benchmark plans analyzed were: Colorado State Employee Plan; Colorado's Largest HMO; FEHB Plan; Colorado Medicaid; Kansas Medicaid Expansion; Kentucky Medicaid Expansion; Idaho Medicaid Expansion; Virginia Medicaid Expansion; West Virginia Medicaid Expansion; and Washington Medicaid Expansion.

Our analysis involved using underlying base period data that we believe to be comparable to the Medicaid expansion population in Colorado. The Massachusetts health care system data was used in conjunction with this Colorado specific data.

State of Arizona

Arizona Health Care Cost Containment System (AHCCCS)

2008 – 2010

Arizona Medicaid Risk Adjustment: Wakely developed the risk adjustment methodology for AHCCCS two years ago and has worked with them to update the methodology and results on a yearly basis. Our work has included the following areas: selection of risk adjustment model; calibration of risk adjustment model; implementation of model into both bidding and rating approach; anticipating and developing responses to health plan questions; and communicating the methodology and results to health plans.

Medicare Advantage Bids

Wakely develops and certifies Medicare Advantage bids for a number of health plans. Bids are developed consistent with CMS instructions and requirements and are subject to review after submit and periodic actuarial and financial audits. The Medicare Advantage program has a very robust risk adjustment program. We assist our clients in understanding changes in the risk adjustment methodology and model, estimating the impact of changes in coding practices and health plan enrollment.

Commercial Clients

Wakely consultants assist health plans in pricing and filing individual and small group health benefit products. This work includes developing area factors, age/gender factors, the impact of benefit changes, and new business and renewal underwriting.

Education

BA, Actuarial Science and Mathematics, University of Nebraska, Lincoln, Nebraska (1996)

Professional Designations

Fellow, Society of Actuaries (FSA)

Member, American Academy of Actuaries (MAAA)

Professional Affiliations

Colorado Group Insurance Association (CGIA) Legislative Committee 2005 – 2006

Julie Peper FSA, MAAA

9777 Pyramid Ct., Suite 260, Englewood, CO 80112

JulieP@wakely.com • 720.226.9814

Profile

Julie Peper is a Senior Consulting Actuary in the Denver office of Wakely Consulting Group.

Professional Experience

Wakely Consulting Group

Denver, CO

Senior Consulting Actuary

2011 – Current

- Lead or supporting actuary for exchange planning for Delaware, Colorado, Illinois and Rhode Island. This work includes actuarial analysis to assess the premium impacts of the various Affordable Care Act (ACA) requirements
- Support for Robert Wood Foundation grant work around exchange planning for risk adjustment and reinsurance
- Led prescription drug analysis for client to determine amount of government program prescriptions that may have not been paid in accordance with federal and state laws
- Supporting clients in feasibility studies for Medicaid managed care programs in several states

Ingenix Consulting, Denver, CO

Managing Director

2007 – 2011

- Provided actuarial support for a state's health care reform agenda, including review of benefit designs, actuarial assumptions, comments regarding projected costs and savings, and contributed to the legislative report detailing the findings
- Oversaw the monthly reserve process for a health plan with almost \$1 billion in reserves
- Established Medicaid rates for a competitive bid process, including recommendations to the state on their proposed risk adjustment methodology. The process enabled the plan to grow membership over 50%
- Utilized software to group data into treatment groups to develop risk factors by condition that supported scoring criteria for a standard health questionnaire for a state's individual health insurance market
- Provided support to a hospital in their financial negotiations with a health plan and provider group in developing a three party risk contract

- Oversaw the building of a financial forecast model for a company with over \$1.5 billion in annual revenue
- Analyzed data for a disease management program to determine if the program is providing savings by moving members to equally effective but lower cost medical care
- Support for Medicare Advantage and Part D bid submissions and analyses

Kaiser Permanente, Denver, CO

Managing Actuary

2005 – 2007

- Directed all actuarial functions in Colorado, including reserves and forecasting, fee schedules, pricing and monitoring of all lines of business, product development, and staff management. Also provided strategic input as a member of the marketing, sales and business development leadership team.

Anthem Blue Cross and Blue Shield, Denver, CO

Director II

2004 – 2005

- Responsible for pricing and related functions for all lines of business, including individual, small group, large group, dental, vision and Medicare Supplement for Colorado and Nevada
- Accountable for provider contract analyses related to facility negotiations
- Member of the actuarial committee that determines the impact of moving certain prescription drugs on or off formulary

Deloitte Consulting LLP, Illinois and Colorado

Senior Manager

1997 – 2004

- Managed a range of projects for a mid-size HMO, including but not limited to the creation of management and provider network reporting packages, book of business analyses, and rate development and filing
- Supported the actuarial department of a health plan in aligning pricing strategies for various product offerings
- Provided guidance to the underwriting department of a health plan with respect to current rating methodologies, policy implementations and decision-making controls
- Created an Administrative Expense allocation model for a BCBS plan
- Led team and organized communications between consultants, client and vendor in renegotiation of \$50 million behavioral health contract
- Directed and performed modeling for benefit design strategy, renewals, trend analyses, utilization studies, vendor negotiations and funding arrangement alternatives for a variety of employer clients

Triple-S, Inc., Puerto Rico

Actuarial Analyst

1994 – 1997

- Assisted top management in safe guarding the stability and solvency of the largest health insurance company in Puerto Rico through liability calculations, community and individual rate development and filing, trend analysis and pricing of large group accounts

Education

BS, Mathematics, Valparaiso University, Valparaiso, Indiana

Professional Designations

Fellow, Society of Actuaries (FSA)

Member, American Academy of Actuaries (MAAA)

Ann Hwang, MD

One Constitution Center, Suite 100, Boston, MA 02129

AnnH@Wakely.com 617-939-2005

Profile

Ann Hwang, MD is a Senior Consultant with the Wakely Consulting Group. She provides strategic and policy advice to states that are developing health insurance exchanges as part of health reform. Prior to joining Wakely, she was Senior Health Policy Advisor to the Commonwealth Health Insurance Connector Authority, where her work focused on evaluating the potential impact of national health reform on states, particularly Massachusetts, and helping to implement national health reform at the state level. She has conducted analyses of policy issues relating to health reform, such as affordability, mandate compliance, and program design. Dr. Hwang brings legislative and public policy experience at both the state and national level, having previously worked as a legislative aide to U.S. Senator Richard J. Durbin and as a program associate with several non-profit policy organizations.

Dr. Hwang is an internist at Brigham and Women's Hospital in Boston and a clinical instructor at Harvard Medical School, where she teaches medical students, residents, and mid-level providers. She received her medical degree from the University of California, San Francisco, and completed her internship and residency in internal medicine at Brigham and Women's Hospital.

Professional Experience

Commonwealth Health Insurance Connector Authority

Boston, MA

Senior Health Policy Advisor

9/2009 to 12/2010

- Assessed impact of national health reform on Massachusetts
- Worked collaboratively with other agencies toward implementation of national health reform
- Provided analysis on policy issues of interest to the Health Connector, such as affordability, mandate compliance, and program membership
- Utilized a range of analytic methods including statistical analysis of primary datasets, review of secondary sources, development of survey tools, and legislative analysis

Brigham and Women's/Faulkner Hospitalist Program, Harvard Medical School (HMS)

Boston, MA
Staff Physician and Clinical Instructor
7/2009 to present

- Attend on general medicine service
- Supervise and teach house staff, physician assistants, and medical students
- Teach in HMS introduction to clinical medicine and health policy courses

Office of Richard J. Durbin, United States Senator

Legislative Fellow
9/2004-11/2005

- Drafted legislation, oversight letters, and statements on international and domestic health issues
- Worked for the successful passage of budget and appropriations amendments to increase support to international HIV/AIDS programs
- Selected as an American Association for the Advancement of Science (AAAS) Congressional Science and Technology Policy Fellow

Community Activities

Pre-Medical Advisor, Currier House, Harvard College
Volunteer Clinician, New England Center for Homeless Veterans

Education and Training

Internship and Residency, Internal Medicine, Brigham and Women's Hospital, 6/2006-6/2009

Licensed in Massachusetts and board certified in internal medicine

MD, School of Medicine, University of California, San Francisco, 2003

Regents' Scholar

MPhil, History and Philosophy of Science, Cambridge University, 1998

Keasbey Scholar

AB, summa cum laude, Biochemical Sciences, Harvard University, 1997

Phi Beta Kappa, Captain Jonathan Fay Prize and Diploma, Jacob Wendell Scholar

Kathie J. Mazza

One Constitution Center, Suite 100, Boston MA 02129

KathieM@Wakely.com • 781 248 6127

Profile

Ms. Mazza brings to Wakely an extensive health care background with a distinguished track record in sales and sales management, product strategy, sales and marketing operations, marketing/public relations and customer service. She has strong leadership skills, is able to lead with influence and regards listening as a key skillset of a strong communicator. Career path has been distinguished by notable successes in exceeding sales targets and in leading projects on time, to plan and on budget.

Ms. Mazza joined Wakely in March of 2011 as a Senior Consultant. She has worked closely with the states of Illinois and New York on exchange planning, timeline assessment and implementation activities. This work has including the development of a business operations plan, goal setting, needs assessment, and marketplace and broker analyses.

Professional Experience

MultiPlan, Inc. (acquirer of Private Healthcare Systems)

Waltham, MA

1999-2/2011

Director, Product Strategy/Sales Support

Divisional lead charged with planning and executing a complex, multi-year effort to integrate all PHCS clients onto MultiPlan platforms impacting all customer touch points, including claim re-pricing, billing, network data, as well as the combined product portfolio. Reported directly to the Chief Sales and Marketing Officer.

- All 300 plus clients successfully implemented on time and on plan
- Effort required extensive educational focus for sales teams from both companies in order to ensure optimal cross selling for revenue generation and effective management of client relationships for future positioning
- As a result of this success, selected to represent Sales and Account Management Division on corporate Integration Team under COO's Strategy and Planning group following company's March 2010 acquisition of largest competitor

Director, Sales and Marketing Operations

Responsible for leading four departments charged with executing the CMO's business plan (Client Implementations, RFP and Analytics group, Account Service Support and Customer Project Management)

- Successfully led 3 year major undertaking to convert all customers to a claims re-pricing engine; achievement of goal resulted in award of unique incentive from the Office of the President

- Significantly improved quality and accuracy of RFP process through the development of a Subject Matter Expert (SME) program and achieved a 99.9% performance standard on turnaround time for more than 10,000 annual client requests for analytics and RFPs
- Conceived and led development of Customer Snapshots, a web based application that allows managers and employees throughout the country to readily access profiles of all 300+ corporate customers
- Collaborated with Finance Division on creation and production of monthly Revenue, Forecasting & Sales Performance Book for CEO, CFO and CMO

Director, Client Services

Responsible to the CMO for increasing Network and Care Management product line revenues and membership through leadership of one of two Account Management teams charged with growing the customer base; performed all sales management functions from forecasting and business planning to management, training and development of staff.

- Achieved successive year over year corporate revenue growth of 106% (2003/2002); 107% (2002/2001); 106% (2001/1999), with annual revenue targets exceeded in 3 of 4 years
- Represented customer needs in successful implementation of multiple new systems needed for Y2K

Fallon Community Health Plan

Worcester, MA

1997-1998

Manager, New Sales

Managed sales staff of six; developed and expanded broker distribution channel; created sales pipeline reporting process; designed sales cycle model; recommended pricing parameters and implemented sales campaigns in position reporting to CMO.

- Exceeded sales quota in every quarter (new sales results ranged from a minimum of 118% of quota to a high of 222% of quota)
- Expanded broker distribution channel by more than 20%
- Sold nine Target accounts in 1Q98
- 1997 marked Fallon's third best sales year in its' 20-year history

Blue Cross Blue Shield of Massachusetts

Boston, MA

1980-1996

Director, Business Consulting and Public Relations

Conceived and managed special events and community programs for \$1.8B sales and

service division; directed business planning process; developed targeted advertising strategies and managed Health Information Service Center (HISC).

- Produced calendar of over 100 customer events and community programs
- Leveraged \$75K of free television and print media time for one PR event that resulted in a direct mail response of more than double the industry standard
- Developed and implemented print advertising campaign to deliver focused sales messages in targeted areas
- Managed and produced 1996 divisional Business Plan
- Downsized and closed experimental Service Center (in retail shopping mall) 4 months ahead of schedule

Business Unit Leader, Central Region

Directed sales team of 8, service group of 15 and off-site service center staff of 9.

- Sold largest account throughout division in 1995 (\$24M annual premiums) and largest account in region in 1994; retained 98% of existing customer accounts
- Produced special events for Central Region that resulted in the creation of a new Public Relations position within the sales division

Major Account Executive

Managed largest accounts in Central Massachusetts.

- Retained 100% of clients and delivered significant growth in 2 flagship accounts (DEC and Norton Company)

Director, Marketing Services

Delivered professional training/development and developed special marketing projects and programs.

- Conceived and developed eye wear discount program and a health club network for more than 2M BCBSMA members
- Researched, wrote and produced a comprehensive internal and external presentation manual on Other Party Liability; later invited to present material to a South Carolina sales force

Director, Product Management

Initiated new product development and managed existing group product portfolio.

- Directed major corporate effort to revitalize flagship indemnity product while HMO and PPO products were under development or redesign
- Assessed utilization review protocols and implemented new standards to achieve cost savings
- Forecasted member enrollment in group products within 5% of actual enrollment

Director, Customer Service

Managed staff of 225 in home office, directed and measured customer service activities in eight regional offices.

- Directed efforts of senior managers to address CEO mandate to improve service performance
- Conceived “The Great Mail Blitz” a campaign that established a corporate record for reducing customer correspondence inventory.

Various Sales Positions

Account sales, territory management and major account retention.

- Retained 100% of clients each year, every year
- Sold national managed care benefits to Stone & Webster, a large prestigious house account
- Recognized as “Sales Representative of the Year” in 1983
- Selected to fill a new, highly coveted position managing national/major accounts

Education

BA, *Magna Cum Laude*, Wheaton College, Norton, MA, 1979

Wheaton Scholar. Concentration in Economics. Selected as an Exchange Student for Williams College (1977-1978), Certified Health Consultant (CHC)

James Woolman

One Constitution Center, Suite 100, Boston, MA 02129

JamesW@wakely.com • 617-939-2009

Profile

James Woolman is a Senior Consultant working in the Boston office of Wakely Consulting Group. From 2006 to 2010, James helped build and manage the Commonwealth Health Insurance Connector Authority, the independent authority established in 2006 to implement Massachusetts' historic health reform legislation. As the Manager of Finance and Analytics, James was responsible for developing and managing the Connector's analytical, reporting, and health care finance functions. He was also instrumental in developing strategy for multiple health plan procurements and helped develop a number of innovative payment strategies, bidding incentives, and risk sharing and risk adjustment programs. James also has significant experience in public and private health insurance with a deep understanding of health care finance, policy, and strategy. He has worked in provider contracting and product development for a commercial HMO based on Massachusetts as well as the finance area of the Massachusetts Medicaid program, where he worked on provider reimbursement, budgeting, and fiscal policy. James holds a Master's Degree in Public Policy from the John F. Kennedy School of Government at Harvard University, where he concentrated in health care policy and financial management. He received his Bachelor's Degree in History from Columbia University.

Professional Experience

Extensive knowledge of health care finance, policy, and operations, with particular focus on reimbursement strategies, financial and clinical analytics, risk modeling, negotiation strategy, and budget development. Excellent analytical abilities combined with strong strategic thinking and innovative problem solving skills. Strong leadership, interpersonal, and communication skills. Demonstrated abilities in project management, information systems, vendor oversight, and staff development.

Work Experience

Wakely Consulting Group

Boston, MA

May 2011 – Present *Senior Consultant*

Tufts Health Plan

Watertown, MA

May 2010 – May 2011

Senior Manager, Contracting Strategy & Analytics

Developed network contracting strategy for nation's second highest rated HMO, covering 750,000 commercial and Medicare Advantage members in Massachusetts and Rhode Island. Provided strategic and analytical thought leadership to ongoing provider contract negotiations and represented Network Contracting on critical corporate initiatives. Worked closely with Actuarial, Government Affairs, and Product Strategy departments to ensure that contracting efforts supported pricing, product, and regulatory imperatives. Developed strategic content and presented often to senior leadership.

- Initiated and led the development of a comprehensive network and product strategy to align contracting efforts with changes in the marketplace related to reimbursement, medical management, and product development, subsequently adopted by senior leadership as dominant corporate strategy.
- Led network-related components of a new tiered-network product, a major competitive priority. Created a novel cost and quality-based tier placement methodology, developed provider negotiation and communication strategy, and represented network contracting on cross-functional product development workgroup.
- Led the assessment and re-alignment of operational and analytical capabilities to support transition to risk-based reimbursement, focused on the development of enhanced financial controls and scalable analytic infrastructure.
- Managed the development of critical unit cost inputs to annual corporate planning and pricing processes.

Commonwealth Health Insurance Connector Authority

Boston, MA

Nov 2006 – May 2011

Manager of Finance & Analytics

Helped build new agency created to implement Massachusetts' historic universal health coverage expansion. Responsible for developing and managing analytical infrastructure and health care finance functions for a Medicaid managed care program and commercial insurance exchange for individuals and small businesses, together covering roughly 200,000 individuals. Worked closely with senior management on a wide array of ad-hoc and cross-functional projects. Displayed creativity in developing solutions to complex strategic, tactical, and operational challenges. Managed two FTE's and several analytical and actuarial vendor contracts worth approximately \$500,000 annually.

- Developed strategy for three major managed care procurements covering 170,000 lives worth approximately
- \$900 million per year. Created innovative payment strategies, bidding incentives, and risk sharing programs that saved the state more than \$100 million over three years.
- Designed and implemented novel risk adjustment methodology that fit successfully within a competitive bidding model. Achieved negative year-over-year capitation trend while attracting a new, for-profit market entrant, a first for Massachusetts.
- Managed financial components of five MCO contracts, including capitation payment and rate development, financial reporting, and administration of risk sharing settlements. Worked effectively with contracted health plans to explain and administer complex payment terms.
- Built analytic and reporting infrastructure, including SAS-based data management and claims/eligibility reporting processes and the introduction of DxCG predictive modeling.
- Performed extensive population and financial modeling to forecast enrollment, administrative revenue, and program cost. Worked closely with state budget staff to develop annual program budget and Medicaid waiver renewal.

Massachusetts Division Of Health Care Finance And Policy

Boston, MA

May 2005 – Nov 2006

Senior Health Policy Analyst, Pricing Policy and Financial Analysis Group

Designed, executed, and presented complex financial and clinical analyses to support senior level decision-making related to Medicaid payment policy. Selected projects include:

- Performed all financial projections and acuity analyses during nursing facility and outpatient hospital contract rate development (combined annual spending: \$1.9 billion).
- Developed a DRG-based model to predict the financial impact of changing the Uncompensated Care Pool, a safety-net program for uninsured and underinsured individuals, to a Medicare-based payment adjudication system.
- Created payment model for the state's first contract for nursing home-based acquired brain injury services.
- Participated actively in contract negotiations and provided all related financial analysis.

Community Catalyst, Inc.

Boston, MA

Sep 2004 – May 2005

Consultant, Prescription Access Litigation Project

Analyzed state and federal prescription drug reimbursement policy for consumer advocacy organization seeking to influence policy reform.

- Wrote a 45-page report highlighting opportunities for drug pricing reform.
- Co-authored published article on Medicaid pharmacy reimbursement.

Boston, MA

Summer 2004

Summer Associate

Analyzed strategies to expand health insurance coverage among small businesses. Researched developments in consumer-driven health insurance and tax-exempt hospital financing.

Michael Shen & Associates, P.C.

New York, NY

Aug 2002 – Aug 2003

Paralegal

Supported all legal and administrative functions for a small New York-based law firm specializing in plaintiff-side employment discrimination.

Education

Harvard University, John F. Kennedy School Of Government

Master of Public Policy, June 2005.

Dual concentration in Health Care Policy and Financial Management.

Columbia University

Bachelor of Arts in History, May 2002,

Phi Beta Kappa, magna cum laude, Departmental Honors.

Steven McStay

One Constitution Center, Suite 100, Boston, MA 02129

SMcStay@comcast.net . 978-210-5402

Profile

Steven McStay brings more than 15 years of experience in project and program management with software implementations and infrastructure projects, particularly in the areas of eligibility and enrollment.

Prior to joining the Wakely team, Mr. McStay was a member of the program team developing and implementing all operating policies and procedures of Massachusetts' health care reform program Commonwealth Care.

His most recent accomplishments include working with internal and external customers in strategy development, requirements definition and implementations of Medicaid Management Information Systems, Premium Billing and Enrollment Systems, and Customer Relationship Management systems.

Mr. McStay has a Master's in Business Administration from the Monterey Institute of International Studies and a Bachelor of Arts degree in Economics from the University of Massachusetts at Amherst. He is a member of the Project Management Institute and is a certified Project Management Professional (PMP).

Mr. McStay is an experienced project manager with a proven track record implementing Health Care Reform in Massachusetts as a member of the Commonwealth Care program team. Key initiatives include: startup operations, program stabilization, ongoing operational projects, and new program development. Creative problem solver with business management experience in both public and private sectors. Accustomed to working with all levels across organizations and has the ability to develop relationships to ensure successful policy implementation.

Experience

Independent Contractor (06/11 To Present)

- Consult as a subject matter expert regarding exchange operation requirements of the Affordable Care Act (ACA).
- Member of proposal writing response team responsible for coordinating technology partner responses to Medicaid Management Information System proposal functional and technical requirements.
- Created project plans for bid responses for IT gap assessments related to implementing the ACA.

Dell Inc. – Health Care Reform Program Manager (06/10 to 06/11)

- Delivered strategic planning and operational change management responses to proposals from states implementing the requirements of Health Care Reform.
- Collaborated with internal Dell departments and strategic partners to develop solutions compliant with the ACA requirements to support member eligibility, CRM, enrollment, and premium billing for a health insurance exchange.

Commonwealth Health Insurance Connector – Senior Project Manager and PMO Lead (2007 to 2010)

- Provided overall project management to ensure Commonwealth Care program regulations and system requirements were implemented.
- Served as project lead and subject matter expert on a successful multi-year transition to a new Massachusetts State Medicaid Management Information System.
- Supervised project managers on system enhancement projects that included open enrollment website, premium billing stabilization, 1099HC forms, eligibility determination, and implementing ongoing policy changes.
- Lead internal project team to define business requirements and develop business process flow diagrams to support writing the request for proposal for call center operations and premium billing system.
- Created and maintained project plans for both individual projects and overall program project monitoring.
- Directed team in completing project deliverables per the planned schedule and cost.
- Worked with the COO, CIO, and CFO on program development and issue resolution.
- Developed successful working relationships with Massachusetts state health agencies, Medicaid managed care health plans, vendors, and consultants.

ICG Commerce – Account Manager (2003 to 2007)

- Provided project management and delivered strategic sourcing services to assigned customers.
- Coordinated efforts of internal category sourcing experts and customer purchasing professionals to achieve timelines and overall operational goals.
- Led the Request for Quote process, negotiation preparation, and business case preparation and served as single point of contact for suppliers on customer's behalf.
- Presented status updates and savings results to client executives; ensured project teams were sufficiently resourced and deliverables exceeded customer expectations.
- Provided program management to sourcing process for MRO materials that delivered \$10M in annual savings for a Fortune 100 company.
- Managed over 30 IT subcontractor temporary labor and office supply vendor relationships.
- Delivered a successful implementation of web-based software to manage subcontract labor procurement, time tracking, and vendor invoicing.

Independent Contractor – (2002 to 2003)

- Served as project manager for software implementations at multiple Fortune 500 companies for QRS Corporation's global supply chain software application; work

included project management, business process redesign, software configuration, scoping and planning, training and knowledge transfer to customers.

- Served as project lead integrating web-based global sourcing software to existing software packages with a focus on purchase order visibility for suppliers and trace/track logistics functionality.
- Managed customer implementation projects from pre-sale scope definition through go-live.

QRS Corp. – Project Implementation Manager (2000 to 2002)

- Led business process redesign and system implementations; collaborated with account managers, product development, and quality assurance to resolve customer issues.
- Conducted customer interviews to analyze current business practices and system functionality in order to implement Client/Server and web-based business-to-business e-commerce solutions.
- Served as liaison between customer and external consulting team to ensure successful implementations.
- Wrote functional interface specifications and test plans.

Education

Master of Business Administration, Monterey Institute of International Studies

Bachelor of Arts, University of Massachusetts

Other

Certification - Project Management Professional (PMP): Member Number 1115856

Software proficiency – MS Project, Word, Excel, PowerPoint, Access, Visio, SharePoint

Former Peace Corps Volunteer

KPMG

Lorna Stark, Partner

345 Park Avenue, New York, NY 10154
lstark@kpmg.com 212 872 3396 office

Background

Lorna is KPMG's national Champion for Health Benefit Exchange (HBE) services. She is a partner in KPMG's Public Sector Advisory Services practice focusing on state and local government clients as well as not-for-profit entities. Lorna has experience in providing advisory services to many of KPMG's most prominent public sector clients and various agencies of the State of New Jersey. During her career Lorna has been responsible for managing many large and complex projects and in developing comprehensive reports and other deliverables to meet clients' unique needs.

Function and Specialization

Lorna is a partner in the Public Sector Risk and Advisory Services practice focusing on state and local government clients as well as not-for-profit entities. She is a National Champion for Health Benefit Exchange offerings.

Professional and Industry Experience – Similar Projects

Commonwealth of Pennsylvania – Health Insurance Exchange Planning Assistance

Lorna is currently serving as engagement partner for a team supporting the Pennsylvania Insurance Department (PID) as they develop plans for implementation of the State's Health Insurance Exchange (HIX). KPMG, serving as the prime contractor, is working with PID to support the following areas:

- Pennsylvania Insurance Marketplace Research
- Integration of Information Technology
- Governance Models
- Resource Needs
- Framework Options and Related Requirements
- Policy Decisions and Critical Milestones
- Stakeholder Planning

Lorna's team is providing the Commonwealth with the following deliverables:

- An outline of the critical policy decisions that must be made, and the optimal order in which those decisions should be made, along with the corresponding issues and analyses required to make those decisions
- Documented milestones in each “Core Area of Exchange establishment” as set forth in the Exchange Establishment Grant Announcement
- A Stakeholder Communications Plan

Other Projects

- Recently led an engagement for the New Jersey Department of Education to conduct detailed assessments of 29 New Jersey School Districts including Newark, Jersey City, West New York, Trenton, East Orange, Elizabeth, Union City, and Harrison. The performance audits included an assessment of key internal controls of the districts’ core business and financial processes and a historical expenditure analysis covering transactions from two fiscal years to identify potential irregularities and discretionary spending. The business processes included in the scope of the audit related to the assessment of internal controls were budgeting, accounts payable, payroll, human resource services, financial management, purchasing, facilities management, grants, student activity funds, technology, inventory, and pupil transportation.
- Lorna currently leads our Stimulus Funding readiness assessment for the City of New York’s Department of Education (NYC DOE). This work consists of identifying the significant compliance and reporting requirements and assessing the Department’s readiness to fully comply with those requirements that relate to the programs for which the NYC DOE is receiving or expects to receive, both directly and indirectly, under the American Recovery and Reinvestment Act (the Act).
- Served as the engagement partner on the countywide organizational analysis of Camden County New Jersey. This performance/management review has included the following departments, Board of Social Services, Health, Public Works, Buildings, Finance, Budget, Sheriff’s Office, Corrections, Parks, Public Safety, Administration, Juvenile Justice, County Clerk, and Surrogate’s Office. This review included identifying opportunities for the County to improve operations through efficiency of work flow, changes in organizational structure, discontinue non-mandated low-value services and reallocation of resources. This engagement identified over \$1.5 million in potential cost savings.
- Lorna currently leads our engagement to develop, administer, and report on the Learning Environment Surveys for the New York City Department of Education (NYCDOE). This initiative of the NYCDOE includes surveying all teachers, middle and high school students and parents of the City’s 1400 public schools. This initiative is a component of the Department’s overall initiative of accountability and transparency. The objectives of the surveys include: 1) obtaining feedback on each school from parents, students, and teachers on key conditions for student learning and improvement in the areas of academic expectations, communication, engagement, and safety and respect; 2) giving all parents, students, and teachers an opportunity

to inform their schools and the DOE about how they experience their schools as a basis for improving student learning and outcomes; and 3) incorporating parent, student, teacher views about their schools' learning environment into each school's annual Progress Report (scorecard) as part of the DOE's new accountability framework.

- Served as the partner to assist the New York City Department of Education in managing and monitoring the 2004, 2005, and 2007 selection of parent representatives on Community and Citywide Education Councils. Maintaining a high level of integrity, and developing an overall process that is transparent and defensible was critical to this effort. These engagements included assisting the NYCDOE in:
 - Developing and executing the application, nomination, and feedback processes surrounding Community and Citywide Education Council parent candidates
 - Establishing and administering the voting process for selecting parent Council members
 - Documenting the above items highlighting how the methodology utilized was fair and accurate records are maintained to support the results of the overall selection process
 - Providing general advice throughout the project regarding fairness, accuracy, dispute resolution, and potential challenges.
- Led KPMG's pro bono project for the NYC Voter Assistance Commission to monitor the development of the first-ever Video Voter Guides for the primary and general elections of Citywide and Borough offices in 2005. KPMG was asked to perform this role to help ensure the integrity and fairness of the process.
- Served as the concurring review partner to complete a performance audit of the City of Yonkers Board of Education. The Audit was conducted in accordance with the standards applicable to performance audits contained in Generally Accepted Government Auditing Standards and included a review of internal controls and operational efficiency within various operational areas of the District. The team documented the operational processes under review, created applicable audit programs, performed testing, and identified strengths and weaknesses in internal controls deficiencies. In addition, the team conducted staffing assessments, cost-benefit analyses, and benchmarking, as well as assessed compliance with applicable laws, regulations, and policies.
- Served as the partner on the New York City Leadership Academy engagement to provide assistance related to documenting the development of the Academy's programs and related processes. Assisted in redesigning the process for candidate application to the Academy's most complex program, the Aspiring Principals Program (APP). Led the development of a Microsoft Access Database to track all participants by program, providing detailed data by participant including assigned school, region, local instructional superintendent, etc.
- Served as the engagement partner on a business process improvement and benchmarking project for Molloy College in Rockville Centre, NY. This project

focused on the student billing practices and management of student accounts receivable by the College's Bursar and Financial Aid Offices. Two benchmarking efforts were also included: 1) to compare business and student billing collection policies and procedures to peer institution in the NY metro area and 2) to compare implementation/functionality of Jenzabar information management system to two other institutions that have implemented Jenzabar.

- Recently led a process improvement and program assessment project for Seton Hall University related to their Education Opportunity Program (EOP). This engagement included identifying operations improvements related to the business processes of the EOP office as well as reporting on the interactions and communications between the EOP office and other University offices including student financial aid and the registrar.
- Led a business process improvement engagement related to the Bursar, Student Financial Aid and Registrar office of the Polytechnic University. This project resulted in recommendations for improvements to the processes related to dormitory fee collections, changes to grades, degree audits, and budget preparation and monitoring.
- Served as the concurring review partner for KPMG's Yellow Book performance audits of program compliance for the Empire State Development Corporation. Lorna has guided the engagement team in developing the approach, audit programs and report format for these performance audits as well as reviewed all deliverables for quality assurance purposes.
- Led a high-level budget review of 10 of New Jersey's 23 Abbott districts. The engagement involved the preparation and review of detailed spreadsheets containing various budget and actual data for each of the 10 Abbott districts. Analysis of historical trends and budget-to-actual amounts for district revenues and appropriations as compared to the 2004 budget to determine if increases in spending were justified, and recommended potential areas for budget reductions.
- Served as partner for the engagement to develop policies and procedures for review of 540 districts long-range facilities plans as required under the New Jersey Education Facilities Construction and Financing Act of 2000. This project also included the development of requirements for a plan review tracking database, project tracking and reporting database, and data mining efforts to share relevant data between state agencies.
- Served as the engagement partner in an efficiency study for the State of Connecticut Oversight and State-appointed Control Board for the City of Waterbury, CT. The objective of this engagement was to work with the Control Board to identify potential areas of savings for the City of Waterbury.
- Served as engagement partner for the efficiency audit of the Vernon Township School District, NJ. The objective of this engagement was to identify both efficiencies and opportunities for improvement in the District's administrative operations, school transportation, student support services, grants management, building operations/maintenance and special education functions.

- Served as engagement partner in process analysis of New York City Human Resources Administration's payment process for residential treatment centers. This project included developing recommendations to clear a backlog of payment and assisting in implementation of our process improvement recommendations.
- New York City Office of Management and Budget – Development of cost models, agency training, and review of cost allocation methods and resulting rates for capital expenditures captured in the general fund.
- Developed a policy and procedures manual for the New York State Environmental Facilities Corporation. This manual included the identification of all relevant internal controls within each business process.
- Developed an internal control manual for the Roosevelt Island Operating Corporation (RIOCI) and a related database of all identified controls for RIOCI management's use in performing periodic assessments of the controls. All financial, administrative, and operational processes were included.

Publications and Speaking Engagements

- Presented on the topic of activity-based costing for national industry organizations including the Reason Foundation and National Government Finance Officers Association.
- Presented on the topic of Contract Compliance and Management for the Association of School Business Officials.
- Presented on the topic of Governmental Accounting Standards Board – Statement No. 49, *Accounting and Financial Reporting for Pollution Remediation Obligations* for internal, client and state society audiences.

Other Activities

Human Services, Housing, K-12 Education, General Government, Labor, Public Authority, Public Health, Activity-Based Costing, Yellow Book Performance Audits, Vendor Selection, Agreed-Upon Procedures, Business Process Analysis, Performance Measurement, Program or Compliance Audits, Contract Compliance Services, Reconciliation Assistance, Regulatory Compliance

Representative Clients

New York State
City of New York
State of New Jersey
New York City Department of Education
Commonwealth of Pennsylvania

Professional Associations

AICPA

New York State Society of CPAs
Government Finance Officer's Association
Association of Government Accountants
Association of School Business Officials

Education, Licenses & Certifications

BS degree, State University of New York, University at Albany
Registered CPA, New York State and New Jersey

Louis G. Tarricone, Senior Manager
Two Financial Center, 60 South Street, Boston, MA 02111
lgtarricone@kpmg.com 617 988 5887 office

Background

Lou is a senior manager with KPMG's Advisory Services practice. He has more than 20 years of experience in performing and managing information technology-related initiatives in the healthcare, public service, and financial services industries. He has hands-on experience with IT strategic planning and governance, program and risk management, systems analysis, design and deployment, quality assurance, business process improvement, and technology outsourcing.

Lou led the firm's Transition Management practice and returned to KPMG after leading a major systems integrator's overhaul of its financial systems, including program governance, IT and general controls, application development process, and incident and problem management processes.

Clients include government entities, health services organizations, and companies in the financial services, manufacturing, and technology sectors.

Function and Specialization

IT Advisory Services practice, focused on IT Project Quality Assurance, Information Security, IT Performance, and Systems Integration.

Professional and Industry Experience - Similar Projects

- Led project to review exchange requirements and architecture and to assess specific technical solution requirements for Pacific Northwest state's health insurance exchange organization.
- Performed IT Gap Analysis, analyzed and/or refined state's insurance exchange architecture, and defined implementation road map and implementation budget for multiple state exchanges.
- Assisted state exchange organizations in developing the technology response and budget for their submission of CMS/CCIIO Exchange Establishment Grants for three Level 1 grants and one Level 2 grant requests. This analysis and response included the allocation of project activities and corresponding budget between the exchange and Medicaid. To date, three of the grants have been awarded and the fourth is under CMS/CCIIO consideration.
- Assisted two state exchange organizations with their vendor assessment processes for technology components and integrators for implementation of health insurance exchange.

- For an innovative universal healthcare entity, performed technology review, requirements assessment, and independent acceptance tests for key health insurance administration functions, including enrollment, invoicing, hardship waiver and refund processing, late notice processing, disenrollment processes, and financial reporting. Assisted in redesign and documentation of key business processes, Led validation of conversion of financial data. In its first two years of operation, the entity had reduced the state's uninsured population by 70 percent.
- Co-Led PMO for the redesign and testing of a major New England HMO insurance product, enabling the attainment of National Committee for Quality Assurance (NCQA) accreditation.
- Co-Led PMO for the redesign of a premier HMO product streamlining and correcting system processing, administrative, contracting and medical policy problems for a major Health Services Provider.
- Led project that analyzed and documented the Indemnity and Managed Care Claims processing systems for a major health services provider and their outsourced data processing vendor to enable financial controls and systems utilization.
- As part of a four-year transition program, led Operational Readiness Assessments for a major health services company that was replacing 13 legacy claim systems and 8 legacy membership systems to new platforms.
- Performed assessments of processing accuracy, data quality, and operational readiness on enrollment, billing, and claims processing solutions for public and quasi-public healthcare agencies and providers. One of these reviews was of a large health insurer's claim processing and real-time membership system running on IBM mainframes and supporting over 3000 concurrent users. Analyzed testing methodology, execution, and results. Performed data quality analysis for migration of eligibility, claims, and physician data. Identified and helped resolve coding, process timing, record lock and file maintenance issues
- For a large quasi-public healthcare agency, performed load analysis of DEC VAX-based claims processing system, including identification of performance bottlenecks in inquiry access, data backup, and nightly batch processing.
- For a \$1 billion federal government contractor, led the successful response to a Defense Contracting Audit Agency (DCAA) accounting system audit, retaining the contractor's good standing, and freeing up greater than \$100 million in pending contract awards.
- Led implementation of \$50 million multinational financial system, including redesign of chart of accounts, and rollout of nine ERP modules including AP, GL, AM, AR, Billing, PO, Projects, Expenses, and reporting data warehouse.
- Led end-to-end process for implementation multinational, multicurrency time & expense capture system and processes used each pay cycle by over 10,000 professionals, including requirements gathering, package selection, design, migration, training, and rollout.

- Led the assessment of the application development and testing processes and recommended improvements to the senior executive sponsor for a top-tier global financial institution with over \$5 trillion under custody.
- In response to rapid growth and international acquisitions by a \$3 billion corporation, led development of corporate information governance strategy as well as successful implementation of program to develop and maintain single source of customer master data for use by all operational and data warehouse systems.
- Led project to create a third-party vendor Information Security Risk Management strategy and definition for a top 10 global custodial bank. Developed overall program strategy, initial vendor risk categorization approach and tool, detailed assessment strategy and tool, and assessor training materials and approach.
- Led assessment of Information Security and Privacy policies and procedures of international professional services and outsourcing firm against requirements of new Massachusetts privacy regulation, MA 201 CMR 17.

Other Activities

Professional mentor for university students and recent graduates, avid runner and coach. He is active in the MIT Alumni association and the MIT Enterprise Forum.

Representative Clients

Commonwealth of Massachusetts

Multiple state health insurance exchange organizations including Rhode Island, Oregon, Ohio, and Missouri

Multiple global financial institutions

New York State Division of the Lottery

Professional Associations

Member, IEEE, 20+ years

Member, MIT Enterprise Forum

Education, Licenses & Certifications

MS degree in engineering, Massachusetts Institute of Technology

BS degree in mechanical engineering with concentration in electrical engineering, Kettering University

David R. Gmelich, Director

Two Financial Center, 60 South Street, Boston, MA 02111

dgmelich@kpmg.com 617-988-1047 office

Background

David is a director in KPMG's Advisory practice with over 20 years of professional experience serving federal, state, and local government clients. His experience includes organizational and process analysis, performance improvement, operational auditing, and project management. David also completed an assignment at KPMG's Department of Professional Practice where he assisted in developing firm policy around the delivery of professional services to governmental entities.

Function and Specialization

David provides advisory services to the government and higher education engagements.

Professional and Industry Experience – Similar Projects

State of Rhode Island – ARRA Section PMO and 1512 Data Quality Review Assistance

Assisted a state's stimulus program office in establishing a program management function to help oversee and manage state agency use of funding provided under the ARRA. During the initial phase, David and his team worked with state staff to design an organizational structure for the office, associated roles and responsibilities, and worked to develop a suite of program and project plans (e.g., program master plan, including a risk management plan, a communication plan, a scheduling plan, and supporting tools and templates as well as set of individual project plans) to help satisfy the office's executive mandate. Finally, David and his team provided a series of program management training sessions to subject staff members around their assigned PM roles and a transition plan to assist in project handover. During the second phase, David developed a data quality assurance process to address the state's ARRA Section 1512 reporting requirements, and specifically by developing and executing a risk assessment methodology to prioritize the state's higher risk agencies/programs, drafting a quality checklist to assist OERR personnel in reviewing prime and subrecipient state submissions, and documenting the risk assessment approach and Data Quality Review procedures in the formal policy and procedures document.

Commonwealth of Massachusetts Office of the State Treasurer and Receiver General – Cash Flow Process Analysis and Improvement

Conducted a multiphased cash flow assistance project for an Office of the State Treasurer. David's initial process analysis phase began with interviews of the key stakeholders with the State Treasurer's Office as well as the State Comptroller and the Department of Administration and Finance to gain an overall understanding of the process. His team then conducted functional walk-throughs and constructed maps of the cash flow forecasting process itself as well as the supporting feeder inputs to the collective cash flow forecast output. The team used the resulting documentation from these analytical steps to help identify opportunities for improvement around roles and responsibilities of key process participants, gaps in accountability for critical inputs/outputs, etc., and key differences in definitions of cash flow data input risking inconsistent output and unclear management reporting. During the second phase of the project, David helped to develop current policies

and procedures for use by the stakeholder line staff to first-line supervisor and middle management. For the final phase, David and his team supported the development of an improved automated tool to support the future analytical needs of three key stakeholder groups. The team began with helping to outline application requirements in support the tool's development. David performed supplemental analysis to help map the key data elements within the financial application (MMARS) to the proposed application. He then helped develop a testing plan to support user testing of the new application and provide observations and recommendations to the stakeholder on the testing results. (June 2008–August 2010).

Other Projects

- Effectively managed an extensive training program to support implementation of a worldwide financial system for a key Department of Defense Agency (March 1997–April 1999)
- Provided program management support for implementation of a worldwide financial system for a key Department of Defense Agency (March 1997–April 1999).
- Assisted two large New England utility service operators to assess their readiness to accept and administer federal funding under the American Recovery and Reinvestment Act (ARRA) of 2009. David and his team researched relevant compliance requirements applicable to organizations and compiled an assessment tool. Following completion of the tool, his team began to assess each entity's compliance with the specified requirements identifying potential shortcomings or gaps requiring management's attention. The final project task was to conduct element of a mock A-133 audit to ascertain overall compliance following the initial diagnostic review (June 2010–February 2011).
- Presently assisting a large City government to develop a centralized reporting process for ARRA Section 1512 reporting requirements. Our current project work includes performing a gap analysis over the Act's requirements against the City's current reporting protocols, developing a reporting process event calendar/supporting procedures reflecting key dates, process milestones, and a stakeholder training program to communicate required process changes instituted by City management (April 2010–Present).
- Conducted a performance assessment of over 70 state agencies on behalf of a state government. This project assessed agency performance in six attribute areas such as Quality and Process Management Practices, Program Effectiveness, Independent and Internal Audits, Internal and External Customer Satisfaction, Fiscal Productivity and Efficiency, and Statutory and Regulatory Compliance. Some of the state's agencies included in the scope of the project included the Department of Retirement Systems, Office of the Attorney General, the State Gambling Commission, the State Horse Racing Commission, the State Lottery Commission, the State Patrol, the Department of Licensing and the Office of the Secretary of State (July 2002–November 2002).
- Conducted a performance audit of personal and purchased services contracting practices of seven state agencies on behalf of a state government. This project addressed the controls over each contracting function as well as the corresponding performance measurement processes (July 2002–November 2002).

Other Activities

KPMG National Instructor charged with delivering methodology and technical trainings to advisory staff.

Representative Clients

State of Rhode Island

State of Massachusetts
State of New York
State of Washington
City of New York
City of Boston
Yale University
ISO – New England
NY-ISO

Professional Associations

Member, Institute of Internal Auditors
Member, Project Management Institute

Education, Licenses & Certifications

BA degree, University of California, San Diego
MIA degree, Columbia University
Certified Project Management Professional

Ian Gilmour, Partner
333 Bay Street , Suite 4600
Bay Adelaide Centre , Toronto, Ontario M5h 2s5
Igilmour@Kpmg.Ca Tel +1 416 777 8211

Background

As an associate partner at KPMG's member firm in Canada, Ian has 25 years of experience in applying information technology to support business innovation, including 15 years of business design experience using enterprise architecture techniques. He has been a business architect for Architectural Centre of Excellence projects for the Province of Ontario and has introduced enterprise architecture design methods within the Government Online Program for the Government of Canada.

In the health care field, he has been a strategist and architect for the planning and design of eHealth initiatives in Canada and the United States, including the HHS Connects project for New York City. He is currently engaged in planning the development and operation of the Health Insurance Exchange for the State of Oregon.

Prior to joining KPMG, Ian was chief methodologist and a partner at Chartwell IRM Inc. Prior to joining Chartwell, Ian was the associate director of the Convergent Engineering Institute (San Mateo, CA). The Institute was founded by Dr. David Taylor, a leading authority on the use of business objects to specify business designs and to implement component-based IT solutions.

Function and Specialization

Ian has 25 years of experience utilizing information technology to support business innovation, with 15 years specifically focused on business design using enterprise architecture. He has been a strategist and architect in the health care field. Currently, he is combining these experiences to assist public sector clients in information as well as Health Insurance Exchanges.

Professional and Industry Experience – Similar Projects

State of Missouri Health Insurance Exchange Planning

- Develop high-level strategy and architecture for the development and operation of the State of Missouri Health Insurance Exchange as funded by a federal government planning grant. This project will help ensure that the OHA has a set of strategic-level blueprints and a road map for exchange program development and the design and implementation of enabling technology.

Health and Human Services Connect, City of New York City IT Architecture Quality Assurance and Governance

- Review and assuring the quality of architectural processes and deliverables for a \$100 million project to provide shared information and client-centric service delivery for 15 health and human service agencies in the City of New York. Establishing governance processes for project portfolio management, solution architecture review, and the development of enterprise architecture frameworks and methods.

Other Projects

Ministry of Health and Long-Term Care – e-Health Business Architecture

- Led a team that supported the development of a business architecture for the provision of electronic health services in the Province of Ontario. Ontario is planning to invest up to \$2.5 billion in e-Health between now and 2015, when a full electronic health record will be available for every Ontario resident. The Chartwell team was asked to integrate the business architecture work from four other projects (Diabetes Registry, e-Health Portal, Health Information and Access Layer and the Identify and Access Protection projects) to generate a more coherent e-Health business model.

Ontario Ministry of Health and Long-Term Care – Shared Care Pilot Evaluation

- Provided program evaluation methodology support for a formative evaluation of six shared-care pilot sites focusing on the use of allied health professionals in family health care teams to manage patients with chronic conditions. The project provided a qualitative and quantitative assessment of the outcomes of the six pilot projects and made recommendations concerning the rollout of the program to other family health groups.

Ontario Ministry of Health and Long-Term Care – Health System Information Utility Implementation Plan

- Supported the development of a project charter and deliverable specifications for the planning, design, and implementation of a Health System Information Utility, which will be a “single source of truth” for population health data and health service provider performance.

Ontario Ministry of Health and Long-Term Care – Health System Information Utility

- Supported the development of accountability and governance models for a proposed health system information utility designed to provide population health data and health system performance data to support research, policy decisions, and operational decision making to stakeholders across the Ontario public health care system. Assignment included the analysis of options for retaining or devolving current information management and decision support programs and services, logic model for the programs and services, performance indicators, and governance and accountability requirements associated with different program delivery models.

Ontario Ministry of Health and Long-Term Care Accountability Initiative

- Business architecture consultant for the design of a framework to increase accountability of program managers and service providers within the publicly administered health care system in Ontario. Provided design guidance to teams developing accountability policy, accountability agreements, performance indicators, and information systems for performance reporting. Supported the development of draft inventories of current health system programs and services, performance indicators, and information management systems.

Peter T. Blessing, Director

Two Financial Center, 60 South Street, Boston, MA 02110-2371
pblessing@kpmg.com 617-988-1559 office

Background

Peter Blessing is a director in KPMG's Forensic Advisory Services practice. He has nearly 20-years of experience conducting investigations and providing fraud risk and compliance advisory services to clients in a variety of industries, including national/multinational public companies and closely held corporations, as well as the government and not-for-profit sectors.

Peter has conducted and supervised numerous complex domestic and international fraud and misconduct investigations on behalf of special committees to the Board, management and the government on matters involving alleged financial misconduct, including fraudulent financial reporting, asset misappropriation and embezzlement, insider dealing and conflict-of-interest, money laundering, public corruption and FCPA violations. Peter has also conducted due diligence investigations related to various transaction related engagements.

In addition, he has completed anti-fraud program reviews and fraud risk assessments, has provided compliance advisory and project management services to organizations under regulatory scrutiny, and performed in an independent corporate monitoring role reporting to US federal government agencies. Peter has also advised companies on establishing and implementing corporate ethics and compliance programs, including FCPA compliance programs.

Function and Specialization

Peter is a certified fraud examiner providing investigative and integrity advisory services, specializing in fraud and misconduct investigations and diagnostics, fraud risk management, and compliance and monitoring.

Professional and Industry Experience – Similar Projects

Investigative, Integrity Advisory and Compliance Experience

- Core PMO member of KPMG team providing project management assistance to a multi-billion dollar financial institution as they responded to significant regulatory scrutiny around the adequacy of its Home Lending operations. KPMG provided project management support for client workstreams to assist with meeting documentation, construction and implementation of policies and procedures, process flows, reconciliation and control reports, and overall remediation efforts.
- Integral member of international team supporting the independent corporate monitor of a global banking institution subject to compliance with the terms of a U.S. Department of Justice Deferred Prosecution Agreement and an SEC Consent Order.

Conducted forensic and analytical review, conducted independent testing and prepared reports subsequently provided to these US Government Agencies.

- Managed a forensic data analysis project for a global IT Services provider related to procure to pay and travel and entertainment processes and transactions.
- Conducted FCPA compliance program assessments for global manufacturing and medical devices companies with locations in emerging market countries, and conducted FCPA accounting and bribery investigations for technology and manufacturing companies in China, Singapore, India and Mexico.
- Conducted an antifraud program gap analysis on behalf of the Comptroller of the Commonwealth relating to payment and procurement related fraud. Assisted the Comptroller to identify and assess relevant fraud risks and related key controls; and to review existing antifraud program elements. Developed observations and recommendations to assist the Comptroller in enhancing its efforts to prevent, detect and respond to fraud
- Conducted an investigation into allegations regarding the improper handling of tax collection matters for the City of Providence, Rhode Island. Also assessed the City's tangible tax assessment and collection processes, and provided observations and recommendations for improvements.
- Conducted international investigation on behalf of global power company related to misappropriated high value components worth in excess of \$1 million. Investigation supported successful insurance claim filing.
- Assisted global investment bank with fraud scenario identification and assessment. Conducted forensic data analytics on selected priority scenarios.
- Conducted investigation and prepared expert report identifying multi-million dollar misappropriations by one partner in more than 30 mixed-use real estate developments. Provided deposition testimony; named as expert witness at trial
- Conducted investigation of financial reporting fraud allegation on behalf of Audit Committee of a \$3 billion public company, relating to improper accruals and a multi-million dollar book/bank imbalance.
- Led investigation of behalf of the Board of Education regarding self-dealing and conflict of interest allegations by the CEO of one of the 20th largest school systems in the US. Testified at subsequent federal criminal trial of CEO, who was convicted on corruption charges.
- Provided antifraud program assessment and design services to a global power company. Drafted and revised antifraud program policies, including those related to reporting, evaluating and investigating fraud and misconduct.
- Led Independent Monitoring team for 3 year period after firm appointment by the Federal Highway Administration (US DOT) as Independent Monitor of the US Northeast subsidiary of an international highway construction firm following employee indictments on bid-rigging charges. Provided anti-trust and ethics/compliance program advisory and monitoring services.

- Led a team analyzing tens of thousands of transactions in a multi-million dollar accounts receivable scheme, supporting a successful fidelity claim filing by a Fortune 200 global media and entertainment company.
- Conducted investigation and fraud risk assessment relative to technology purchases for the nation's second largest school district.
- Completed code of conduct, ethics program and FSGO compliance reviews for a number of companies in the technology, retail, energy, manufacturing and not-for-profit sectors.

Public Service Experience

- Conducted sensitive and complex investigations of judicial, state and city officials on bribery, extortion, racketeering and ethics charges. Member of primary investigative team in matter that resulted in multiple count indictment, guilty plea and jail term for former RI governor in large scale corruption case. Other cases resulted in jail time for city officials and other participants;
- Member of task force investigating massive bank fraud and embezzlement of approximately \$15 million. Subsequent prosecution resulted in 30 year jail sentence for defendant, the longest white-collar sentence in state history.
- Performed net worth and forensic accounting analyses related to narcotics investigations, resulting in significant financial recoveries.

Prior Professional Experience

Boutique consulting firm – Director, Fraud Investigations, Boston, MA

Honeywell – Manager, Global Security Services, Morristown, NJ

Another Big Four firm – Manager, Business Fraud & Investigation Services, Los Angeles, CA and Boston, MA

RI Department of Attorney General – Investigator, Special Prosecution Unit , Providence, RI

Publications and Speaking Engagements

Speaker, Institute of Internal Auditors, Boston Chapter Seminar, “Fraud Risk Management Considerations for Internal Audit”

Speaker, Massachusetts Department of Attorney General Training Seminar, “Performing Forensic Investigations”

Michele M. Miller, Senior Manager
2851 Charlevoix Drive, Suite 305, Grand Rapids, MI 49506
MMMiller@kpmg.com 313-230-3382 office

Background

Michele is a successful and proven IT professional with nearly 20 years of experience in IT management and sourcing advisory. Michele specializes in transition and transformation with further emphasis on sourcing optimization through governance, program enablement, knowledge management, and project management. Additional areas of specialization include process design and training, technical solution review, and cross-tower process integration. International transformation experience has been gained in Singapore, Brazil, Mexico, New Zealand, Argentina, Sweden and the United Kingdom. With a balanced portfolio of public and private sector engagements, Michele has worked at the local, state, and federal levels leading transactions, managing transition projects, and overseeing transformation optimization.

Function and Specialization

Information technology/governance. Strategy and assessment, solution, implementation, and optimization. Specializing in transition/transformation and program/project management with emphasis on Infrastructure services, service desk, end user services, and print services.

Professional and Industry Experience – Similar Projects

- Led or participated in over 30 + infrastructure assessments for a variety of clients and industries.
- Led or participated in infrastructure sourcing engagements for multiple industry clients.
- Authored white papers relating to IT service management and knowledge management.
- Developed, trained, and conducted Managed Services Process Integration Workshops for multiple clients globally.
- Developed, trained, and implemented ITIL road maps for incident, request, asset, problem, change, and configuration management processes for multiple clients.
- Implemented governance processes for multiple industry clients in support of blended sourcing solutions.
- Implemented multiclient service desks in the United States, Asia/Pacific, EMEA, and Latin America.
- Designed strategy and implementation of Service Desk capability as part of a major retail client's shared service model.

- Directed a major program for a chemical industry client, which entailed overseeing implementation of 26 separate projects globally in the rollout of 40,000+ workstations.
- Architected IT service management processes in the area of availability management, capacity management, change management, incident management and problem management for a chemical industry client.

Specializations

- ITIL / ITSM Certification v2 & v3
- Program and Project Management
- Governance
- Knowledge Management
- Service Desk Management and Support
- Service Management
- Process Development, Training and Deployment

Publications and Speaking Engagements

August, 2010 – Published White Paper via EquaTerra "Knowledge Management Makes a Come Back".

January 16, 2008 - Published White Paper via EquaTerra – "IT Service Management – A Roadmap For Success".

January 19, 2008 – Key Speaker for the American Association of University Women at the University of Texas-Tyler Seminar on Women in the Workplace: "The Power Within Us – Negotiating Your Future".

Representative Clients

Aetna, Aflac, Anthem Wellpoint, AstraZeneca, Broward County – FL, Cardinal Health, City of Austin, City of Nashville, Commonwealth of Pennsylvania, Constellation Brands, Inc. CVS, FairHealth, The Hartford, Internal Revenue Service, JP Morgan Chase, Municipal Securities Rulemaking Board, Teachers Insurance Annuity Association (TIAA)

Education, Licenses & Certifications

Western Michigan University
ITSM / ITIL v.2 & v3

Roger Abbott, Senior Manager

KPMG LLP

333 Bay Street Suite 4600, Toronto, Ontario M5H 2S5

rgabbott@kpmg.ca Tel +1 416 777 8316

Background

Roger is a manager with KPMG Canada and a senior business, application, and technology architect with extensive experience in planning, architecture, business and systems analysis, and logical systems design of strategic business automation solutions. His 20+ years of experience includes provincial health care as well as other government services, Web-based service delivery applications, financial trading systems, and supply chain management systems.

As an architect, Roger has extensive business and systems architecture experience eliciting, identifying and translating high-level, conceptual user requirements into clear business requirements and architecture specifications. He has worked extensively creating solutions for programs and services at the provincial, federal, and municipal level and has held a number of lead roles in strategic service design initiatives. Roger's software engineering experience has enabled him to support a number of business initiatives in developing strategies for the application of technology to business solutions.

Roger brings vision, leadership, and a distinctive combination of business and technology architecture skills to mission-critical projects. He has extensive experience managing projects from inception to conclusion, including the development of strategic plans and justification with supporting information, application, and technology architectures and designs. Roger's well-rounded business and software engineering experience supports his proven ability to develop and implement business strategies and associated new applications and technologies.

Function and Specialization

Robert is a business, application and technology architect with extensive experience in health care, government, and Web-based applications. With over 20 years of experience, his vision and combination of business and technology brings a distinctive skill set in implementing and developing business strategies for new applications.

Professional and Industry Experience - Similar Projects

Healthcare Experience

- **CCAC Case Management Conceptual Data Model** – Ministry of Health and Long-Term Care – Roger developed a detailed conceptual data model of the CCAC Case management process. The project used a previously developed high-level business architecture as input into the development of the detailed conceptual data model.

representing the full CCAC operational process including registration, assessment, service planning, service delivery (both in and outsourced) as well as LTCF admissions and waitlist management.

- **Information Management and Decision Support Strategy** – Ministry of Health and Long-Term Care – Roger played a lead role in developing a strategy for Information Management and Decision Support (IM/DSS) for the Ministry of Health and Long-Term Care. The process included an inventory of current ministry information systems, and an analysis of information flows. High-level operational, decision support, research, and external data flows were classified and related to primary business functions ranging from CCACs and hospitals through ambulance and Cancer Care. The project evolved from a focus on accountability to a focus on the entire Ministry beyond just the accountability function and included management of privacy/personal data via the Data Institute. A preliminary architecture was developed as a straw model for discussion. The proposal was well received and a decision on further steps is pending.
- **Enterprise Business Architecture** – Ministry of Health and Long-Term Care – MOHLTC required assistance in the development of a Business Architecture for the Ministry. Chartwell was engaged to assist in the development of both an “As- Is” and “To-Be” business architectures and gap analysis. During the course of the engagement, Roger worked with business representatives to develop the As-Is architectures for Acute Services and Community Health divisions. Roger also participated in the development of the high-level To-Be models for the entire Ministry. Roger is currently assisting in the validation of the As-Is business architecture with the business representatives.

Integration Architecture Experience

- **Integrated Student Aid System – BC Ministry of Advanced Education, Student Aid Branch** – This change initiative developed an integrated solution to deliver student aid in British Columbia. Roger led a team of 8 architects to develop detailed requirements for the system. The engagement involved extensive consultation with senior management and staff to develop a detailed To-Be architecture for a comprehensive, large-scale solution for the future of the branch. The resulting architecture delivers on key business objectives including seamless integration with a number of service delivery partners, cost effectiveness, compliance, client satisfaction, and improved effectiveness. The architecture provided an integrated and aligned model of the requirements to both deliver student aid and to manage the 15 percent change in business rules and work flow that occur each year.
- **Crown Case Management System** – Ministry of the Attorney General – This project extended the business and technical architecture of the Crown Prosecution Program to identify business requirements for the development of a case management solution for criminal prosecutions. The project team worked with Crown attorneys, case management coordinators and the management team of the Criminal Law Division to develop the business model for the future of Crown Prosecution Program as well as the business function and information requirements for a case

management system. Roger led the development of the business and technical architectures and contributed to the development of a procurement strategy for the solution.

- **NewsGate Implementation Planning and Architecture** – TorStar Corporation, CIO Office - TorStar engaged KPMG to develop an Enterprise As-Is Architecture assessment, To-Be Architecture, implementation plan and cost estimate. The architecture included integration with and/or replacement of a large number of systems within TorStar. The overall effort included an implementation project plan and cost estimate for the Transformation Initiative. Roger managed the development of the As-Is and To-Be architectures with team members that included TorStar and vendor staff. The initiative upgraded their primary print production system to a content production system that incorporates the ability to share content across media properties and delivery formats (e.g., Web and Print.) The development of the implementation project plan leveraged the architectures to ensure transition activities were fully identified. In addition, the plan incorporates leading practices provided by the vendors and input from TorStar technical and business staff.
- **Integrated eCommerce Architecture – Aviva, Canada** – Aviva Canada engaged Chartwell to develop an application architecture for their enterprise eCommerce initiative. Roger developed a high level To-Be application architecture that addressed the business needs for the integration of multiple legacy and Web systems into a single client experience for eCommerce. The business and technical architectures included a Service Oriented Architecture (SOA) approach that addressed a number of key business concerns. Roger worked with business and systems stakeholders to develop, review, and approve the final architecture. The application architecture was presented to senior management for incorporation into their business planning process.
- **www.gov.on.ca Super Portal** – Management Board Secretariat - Roger led the project to integrate all of the Government of Ontario Web sites into the Government of Ontario Super Portal (www.gov.on.ca). This single point of entry is the primary face of the Ontario government to the world. The challenge was to integrate over 200 different Web sites on multiple hardware and software architectures into a single Web site with seamless access, a common look and feel, and a “no wrong door” navigation approach. The project created the architecture of the Super Portal as well as the Government of Ontario Portal Federation. This federation defines the architecture for commonality between all portals in the Ontario government in terms of shared services and standards. These architectures were presented and approved by the Province’s Architecture Core Team (ACT) and Architecture Review Board (ARB.) In addition, logical and technical architectures were defined to the level necessary for preparation of several tender documents.

Integrated Service Delivery Accountability Model – Ministry of Consumer and Business Services – Roger developed a business framework to define accountability, roles, and processes associated with integrated service delivery organizations and their partners and

service providers. One key aspect of this assignment was the creation of reengineered business work flows to define leading practices associated with accountability. Scenarios included the set and management of agreements, handling changes in project environments, etc.

Representative Clients

Ministry of Health Long-Term Care
BC Ministry of Advanced Education Student Aid Branch
Ministry of Attorney General
TorStar Corporation
City of Toronto
Aviva Canada

ARUN IYER, SENIOR ASSOCIATE

KPMG LLP
515 Broadway, 4th Floor, Albany, NY 12207-2974
aiyer@kpmg.com 518-427-4774 office

Background

Arun is a senior associate in KPMG's Advisory Services practice with over eight years of experience in leading and coordinating IT projects. He has served as functional and technical analyst with responsibility for quality assurance, quality control, and software implementation. Arun is experienced in Project Management, Quality Assurance, and Auditing for public sector clients. Prior to joining KPMG, He gained experience in systems integration at many clients working as System tester, Design Engineer, Functional Analyst, and Software Architect.

Function and Specialization

Arun is a member of the IT Advisory Services practice specializing in Quality Assurance and IT Project Monitoring for ERP and Health and Human Services IT implementations.

Professional and Industry Experience - Similar Projects

Arun has specialized in developing IT solutions for the public sector in Health and Human Services and Financial Services (ERP). He has audited Financial ERP systems for Manufacturing and Insurance clients in private sector. Arun is proficient in designing and documenting functional specification, test specification, migration plan and user acceptance testing (UAT). He has experience with Business Process Modeling and integration using Service Oriented Architectures. He has been responsible for monitoring change control process and migration process as well.

Quality Assurance – State of New York, Department of Health, Medicaid Data Warehouse and Rate Setting project

- Reviewed requirements analysis process and document developed using Rational Requisite Pro for converting and upgrading legacy eMedNY Data Warehouse (Teradata) with new Oracle Business Intelligence solution (OBIEE).
- Tracked business requirements, functional specifications, design specifications, technical specifications, test specifications, test scenarios, and test results in Req Pro tool and helped ensure accuracy of traceability matrix.
- Reviewed Technical Design deliverable for Data Model, Data Delivery and Extract-Transform-Load with agreed-upon Data Architecture Standards. Data Quality review included review of results from profiling tools such as ERWin Data Profiler and Oracle Warehouse Builder.
- Performed data quality verification and testing for converted Medicaid data to support new Medicaid Data model, BI Model, Meta-Data and new BI reports and requirements.
- Reviewed Business and Functional Requirements models developed using Oracle Business Process Analyzer for new NYS Department of Health (DOH) rate-setting application. Participated in Rate Setting application scoping meetings involving different stakeholders from ISHSG, OHIP, and Medicaid Services.

Medicaid Audit and HCRA Compliance – State of New York and State of New Jersey

- Performed audit of eMedNY system in DOH testing IT general controls related to security roles and work flow rules. Tested MMIS business controls related to provider enrollment and certification, eligibility checks, claims, payments, and suspense processes.
- Participated in review of Medicaid provider claims and payor invoices for the State of New York based on Health Care Compliance Act (HCRA) using data analysis tool IDEA[®] to extract, transform and run queries to find underpayment or overpayment by the State.
- Participated in single audit for the State of New Jersey to audit applications such as Medicaid System (MMIS) and Electronic Benefit Transfer (EBT). Tested IT Application and Process controls related to provider claims, rate charge codes, suspension, compliance, approval, and eligibility.

Quality Assurance – City of New York, Financial Management System

- Provided quality assurance and risk assessment services as lead technical analyst to the New York City Financial Information Services Agency for upgrading ERP system from CGI-AMS legacy to Advantage 3.0.
- Provided Project Management assistance for conversion of subproject to monitor conversion development, testing, conversion iterations, acceptance criteria and reconciliation.

- Reviewed the change control process using Clear Quest and Req Pro tools to understand updates to conversion requirements since finalized baselines, documented gap analysis, tracking requirements to test cases, and tracking defects in Clear Quest to requirements. Reviewed setup of Clear Quest UCM to evaluate if each project work stream's customized needs were met and aligned to SLDC phases. Reviewed diff analysis between old and new updates in project source hierarchy.
- Reviewed integration architecture of FMS3 accounting with FMS2 budgeting system and DOE FAMIS financial system using MQ messaging server and BCV split. Reviewed and monitored reconciliation of reference, accounting, and budget data between systems.
- Reviewed interfacing of vendor self-enrollment system (VENDEX), contracts system (OASIS), and self-service payment portal (PIP) for security, historical reports and system interfaces.
- Reviewed the FMS/3 Business Objects and data warehouse reporting architecture, ETL design, BO Universe and Dimensions to enable regulatory, financial, and performance reporting.
- Reviewed UAT test results, monitored defect ratio for each module, compared reconciliation procedures and their results, and go-live issues list before each major work stream release.

Quality Assurance – City of New York, ACCESS NYC

- Served as lead technical analyst to provide QA services to the NYC for project ACCESS NYC. Reviewed work plan for implementation, formal business requirements, software specification, detailed design and test script deliverables in different phases of SLDC for screening tool developed using CURAM framework for programs like Food stamps, Summer Meals, Temporary Assistance, Unemployment Insurance, and Universal Prekindergarten.
- Actively participated in JAD sessions, post-implementation reviews, and UAT in many NY City agencies to review requirements and application acceptance.
- Reviewed usage of security tools such as Watch Fire Web application scanning, Web Trends analyzer, help desk tools like Remedy and I-Wise, and business rules editing tools like CIARA.

Independent Validation and Verification, NJKiDS Project

- Delivered Independent Validation and Verification (IV&V) service to the State of New Jersey for Child Support project NJKiDS using IEEE IV&V standards to review efficiency and project risks.
- Reviewed Data Conversion plan, Test Management Plan, Quality Assurance Plan, Database Administration Plan, Technical JAD session documents, and Rational Rose Use Cases.
- Performed verification and assessment for usage of tools such as Rational Requisite Pro used for gathering requirements in a UML Use Case format in Rapid Application

Development life cycle. Verified the traceability from policy document to business requirements in Req Pro tool to ensure compliance with the policy mandates and changes.

System Integration – Office of Mental Health, State of New York

- Worked as a senior consultant for Keane, Inc., to design a Web-based online automated tool for auditing consolidated financial statements for the State of New York Health Service providers that enables online statement filing and auditing using .NET architecture. Used Object Oriented Design and software design patterns (Model View controller, Strategy pattern), used NUnit tool for unit testing and quality assessment templates in evaluation and implementation.
- Assisted in integration, testing, and quality control of rate-setting application for health service providers in NY State using .NET, Oracle and Crystal Enterprise server. Designed data integration methods and reconciliation reports for interfacing eMedNY system DOH, and ARS system in Office of Mental Health. Developed test cases for UAT and System Testing based on converted data from MMIS system, old Provider financial statements and new rate codes. Also reviewed the system for HIPAA compliance and end-user accessibility standards.

Functional Requirements Analysis – CompSys Technologies

- Developed business requirements for the City of Buffalo Time Keeping System application and identified critical controls and features for migration to a Web-based application with Teradata back-end database. Developed technical specifications after multiple end user sessions and identified key control areas with respect to reporting, logging, and security.
- Developed business and functional requirements for vendor sourcing initiatives including data warehousing and document management. Assisted in writing proposal for fixed price contract.

Software Development and System Integration

- Developed test specification, formal inspection, and peer review templates for Carrier-UTC based on CMM standards for software quality assessment. Developed near real-time software in C++ for remote control of container cooling systems through satellite link. Used IBM Rational Req Pro to document requirements, UML use cases, test requirements, and test cases to understand coverage of testing. Logged defects in test results in Clear Quest and tied it back to the requirements. Performed change impact analysis to review the number of requirements that needed to be modified for a ClearQuest change, and the test scenarios that were impacted for regression testing. Used Clear Case to control versions, migration paths, and developed build scripts.
- Implemented software for remote controlling of robot pipettor chemical apparatus in Bristol Myers Lab using DCOM middleware, transaction server, and ASP dynamic Web pages.

- Implemented document management system for Global Tel*Link to generate and track pin validation system for billing and routing, using VBA objects, JSP, and Servlets in Apache Web Server.

Methodology

- PMBOK, Rational Unified Process, HIPAA, SOA, Web Services, COSO, IT Audit, and SOX 404

Technical Skills

Rational Requisite Pro, ClearCase, ClearQuest, PVCS, MEGA BPM tool, Oracle BPA tool, CURAM Framework, CGI-AMS ADV 3.0, Oracle ERP, Oracle Database, SAP 4.6B (ALE/EDI interface), SQL Server, Teradata database, MS-Access. Software development in C/C++, Java, .NET Framework, C#, Visual Basic, HTML, XML, SOAP, ASP.NET, and J2EE

Representative Clients

State of New York,
City of New York,
State of New York, Office of Mental Health
State of New Jersey
MetLife Insurance
Momentive Performance Materials

Professional Associations

Project Management Institute
Information Systems Audit and Controls Association
Big Brother and Big Sisters

Education, Licenses & Certifications

MS degree in CE, Syracuse University
MS degree in CIS, University of South Alabama
BS degree in CE, Pune University
Associate of Electronics and Telecommunications, Mumbai University
Certified Project Management Professional
Certified CISA

Erica L. Heintz, Senior Associate
KPMG LLP
515 Broadway, Albany, NY 12107
eheintz@kpmg.com 518-427-7421 office

Background

Erica is a senior associate with KPMG's Advisory Services practice focused on Health Benefit Exchange planning development and implementation for various state clients. She has 20 years of experience with government/legislative operations, policy development, and implementation. Her areas of focus include policy implementation and strategy. Erica's skills and knowledge range from identifying opportunities for action to project proposal development, and designing implementation strategy. She has experience in government, healthcare, energy, and environment, and New York State infrastructure needs.

Function and Specialization

Erica has 20 years of experience and is focused on Health Benefit Exchange planning, development, and implementation

Professional and Industry Experience – Similar Experience

Health Benefits Insurance Exchange Policy

Pennsylvania Insurance Department

- Assisted Advisory Services team in preparing the *Draft Report to the Commonwealth of Pennsylvania Insurance Exchange Planning*, October 5, 2010. Efforts included synthesizing available information (Federal laws and proposed regulations, existing State functionality, gaps in information and technology, needed attributes of a working exchange, actions being taken in other states, etc.) and working together to help ensure detailed, accurate, and timely submission of required product. Project was designed to assist Pennsylvania in determining whether and how to proceed in establishing a sustainable State Health Benefit Exchange. Researched and drafted portions of the Stakeholder Outreach Plan for submission to the Commonwealth.

State of Rhode Island Health Insurance Exchange Planning

- Provided support to the Advisory team in completing State of Rhode Island Health Insurance Exchange Planning, *Strategic Architecture Blueprint Report and Strategic Architecture Roadmap and Budget Report*, which were designed to support the strategic planning, gap analysis, design, and budgeting of a proposed Health Insurance Exchange for the State of Rhode Island.

Missouri Health Benefit Exchange

- Participating in process to help the State of Missouri review vendors for their Health Benefit Exchange. Providing assistance to team involved in Missouri Health Benefit Exchange Planning process.

Legislative/Government – New York State

Policy Advisor, Area Health Education Centers

- Facilitated Area Health Education Centers (AHEC) workshop, resulting in AHEC directors agreeing on a strategy and cohesive message to deliver to the NYS Legislature, along with a time line and strategy for delivery. Developed conference content, facilitated discussions, identified existing shortfalls, and led participants in identifying actions and strategy necessary to address their needs. Created day-long workshop on best practices for approaching the legislature to assist participants in formulating a cohesive message to promote their agenda to the Legislature.

Executive Director, New York State Legislative Commission on the Development of Rural Resources

- Developed and implemented policies designed to promote and protect the health and wellbeing of upstate residents, preserving and boosting New York’s health care policies, economic development, environment, and developing affordable housing, and helping to safeguard upstate New York’s infrastructure. Worked with stakeholders in state government, the regulated community, elected officials, federal counterparts and concerned constituents, drafted and introduced legislation, developed and implemented a progressive Rural Resources agenda focusing on rural health care, economic development and infrastructure, green energy, and agriculture. Achieved this with reduced resources while continuing to meet performance goals.
- As executive director of the Rural Resources Commission, acted as advisor to Area Health Education Centers, had regular contact with HANYs, provided feedback and comment to DoH on matters before the department that had particular importance to rural health care providers; (e.g., reimbursement rates, hospital and critical care center closures, licensing of medical professionals, etc.). Worked with health care providers, dental providers, area health education centers, and health associations, on documenting need, drafting legislation to respond to such, and tracking impacts.
- Participated in evaluating both existing and predicted health care system needs (including, but not limited to, health information technology) and proposing measures to address both existing and predicted gaps across New York State; needs vary by both geographic region and economic affluence—both regionally and by facility.
- Established critical relationships with key individuals in the legislature and state agencies, as well as in the private sector, quasi-governmental authorities, lobbyists, private sector interests, and constituents necessary to advance Commission agenda. Worked with State Health Department, NYS Area Health Education Centers, NYS Dental Association, HANYs, and legislative staff from both parties.

Budget Analyst, NYS Division of Budget,

- Assisted with development and oversight for budget for the Commission on Quality of Care and Advocacy for Persons with Disabilities (Commission). Responsible for development and oversight of the annual budget of the Commission, and implementing budget actions governing the Commission's operation, as well as assisting with the budget for the Department of Mental Health. The Commission is responsible for protecting and providing for NYS citizens with traumatic brain injury, so it was critical to ensure that budget actions did not negatively affect direct care received.

Budget Analyst – Mental Health

- Responsible for budget preparation and oversight for the Commission; regular interaction with Commission director and staff, requiring familiarity with Commission's statutory responsibilities; responsible for implementing budget cuts while maintaining statutory compliance and not impacting service quality or levels; assisted in preparation and oversight of the budget for the NYS Department of Mental Health.

Publications and Speaking Engagements/Publications

2009–2010 Session Report of the New York State Legislative Commission on Rural Resources, August 2010.

Rural Futures, newsletter of the Legislative Commission on Rural Resources. 2009, 2010.

Repairing, Updating, and Building New Water/Wastewater Infrastructure, in Today's Economic and Regulatory.

Environment. Clearwaters. New York State Water Environment Association, Inc. Summer 2004. Vol. 23, No. 2.

Groundwater Remediation in New York State, Roundtable Report. New York State Legislative Commission on Water Resource Needs. Summer 2000.

Where Will the Garbage Go? A Staff Report to the Chairman. New York State Legislative Commission on Solid Waste Management. Albany, NY. 1991–1996.

Ash in the Aftermath of Chicago v. the EDF, A Staff Report to the Chairman. New York State Legislative Commission on Solid Waste Management. 1994.

Representative Clients

Commonwealth of Pennsylvania, State of Rhode Island, State of New York, State of Missouri

Education, Licenses & Certifications

MS degree, public administration and policy, Rockefeller College, SUNY Albany

BS degree, Business/Sociology, SUNY Albany

FREEDMAN HEALTHCARE

John D. Freedman, MD, MBA
Freedman Healthcare, LLC

29 Crafts Street, Suite 550, Newton, MA 02458
john@freedmanhealthcare.com 617-243-9509 office

Profile

John Freedman MD, MBA- Principal at Freedman HealthCare, has 20 years' experience in performance measurement & improvement, provider evaluation, performance incentives and managed care. Dr. Freedman served as Medical Director for Quality at Kaiser Permanente in Colorado, and subsequently as Medical Director for Specialty Services at one of the northeast's largest neighborhood health centers, overseeing 40 physicians in 16 specialties. Dr. Freedman was responsible for quality and medical management at Tufts Health Plan, helping them achieve NCQA's #2 ranking nationwide. John also practiced internal medicine and geriatrics for 10 years. Through Freedman Healthcare, Dr. Freedman provided clinical leadership in the design of the Massachusetts cost and quality website. <http://hcqcc.hcf.state.ma.us/>

Education

- 1980-84 Harvard College, Cambridge, MA
A.B. in Biology, *magna cum laude*. Honors thesis: original research in vertebrate physiology
- 1984-88 University of Pennsylvania, Philadelphia, PA
M.D. W.K. Kellogg Foundation Fellowship with Medicare Payment Assessment Commission, Chairman Stuart Altman, Washington, DC.
- 1988-91 Boston University Medical Center, Boston, MA
Internship and Residency in Internal Medicine.
- 1991-93 University of Louisville, Louisville, KY
M.B.A. with concentration in health systems. Beta Gamma Sigma.

Certification

- 1991 American Board of Internal Medicine
2000 Re-certification, American Board of Internal Medicine, valid through 2011
State Medical Licensure: MA (active); CO, IN, KY (inactive).

Experience and Appointments

- 1991-93 University of Louisville, Louisville, KY
Clinical Assistant Professor of Medicine. Full-time clinician-educator; performed health services research on patient adherence and variations in physician practice patterns.

- 1993-94 Kaiser Permanente & Colorado Permanente Medical Group, Denver, CO
General internist and Assistant Medical Director for Quality Improvement in department of internal medicine (91 internists caring for 200,000+ patients). Chaired department's QI committee prepared HEDIS reporting and directed improvement programs. Performed research on predictors of hospitalization for the elderly.
- 1994-99 East Boston Neighborhood Health Center, East Boston and Winthrop, MA
General internist and Medical Director for Specialty Services for largest community health center in northeast US. Supervised 40 specialty physicians at 3 sites; wrote and executed business plans to expand clinical services, opened GI endoscopy suite, and optical laboratory and dispensary. Managed relationships with specialty departments at 2 affiliated Boston academic medical centers.
- 1994-2005 Boston University School of Medicine, Boston, MA
Clinical Assistant Professor of Medicine.
- 1997-2000 CarisDiagnostics, Newton, MA
Co-founder of largest skin pathology laboratory in New England.
- 1999-2005 Tufts Health Plan, Waltham and Watertown, MA
Assistant Vice President and Medical Director for Medical and Quality Management. Leader of clinical measurement programs including Pay-for-Performance provider contracts, physician profiling, public provider report cards, accreditation requirements (e.g., HEDIS), tiered-network products, predictive modeling, and clinical program evaluation (e.g., disease management, case management). Oversaw utilization management activities, including medical technology evaluation, coverage criteria and case reviews. Recipient of 2004 Innovator's Award from America's Health Insurance Plans for Navigator® by Tufts Health Plan, a novel quantitative cost- and quality-based tiered network product.
- 2000-present Tufts Health Care Institute (formerly Tufts Managed Care Institute), Boston, MA
Associate Medical Director. Faculty member (1999-2007, 2009-2011) and Course Director (2000-02) of highly-rated managed care residency rotation for graduating medical residents.
- 2001-2009 New Art Center, Newton, MA
President (2003-05), Treasurer (2002-03), and Executive Committee member of non-profit community art center with over 1400 child and adult students and regionally acclaimed series of professional exhibitions.

2002-present Adjunct Assistant Professor of Medicine, Tufts University School of Medicine.

2005 Massachusetts Health Quality Partners, Watertown, MA
Board Member of leading health care quality collaborative.

2005-2006 Massachusetts Division of Health Care Finance and Policy
Advisory Committee on Public Data Release

2006-present Freedman Healthcare, LLC, Newton, MA
Principal, healthcare quality, efficiency and informatics consulting firm.
Sample clients: Commonwealth of Massachusetts Health Care Quality and Cost Council, Focused Medical Analytics, Inc., Rochester Independent Practice Association (RIPA), the Massachusetts Medical Society, payer and provider organizations, a leading international medical informatics firm, and pharmaceutical manufacturers. Provide strategic consulting regarding performance management and improvement, clinical analytics, and managed care.

2006-2011 Temple Beth Avodah, Newton, MA
Trustee; Member, Executive Committee (2007-2011)

2006-2007 Eastern Massachusetts Healthcare Initiative
Performance Measurement and Reporting Workgroup

2008-present City of Newton, MA
Alderman-at-Large, elected November, 2007 and re-elected November, 2009.
Vice Chairman, Finance Committee; Member, Programs & Services Committee, Post Audit and Oversight Committee, and Special Committee on Long-Range Planning. Health Benefits Task Force.

2008-present Network Health, Inc., Medford, MA
Board member of 175,000 member health plan serving the MassHealth and Commonwealth Care population

Publications

Examination of Health Care Cost Trends and Cost Drivers, Massachusetts Attorney General's Office, June 22, 2011 and August 3, 2011 with analytic support provided by Freedman HealthCare, LLC

http://www.mass.gov/Cago/docs/healthcare/2011_HCCTD_Full.pdf

Massachusetts Health Care Cost Trends, Price Variation in Health Care Services, June 3, 2011, Division of Health Care Finance and Policy with analytic support provided by Freedman HealthCare, LLC

http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/pricing_variation_report.pdf

Freedman JD, Gottlieb AB, Lizzul P. Physician Performance Measurement: Tiered networks, and Dermatology. *Jour Amer Acad of Derm*, 64(6):1164-9, 2011.

Advancing Meaningful Use: Simplifying Complex Clinical Metrics through Visual Representation, the Parsons Institute for Information Mapping, PIIMS Research, October 15, 2010, http://piim.newschool.edu/media/pdfs/PIIM-RESEARCH_AdvancingMeaningfulUse.pdf

Freedman JD for Care Focused Purchasing, Inc. Providers and Performance Measurement: Helping Patients and Providers. *Care Focused Purchasing, Inc., May 17, 2010.* http://www.businessgrouphealth.org/docs/CFP_PositionPaperII_ProvidersPerformanceMeasurement.pdf

Schein JR, Kosinski MR, Janagap-Benson C, Freedman JD. Functionality and health-status benefits associated with reduction of osteoarthritis pain. *Curr Med Res Opin* 24(5):1255-65, 2008.

Freedman JD, Landon BE. Massachusetts' health plans use of selected quality and utilization management tools. *Massachusetts Medical Society* 2008. Available at www.massmed.org

Kosinski M, Janagap C, Gajria K, Schein J, Freedman J. Pain relief and pain-related sleep disturbance with extended-release tramadol in patients with osteoarthritis. *Curr Med res Opin*. 23(7):1615-26, 2007.

Freedman JD for AcademyHealth - Efficiency in Health Care: What Does it Mean? How is it Measured? How Can it be Used for Value-Based Purchasing, May 23-24, 2006 www.academyhealth.org/files/publications/Efficiency_Report.pdf

Miner AL, Sands KE, Yokoe DS, Freedman JD, Thompson K, Livingston JM, Platt R. Enhanced identification of postoperative infections among outpatients. *Emerging Infectious Diseases Journal Volume 10-Number 11, November 2004*

Freedman JD, Beck A, Robertson B, Calonge BN, Gade G. Using a mailed survey to predict hospital admission among patients older than 80. *J Amer Geriatrics Soc* 44(6):689-92, 1996 Jun.

Freedman JD, Mitchell CK. A simple strategy to improve patient adherence to outpatient fecal occult blood testing. *J General Intern Med* 9(8):462-4, 1994 Aug.
Siddiqi SU, Freedman JD. Isolated central nervous system mucormycosis. *Southern Med J* 87(10):997-1000, 1994 Oct.

Cohen LM, McCall MW, Hodge SJ, Freedman JD, Callen JP, Zax RH. Successful treatment of

lentigo maligna and lentigo maligna melanoma with Mohs' micrographic surgery aided by rush permanent sections. *Cancer* 73(12):2964-70, 1994 Jun 15.

Freedman JD, Beer DJ. Expanding perspectives on the toxic shock syndrome. *Adv Intern Med* 36:363-97, 1991.

Recent Invited Meetings and Presentations

Understanding Massachusetts Healthcare Costs; the Attorney General's Reports, Hallmark Health, The Ninth Charles F. Johnson Lecture, Lawrence Memorial Hospital of Medford, November 29, 2011

Follow the Money: Healthcare Expenditures, Financing and Actions to Control Cost, Health Systems I, Suffolk University, Boston, MA, October 3, 2011.

Guest Field Project Facilitator, Quality Improvement and Quantitative Methods in Quality (HCM756), Harvard School of Public Health, September 19, 2011 & January 9, 2012, Boston, MA.

Political Economy of the US HealthCare System,, 2011 Tufts Healthcare Institute's Residency Rotation on Practicing Medicine in a Changing Health Care Environment, August 15, 2011.

Lessons from the Gamer Community for Physicians, O'Reilly FOO Healthcare Conference sponsored by the Robert Wood Johnson Foundation, Cambridge, MA, July 15-17, 2011

How to Improve the Effectiveness of US Health Care Spending, O'Reilly FOO Healthcare Conference, sponsored by the Robert Wood Johnson Foundation, Cambridge, MA, July 15-17, 2011

Best Practices in Hospital Clinical Data Benchmarking Programs, Colorado Hospital Association, Denver, CO, July 26, 2011

All Payer Claims Datasets, Colorado Hospital Association, Denver, CO, July 26, 2011

Testimony of Dr. John Freedman, Annual Public Hearing under Chapter 118G, section 6 ½, Review of Findings from AGO Examination of Health Care Cost Trends and Cost Drivers, Boston, MA, June 30, 2011

http://www.mass.gov/Eeohhs2/docs/dhcfp/cost_trend_docs/cost_trends_docs_2011/John_son_Lois_Challenges_in_Care_Coordination.pdf

Best Practices for Healthcare Data Integration, Business Intelligence Technology Advisors Webinar, June 2011

Best Practices in Hospital Clinical Data Benchmarking Programs, Part 1 and Part 2, Virginia Hospital Association Webinar, June 1 & 8, 2011

How Are We Doing? Measuring Performance in a Hospital, Virginia Hospital Association Webinar, May 25, 2011

How Are We Doing? Performance Measurement in Healthcare, Maine Hospital Association, Portland, ME, May 18, 2011

Best Clinical Practices in Hospital Clinical Data Benchmarking Programs, Maine Hospital Association, May 18, 2011

All Payer Claims Datasets: A Valuable Tool for Accountable Care, Massachusetts Governor's Health Information Technology Conference, Worcester, MA, May 31, 2011

Political Economy of the US Healthcare System, Guest lecturer in Occupational Health Policy and Administration (EH231), Harvard School of Public Health, April 4, 2011, Boston, MA.

The Future of Clinical Practice Planning for Reform, American College of Rheumatology, March 2011

All-Payer Claims Datasets, Massachusetts Health Data Consortium, Waltham, MA, January 11, 2011

How Are We Doing? Performance Measurement in Health Care, South Shore Physician Hospital Organization Annual Meeting, South Weymouth, MA, October 7, 2010

Guest Field Project Facilitator, Quality Improvement and Quantitative Methods in Quality (HCM756), Harvard School of Public Health, September 27, 2010 and January 10, 2011, Boston, MA.

Are Your Physicians Ready for Reform? Healthcare Finance News Virtual Conference and Expo web-based seminar, September 15, 2010.

Transitioning a Provider to an Accountable Care Organization, Recombinant Data Corporation, June 22, 2010, web-based seminar.

Best Practices for Healthcare Data Integration: Health Trends, BIT Advisors, June 17, 2010, web-based seminar.

Political Economy of the US HealthCare System, Harvard School of Public Health, April 12, 2010, Boston, MA.

Testimony of Dr. John Freedman, Annual Public Hearing under Chapter 118G, section 6 ½, Review of Findings from AGO Examination of Health Care Cost Trends and Cost Drivers, Boston, MA, March 16, 2010.

http://www.mass.gov/Eohhs2/docs/dhcfp/cost_trend_docs/presentations/2010_03_16_AGO_Presentation.pdf

Guest Field Project Facilitator, Quality Improvement and Quantitative Methods in Quality (HCM756), Harvard School of Public Health, September 14, 2009 and January 11, 2010, Boston, MA.

Cost & Effectiveness: Healthcare Reform and its Implications for Pharma & Devices, FX Conferences, December 3, 2009, web-based seminar.

Leveraging Profiling within your Organization, ProfSoft University, September 16, 2009, Las Vegas, NV.

Healthcare Reform and Its Implications for Pharma and Devices, FX Conference, November 2009

Alison Glastein

29 Crafts Street, Suite 550, Newton, MA 02458

AGlastein@freedmanhealthcare.com . 617-243-9509 (O)

Professional Experience

Freedman HealthCare, LLC, Newton, MA 2009 to Date

Vice President – Strategy/Business Development

Strategic leader for growing consulting firm focused on health care performance measurement and improvement.

- Develop strategic partnerships with physician groups, hospitals, state and local governments, and nonprofits;
- Identify new business opportunities through networking and responding to formal RFIs/RFPs;
- Serve as a lead writer on white papers and proposals, and editor for client reports and research presentations;
- Manage project deliverables, timelines and deadlines and organize internal work flow;
- Improve public interface efforts through website strategy and new content development.

Breakthrough Cambridge (formerly Summerbridge), Cambridge, MA 2008-2009

Executive Director

Oversaw multifaceted year-round educational program serving urban students and aspiring teachers.

- Actively participated in and further developed an active Board of Directors and Advisory Board;
- Supervised, motivated and evaluated program and development staff of six and one graduate interns;
- Partnered with 34 Breakthrough Collaborate sites that implement an innovative educational model;
- Executed comprehensive development plan to generate revenue in support of ~\$500k operations budget, resulting in more than 10% budget surplus for FY08 and FY09.

PEAR Associates: Providing Expertise and Resources, Sharon, MA 1999-2008

Founder/President

Established and directed consulting firm that provided project management, communications, and fundraising support to nonprofit organizations and educational institutions.

- Solid track record of creating successful grant proposals, concept papers and case statements for health and human service organizations in response to private, state and federal grant guidelines;
- Utilized data to develop compelling case statements in support of public health and educational initiatives;

- Provided interim staff leadership in areas of operations, external affairs and development;
- Created print and online content for clients' internal and external communication needs;
- Clients included: Housing Families, Health Resources in Action/The Medical Foundation, Joint Committee for Children's Health Care in Everett, Kenneth B. Schwartz Center, Malden Public Schools, Norfolk County Children's Advocacy Center, RESOLVE: The National Infertility Association, South Boston Community Health Center, and YWCA Malden.

Healthy Malden, Inc., Malden, MA

1997- 2000

Executive Director

Provided leadership to community health coalition sponsored by the City of Malden and Hallmark Health.

- Conducted community health assessments and used data to identify priority health issues;
- Enhanced awareness of coalition through media relations and networking with local and regional agencies;
- Facilitated task forces on youth health, violence, substance abuse, homelessness, and access to health care;
- Expanded budget by 300% through successful grant writing and fundraising efforts;
- Prepared and managed state and federal grant contracts, including accounting and grant reporting processes;
- Supervised, motivated and evaluated six program staff members and one intern.

Deana's Fund, Woburn, MA

1996- 1997

Executive Director

Developed and expanded newly formed National organization addressing domestic violence prevention.

- Developed curriculum for school-based teen dating violence prevention program;
- Trained teachers, school administrators, youth leaders, and parents on curriculum components;
- Solicited financial support through direct mail and events, more than doubling organizational budget;
- Marketed *The Yellow Dress*, a school-based program that reached 50,000 students nationally;
- Developed and recruited professionals to serve on Program Advisory Board.

HAWC-Help for Abused Women and Children, Salem, MA

1994- 1996

Education Coordinator

Managed domestic violence prevention and education programs in 23 communities north of Boston.

- Implemented the Teen *REACH* dating violence prevention program in schools and youth agencies;
- Facilitated training sessions for health care organizations, businesses, and community groups;
- Represented HAWC through public speaking, media appearances, and committee membership;
- Supervised program assistant and volunteers who aided with prevention initiative.

Education

Institute for Communication Improvement 2007
Certificate in Professional Program Development and Grant Communication

Suffolk University, Boston MA 1994
Master’s in Education, Professional Development
Dean of Students Merit-based Administrative Fellowship (80% Tuition Award)
Teaching Assistant, School of Arts and Sciences, Sociology Department
Director, Campus-based Women’s Center
Advisor, Suffolk Gay-Straight Alliance

Suffolk University, Boston MA 1990
Bachelors of Science, Graduated Cum Laude

Additional Experience

Bunker Hill Community College, Boston, MA 2000-2001
Adjunct Faculty Member for Grant Writing course, Division of Continuing Education

American Heart Association - Massachusetts Affiliate, Framingham, MA 1991-1992
Professional Education Coordinator/Heart-At-Work Program Coordinator

Affiliations/Volunteer Experience

Newton Child Care Commission and Fund, Commissioner 2010-Date
Women in Healthcare Management, Member 2009-Date
MomWorks – Supporting Working Mothers, Founder and President 2006-2008
Sharon MOMS Club, Member, ‘04-‘08;
Co-President, ‘05-‘06; Fundraising Coordinator, ‘04-08 2004-2008
Jewish Family and Children’s Service, Volunteer,
Center for Early Relationship Support 2004-2005
Association of Fundraising Professionals, MA Chapter 2004-Date
Member, ‘00-date; Program Vice Chair, Conference on Philanthropy, ‘02; Co-Chair of
Volunteers, Conference on Philanthropy ‘04, ‘05
Women in Development of Greater Boston, Member 2001-2004
Malden Access Television (MATV), Board of Directors 1999-2000
The Ellie Fund, Board of Directors, ‘98-‘01; Millennium Celebration Committee Co-Chair,
‘99 1998-2001

Honors

Women Making a Difference Award, Zonta Club of Malden/Zonta International 2000
Intercultural Affairs Alumni Award, Suffolk University - Boston, MA

Ellie Soeffing

67 Halcyon Road, Newton, MA 02459
esoeffing@verizon.net . (617) 332-5443

Profile

Ellie Soeffing: Affiliate Consultant at Freedman HealthCare, is a senior healthcare executive with over 25 years of diverse healthcare experience developing businesses, building and marketing products and managing large scale projects and interdisciplinary project teams. Ellie has extensive experience managing large departments and initiatives and working with academic and community hospitals and physicians as well as insurance companies. She is an analytical thinker with a strong understanding of healthcare finance and delivery, managed care contracting, global payments and programs to manage care who brings expertise in health reform, government program (Medicare/Medicaid). population analytics, care integration, patient self-management and chronic care management. Ms. Soeffing has worked closely with physicians in the establishment of IPAs and PHOs and significantly improved their contracting terms and performance in managing capitation. As a consultant, Ms. Soeffing has performed strategic and business planning, project management, market research, reimbursement analysis and contract negotiations for providers, health plans and agencies.

As a Senior Director at Health Dialog Ms. Soeffing oversaw the building and implementation of "Healthy Living Support for Seniors" an evidenced based wellness program based on the research of the Foundation for Informed Medical Decision Making. Using advanced analytics, sophisticated engagement methods, and effective behavior change techniques, the program focused on finding the right individuals at the right time, and providing them with the right tools. Critical components included an HRA, creation of a personalized action plan, positive motivational support, preventative screenings, flu vaccinations, weight management (nutrition and exercise), smoking cessation programs, and educational materials that engaged members and fostered healthy life style changes. Her other previous positions include: Vice President of Managed Care and Director of Managed Care for two Boston area hospitals, Director of Product Management and Strategic Planning Manager for Harvard Pilgrim Health Care, and Administrator for all Ambulatory Care at The Children's Hospital in Boston. Additionally, for two years she lectured on health care payment and reimbursement at the Harvard University Graduate School of Public Health.

Background

Strategic Healthcare Executive with strong operations, financial and business development expertise; history of operational excellence, marketing and lean/process improvement. Recognized for the ability to manage large departments/practices, grow businesses, build programs/products and manage cross-functional project teams. Excellent communications, presentation and negotiation skills.

Competencies

- P&L, budget, and extensive management of departments, teams and complex programs/projects
- Ability to understand the big picture, plan and execute
- Strategic orientation with strong analytical, financial and problem solving capabilities
- Able to gather and distill data; identify trends, implications and opportunities
- Expertise in population analytics, wellness, patient self-management, chronic care
- Lean capabilities: reengineer and streamline processes to improve results and reduce costs
- Deep knowledge of health care delivery and reform; extensive experience working with physicians
- Understanding of health care finance, managed care contracting, global payments/insurance pricing
- Skilled with Medicare/Medicaid demos and contracts and ACO and Medical Home requirements
- Track record of evaluating and implementing new technologies

Experience

Independent Consultant, Newton, MA 1987-1990, 2003-2005, Present
Services include: strategic and business planning, project management, operational problem solving, financial analysis, business development, product marketing and market research, contracting and reimbursement, for physicians, hospitals and health plans.

Identified and developed opportunities:

- Assessed business opportunities and operational readiness and developed strategies for Boston Medical Center Health Plan in light of Massachusetts and national health reform.
- Facilitated strategies for consumer engagement and provider cost and quality measures for BCBS.
- Consulted for multiple organizations on post hospital programs to reduce readmissions.
- Managed operational roll-out and integration of staff model partnership with community physicians.

Health Dialog, Inc., Boston, MA 2005 – 2010
Senior Director, Senior Products

Fiscal and operational management of complex patient programs using nurse health coaches integrating wellness, disease management, medical decision support, and patient engagement. Managed overall CMS relationship, compliance and contract obligations; managed budget and vendors.

- Served as Deputy and Acting Director for contracted Medicare programs with annual budgets of over \$20M with high level of patient satisfaction, improved care and reduced readmissions.
- Worked with clinicians to design/implement evidenced programs on wellness and chronic conditions
- Performed market intelligence and identified market trends and opportunities.
- Drafted position and policy papers; interpreted regulatory requirements and implications.

Brockton Hospital, Brockton, MA

2002 – 2003

Vice President, Managed Care

Oversaw all aspects of payer relationships for Hospital and PHO. Managed Medical Director, clinical and non-clinical staff of 20+. Managed hospital case management department.

- Led efforts to streamline processes. Redeployed case managers reducing LOS for DRGs by 8%.
- Achieved financial turnaround of PHO. Restructured and aligned workforce.
- Managed relationships and joint risk arrangements with large multi-specialty group practices.
- Initiated new financial analyses resulting in rethinking of key relationships and risk arrangements.

deNovis, Inc. (formerly eHealthDirect), Lexington, MA

2001 – 2002

Senior Consultant, Deployment

Subject matter expert on benefit design, provider payment and insurance operations for next generation health plan IT platform. Analyzed client business processes and practices; designed lean processes.

Dash, Maynard, MA

2000 – 2001

Senior Program Manager

Extensive project management of complex, cross company initiatives for technology company and its clients. Negotiated and oversaw relationships with partners and vendors.

- Assumed leadership of building next generation of main product and brought back on schedule.

Harvard Pilgrim Health Care, Brookline, MA

1994 -1999

Strategic Planning Manager, (1998 – 1999)

Identified, recommended and implemented issues of strategic importance to senior management.

- Directed research and analysis on key issues: new products, customer experience, member retention, network strategies, affiliations and acquisitions. Supervised research and project management staff.
- Business planning: facilitated departments/divisions aligning work plans with strategic plan.

- Identified and implemented new strategic planning process leading to shift in strategic direction.
- Managed the annual environmental scan; identified future trends. Introduced scenario planning.
-

Marketing Director, Product Management and Customization (1994 – 1996)

Created new department of 19 product and project managers responsible for development and management of product lines for newly merged \$2.5B company. Extensive relationship management: worked with employers to customize products, represented company with regulatory agencies.

- Developed and implemented strategies and products for large accounts, market segments, and geographic regions enabling company to win new business at rates exceeding 20% annually.
- Managed Commercial, Medicare and Medicaid; successfully expanded products into 4 state region.
- Responsible for cross company implementations and processes including operations and fulfillment.
- Streamlined and standardized processes resulting in cost, service, and quality improvements.
- Co-chaired strategic market and sales planning process for entire organization.
- Evaluated, selected, and negotiated with joint venture partners on new business initiatives, enabling company to enter new, profitable markets including Workers' Compensation insurance.

South Shore Hospital, South Weymouth, MA

1988 – 1994

Director, Managed Care Business Development

Responsible for developing and implementing a managed care strategy and acting as principal negotiator for \$50M in contracts; managed risk contracts. Directed analyses, prepared revenue and volume forecasts.

- Negotiated substantial increases in contract rates and improved terms resulting in additional \$10M.
- Identified strategies for developing relationships with community physicians and employers.
- Initiated business development efforts targeted to steer new volume to hospital.
 - Created new systems/ processes to improve data collection, cost control, and data reporting.
 - Implemented managed care contracts requiring extensive project management and introduction of new business processes across departments resulting in substantial revenue enhancement.

Managed Care Corporation, Boston, MA

1985 – 1986

Marketing Manager / Legal Affairs and Government Relations Manager

Managed hospital and physician contracted networks. Develop strategy and guidelines for selecting new markets and partners. Identified and developed new lines of business. Oversaw complex financial filings. Obtained insurance licenses in record time decreasing time to market for products.

The Children's Hospital, Boston, MA 1981 – 1985

Ambulatory Operations Administrator / Systems and Primary Care Manager

Promoted to Administrator. P&L responsibility and management of primary care and multi-specialty practices and ER. Responsible for capital and expense budgets, joint programs and contracts, quality, licensure and facility planning. Supervised unit managers/staff. Administrator-on-call for Hospital 24/7.

- Initiated systems documentation and troubleshooting projects resulting in recapture of lost revenue.
- Streamlined clinics and call center/registration processes. Managed scheduling/billing/reporting.

Education

University of Michigan

Master's Program in Hospital Administration, M.H.S.A.

- Teaching Assistant for Operations Research--Trained students in project management, operational and staffing analysis, statistical packages, and other analytical tools and engineering applications.
- Summer internship with industrial engineer working on hospital staffing metrics and efficiency.

Cornell University

B.S., with Distinction (Top 10%), Biology

Aveta Business Institute

Lean Design and Six Sigma Green Belt Training – Certifications

Academic Positions

Lecturer, Harvard University, Graduate School of Public Health, 1997, 1998

Lecturer on Healthcare payment & reimbursement strategies including: provider payment methodologies, hospital finances, health care regulation, contract negotiations, cost analysis, performance measurement and Medicare reimbursement.

Professional Presentations

Managed Care Networks Conference, Boca Raton, FL, October 1993

Guest Speaker: "Building Partnerships with Physicians Using Physician/Hospital Organizations (PHOs)"

Healthcare Financial Management Association, Boston, MA, April 1993

Guest Speaker: “Contracting, the Art and the Science”

Board Memberships

Health Law Advocates: Board Member and Treasurer; Chair of Investment Committee; Member, Strategic Planning and Health Reform Committees, 2005 to Present

Newton Wellesley Hospital: Member, Board of Overseers; Member, Community Benefits Committee of the Board of Trustees, 1992-2002

JON GRUBER, PHD

Jonathan Gruber, PhD

MIT Department of Economics

50 Memorial Drive, E52-355, Cambridge, MA 02142-1347

Phone: 617-253-8892

Fax: 617-253-1330

E-Mail: gruberj@mit.edu

Web: <http://econ-www.mit.edu/faculty/gruberj/>

Profile

Dr. Jonathan Gruber is a Professor of Economics at the Massachusetts Institute of Technology, where he has taught since 1992. He is also the Director of the Health Care Program at the National Bureau of Economic Research, where he is a Research Associate. He is an Associate Editor of both the Journal of Public Economics and the Journal of Health Economics. In 2009 he was elected to the Executive Committee of the American Economic Association. He is also a member of the Institute of Medicine, the American Academy of Arts and Sciences, and the National Academy of Social Insurance.

Dr. Gruber received his B.S. in Economics from MIT, and his Ph.D. in Economics from Harvard University. He has received an Alfred P. Sloan Foundation Research Fellowship, a FIRST award from the National Institute on Aging, the Kenneth Arrow Award for the Outstanding Health Economics Paper of 1994, the Richard Musgrave prize for the best paper in the National Tax Journal in 2003, and the 2009 Purvis Prize from the Canadian Economic Association for the best public policy publication of the year. He was also one of 15 scientists nationwide to receive the Presidential Faculty Fellow Award from the National Science Foundation in 1995. In 2006 he received the American Society of Health Economists Inaugural Medal for the best health economist in the nation aged 40 and under. Dr. Gruber's research focuses on the areas of public finance and health economics. He has published more than 120 research articles, has edited six research volumes, and is the author of *Public Finance and Public Policy*, a leading undergraduate text.

During the 1997-1998 academic year, Dr. Gruber was on leave as Deputy Assistant Secretary for Economic Policy at the Treasury Department. From 2003-2006 he was a key architect of Massachusetts' ambitious health reform effort, and in 2006 became an inaugural member of the Health Connector Board, the main implementing body for that effort. In that year, he was named the 19th most powerful person in health care in the United States by Modern Healthcare Magazine. During the 2008 election he was a consultant to the Clinton, Edwards and Obama Presidential campaigns and was called by the *Washington Post*, "possibly the [Democratic] party's most influential health-care expert." During 2009-2010 he served as a technical consultant to the Obama Administration and worked with both the Administration and Congress to help craft the

Patient Protection and Affordable Care Act. In 2011 he was named “One of the Top 25 Most Innovative and Practical Thinkers of Our Time” by Slate Magazine.

Education

Ph.D. in Economics, Harvard University, 1992
B.S. in Economics, Massachusetts Institute of Technology, 1987

Positions

Professor of Economics, MIT, 1997-present
Associate Head, MIT Department of Economics, 2006-2008
Deputy Assistant Secretary for Economic Policy, U.S. Treasury Department, 1997-1998
Castle Krob Associate Professor of Economics, MIT, 1995-1997
Assistant Professor of Economics, MIT, 1992-1995

Director, National Bureau of Economic Research's Program on Health Care, 2009-present
Director, National Bureau of Economic Research's Program on Children, 1996-2009
Research Associate, National Bureau of Economic Research, 1998-present
Faculty Research Fellow, National Bureau of Economic Research, 1992-1998

Board of Directors of the Health Care Cost Institute, 2011- present
Executive Committee, American Economics Association, 2010-present
Margaret MacVicar Faculty Fellow, MIT, 2007-present
Board of the Commonwealth Health Insurance Connector Authority, 2006-present
Associate Editor, Journal of Public Economics, 1997-2001, 2009-present
Associate Editor, Journal of Health Economics, 2001-present
Member, Congressional Budget Office Long Term Modeling Advisory Group, 2000-present
Academic Advisory Committee, Center for American Progress 2004-present
Undergraduate Program Coordinator, MIT Economics Department, 1994-2005
Member, NIH Center for Scientific Review Study Section on Social Sciences, 1998-2002
Co-Editor, Journal of Health Economics, 1998-2001
Co-Editor, Journal of Public Economics, 2001-2009

Fellowships and Honors

Named “One of the Top 25 Most Innovative and Practical Thinkers of Our Time” by Slate Magazine, 2011.
Winner of 2009 Purvis Prize from Canadian Economic Association for Best Public Policy Publication of the year
Elected to the American Academy of Arts and Sciences, 2008
MIT Undergraduate Economics Association Teaching Award, 2007
Named 19th Most Powerful Person in Health Care in the United States, Modern Healthcare Magazine, 2006
Inaugural Medal for Best Health Economist Age Forty and Under, American Society of

Health Economists, 2006
Elected to the Institute of Medicine, 2004
2003 Richard Musgrave Prize for best paper in National Tax Journal in 2003
Member of the National Academy of Social Insurance, 1996
1995 American Public Health Association Kenneth Arrow Award for the Outstanding Health Economics Paper of 1994
National Science Foundation Presidential Faculty Fellowship, 1995
Sloan Foundation Research Fellowship, 1995
MIT Undergraduate Economics Association Teaching Award, 1994
FIRST Award, National Institute of Aging, 1994
Harvard Chiles Fellowship, 1991
Sloan Foundation Dissertation Fellowship, 1990
National Science Foundation Scholarship, 1987
Phi Beta Kappa, 1987

Publications in Journals

- “The Impacts of the Affordable Care Act: How Reasonable Are the Projections?,” forthcoming, *National Tax Journal* (also available as NBER Working Paper #17168, June 2011).
- “Medicare Part D and the Financial Protection of the Elderly,” forthcoming, *American Economic Journal: Economic Policy* (also available as NBER Working Paper #16155, July 2010) (joint with Gary Engelhardt).
- “Do Strikes Kill? Evidence from New York State,” forthcoming, *American Economic Journal: Economic Policy* (also available as NBER Working paper #15855, March 2010) (joint with Samuel Kleiner).
- “The Tax Exclusion for Employer-Sponsored Health Insurance,” forthcoming, *National Tax Journal* (also available as NBER Working Paper #15766, February 2010).
- “Choice Inconsistencies Among the Elderly: Evidence From Plan Choice in the Medicare Part D Program,” *American Economic Review*, 101(4), June 2011, p. 1180-1210 (with Jason Abaluck).
- “Heterogeneity in Choice Inconsistencies Among the Elderly: Evidence from Prescription Drug Plan Choice,” *American Economic Review*, 101(3), May 2011, 377-381.
- “The Importance of the Individual Mandate – Evidence from Massachusetts,” *New England Journal of Medicine*, 364, January 27, 2011, 293-295 (with Amitabh Chandra and Robin McKnight).
- “Projecting the Impact of the Affordable Care Act on California,” *Health Affairs*, 30, January 2011, p. 63-70 (with Peter Long).

“Massachusetts Points the Way to Successful Health Care Reform,” *Journal of Policy Analysis and Management*, 30(1), Winter 2011, p. 184-192.

“The Facts from Massachusetts Speak Clearly: Response to Douglas Holtz-Eakin,” *Journal of Policy Analysis and Management*, 30(1), Winter 2011, p. 194-194.

“Fundamental Health Care Reform for the United States,” *Significance*, September 2010, p. 130-132.

“Buying Health Care, The Individual Mandate, and the Constitution,” *New England Journal of Medicine*, 363, p. 401-403, July 29, 2010 (with Sara Rosenbaum).

“The Cost Implications of Health Care Reform,” *New England Journal of Medicine*, 362, 250-251, June 3, 2010.

“How Sensitive are Low Income Families to Health Plan Prices?,” *American Economic Review*, 100(2), May 2010, p. 292-296 (with David Chan).

“Patient Cost-Sharing in Low Income Populations,” *American Economic Review*, 100(2), May 2010, p. 303-308 (with Amitabh Chandra and Robin McKnight).

“Patient Cost-Sharing, Hospitalization Offsets, and the Design of Optimal Health Insurance for the Elderly,” *American Economic Review*, 100(1), March 2010, p. 193-213 (with Amitabh Chandra and Robin McKnight).

“Getting the Facts Straight on Health Care Reform,” *New England Journal of Medicine*, 361(26), December 24, 2009.

“A Win-Win Approach to Financing Health Care Reform,” *New England Journal of Medicine*, 361(1), July 2, 2009, 4-5.

“Abortion and Selection,” *Review of Economics and Statistics*, 91(1), February 2009, 124-136 (with Liz Ananat, Phillip Levine, and Douglas Staiger).

“Universal Health Insurance Coverage or Economic Relief: A False Choice,” *New England Journal of Medicine*, 360(5), January 29, 2009, 437-439.

“The Case for a Two-Tier Health System,” *Pathways*, Winter 2009, 10-13.

“Nursing Home Quality as a Public Good,” *Review of Economics and Statistics* November 2008, 90(4), 754-764 (with Joe Angelleli and David Grabowski).

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B. Dylan Bannon

363 Washington St. Somerville, MA 02143
bannon@alum.mit.edu 918.441.8338

Education

Massachusetts Institute of Technology Cambridge, MA

B.S. in Economics & B.S. in Biology June 2011

GPA 4.4/5.0

Candidate for M.S. degree: Earth, Atmospheric, and Planetary Sciences, with focus in Geobiology

Work, Research, And Project Experience

Healthcare Market Planning Consultancy Cambridge, MA

Employed by Professor Jonathan Gruber May 2011-present

Acting as Professor Gruber's research assistant. Using his micro-simulation model to model the American healthcare market and determine the best policies for states to take in response to the Patient Protection and Affordable Care Act of 2008.

Research In Microbiogeochemistry Cambridge, MA & Yellowstone Nat. Park

Supervised by Professor Tanja Bosak Feb 2009-Sep 2011, (ongoing)

Conducting ecological and DNA-based analysis on 1) samples of cyanobacteria with the goal of determining what environmental

conditions led to the formation of the fossils known as "stromatolites", and 2) communities of bacteria from stratified, high sulfate

lakes to determine the biological origin of high sulfur isotope fractionation in lakebed sediments. Participated in collection

of samples from Yellowstone National Park.

Research in Labor Economics Cambridge, MA

Supervised by Professor Michael Piore Dec 2010-Jun 2011

Surveyed existing literature on proposed explanations for CEO compensation increases since late-1970s and used regression

analysis on a large panel dataset to test original theories involving inter-industry wage effects. Research was used as an undergraduate thesis in Economics.

Tax Policy Research and Advocacy Campaign Planning Boston, MA

Institute for Policy Studies – New England Office Jun 2010-Sep 2010

Conducted legal and political research to inform activists of the potential repercussions of advocacy of certain pieces of tax

legislation in the US Congress. Specifically, I was tasked with understanding all relevant preexisting law and knowing what

positions individual legislators and advocacy groups held, whether publicly-stated or not, regarding legislation of interest.

Nutritional Appropriate Technology Development Cambridge, MA

Supervised by Professor Jean-Jacques Hamel Sep 2008-Aug 2009

Worked as a group member, and later project leader, on developing a simple, low-cost method of culturing the health supplement

Spirulina platensis to provide an economically-viable nutritional supplement for developing countries. Duties required leading a

small group and working on the optimization of complex chemical processes by combining biochemical knowledge with

numerical models of fluid flow. Official entry into the MIT IDEAS competition.

MIT - China Educational Technology Initiative Xi'an, China & Cambridge, MA

High School and College Teacher, Program Coordinator June 2008-May 2011

Prepared curricula for high school- and college-level science and cross-cultural education, presented those same lectures to

Chinese students in China during one summer. While in China, also spent time with students on cultural exchange activities.

Later, worked as a program coordinator, guiding new students through the program.

MIT Council for the Arts Grant Cambridge, MA

Project Leader May 2009-May 2010

Received grant from MIT Council for the Arts to produce short student films and to exhibit them on campus. Films could possibly

be shown as trailers before features at the on-campus movie series run by the MIT Lecture Series Committee.

Research in Philosophy/Social Theory Cambridge, MA

Supervised by Professor Richard Holton April 2010-Dec 2010

Read philosophical literature related to the way individuals in a society interact with societal constructs, e.g. corporations. This

was followed by collection of data on how corporations differ across jurisdictions in the US and globally and a

RKM COMMUNICATIONS & RESEARCH

R. Kelly Myers. Ph.D. (ABD)

RKM Research and Communications, Inc.
1039 Islington Street
Portsmouth, New Hampshire 03801

Profile

R. Kelly Myers is President and Chief Analyst for RKM Research and Communications, Inc. Mr. Myers is directly responsible for the oversight of all quantitative and qualitative research projects conducted by the firm. He has 22 years of market research and public opinion polling experience. Mr. Myers' experience is rooted in a strong academic background where he developed high standards for methodological rigor, which remain the cornerstone for all research projects conducting at the firm. Over time, his interests have shifted from academics to consumer-based decision-making because he wanted to work in an environment where research has a more direct impact on consumer behavior.

Professional Experience

RKM Research and Communications
Portsmouth, NH
President and Chief Analyst
1996-Present

- Directly responsible for the oversight of all projects conducted by RKM Research and Communications.
- Co-founded an academic survey research center.
- Experience conducting over 1,500 quantitative and qualitative studies over the past 22 years.
- Developed a proprietary research methodology for conducting studies from beginning to end (ODR™).
- Experience conducting research for health plans, hospitals and health systems, provider groups, third-party administrators, brokers, the Commonwealth Connector and the Rhode Island Exchange.

Education

Ph.D., (ABD), Sociology, University of New Hampshire
MA, Political Science, University of New Hampshire
BA, dual-degrees in History and Political Science, Kent State University

Professional Associations

Member of American Association for Public Opinion Research (AAPOR)

Member of American Marketing Association (AMA)

Member of Society for Healthcare Strategy and Market Development (SHSMD)

Presentations

Mr. Myers is an active contributor to academic and trade-show conferences. The following is a partial list of recent contributions.

- Annual Conference of the Society for Healthcare Strategy and Market Development, Chicago, 2005
- Annual Conference of the Society for Healthcare Strategy and Market Development, Phoenix, 2006
- Annual Conference of the American Association of Public Opinion Research, Montreal, 2006
- Annual Conference of the New England Society for Healthcare Strategy, 2007
- Pre-Conference ½ Day Workshop on Healthcare Market Research for the Society for Healthcare Strategy and Market Development Conference, Washington, D.C. 2007
- “Best of the Best” webcast series for the Society for Healthcare Strategy and Market Development, 2008

POLICY INTEGRITY LLC

Steven J. Kappel
Policy Integrity LLC
1855 North Street, Montpelier, VT 05602
sjkappel@policyintegrity.com . (802) 522-0986

Profile

Steve Kappel founded Policy Integrity, a consulting firm that specializes in the development and evaluation of health policy in 2007. In that role, he has worked for a wide range of clients, including Vermont state government agencies, non-profits, and academic institutions.

He has previously worked for the Vermont legislature; the Vermont Program for Quality in Health Care; the Vermont Department of Banking, Insurance, Securities and Health Care Administration; Vermont BlueCross BlueShield; and the Vermont Department of Health.

Steve teaches health policy at UVM. He received a Masters in Public Administration from UVM in 2002.

Summary

A health care policy and analysis professional, with a broad understanding of all aspects of Vermont's health care system, from financing to outcomes research, combined with significant management experience.

Employment

2007 – Current Founder
Policy Integrity LLC

Policy Integrity LLC is a consulting firm that assists clients with the development, presentation, and evaluation of policy alternatives in health care and related areas.

2000 to 2007 Associate Fiscal Officer
Vermont Joint Fiscal Office

Provided nonpartisan policy and financial analysis to the Vermont legislature on a wide range of health care and health financing issues, with a particular focus on the Medicaid program. Work with legislators, members of the administration, and the public to develop legislation. Evaluate policy implementation.

1998 to 2000 Executive Director
Vermont Program for Quality in Health Care, Inc.

Was responsible for all operational aspects of VPQHC, including finance, personnel, planning, and external affairs, including relationships with legislature and multiple constituencies. Worked with Board to Directors to develop strategies to meet mission. Supervised staff of 6. Managed \$500,000 budget. Represented the organization before a wide range of audiences. Wrote or edited publications. Provided leadership in analytical and data management activities. Participated in quality improvement activities.

1997 to 1998 Director of Analysis and Data Management

Department of Banking, Insurance, Securities and Health Care Administration

Directed a 5-person section with broad responsibilities, including development and implementation of health policy, health insurance regulation, development of a statewide health care data base, and analysis of cost, utilization, and outcomes in Vermont's health care system. Developed policy to improve quality and control costs in Vermont's health care system. Advised Department executives, the Governor, and the Legislature. Originated or participated in multi-disciplinary research, including medical outcome, economic, survey, and insurance market reform.

1992 to 1996 Data Manager

Vermont Health Care Authority

Was responsible for financial and utilization analysis in support of health care reform, including development of models for tax and premium-based systems incorporating data from a wide variety of sources including actuarial research and sample data. Worked with a wide range of advocacy groups to develop consensus around economic models. Provided analytical support and testimony to Vermont legislature's Special Committee on Health Care Reform. Worked with health insurers and major employers to develop consensus around a cooperative statewide health care database. Developed a pilot system incorporating claims from Medicare, Medicaid, and two commercial insurers. Designed and implemented a database to manage and analyze Medicare claims information.

1990 to 1992 Director of Data Management

BlueCross BlueShield of Vermont

Directed a department of 5 with an annual budget of \$350,000, with responsibilities for database administration, statistical support and computer training. Designed and managed BCBS's end-user information system that provided support for a wide range of clients, from actuarial services to marketing.

1987 to 1989 Research and Evaluation Analyst

BlueCross BlueShield of Vermont

Developed and analyzed statistical reports for a wide audience, including Actuarial, Underwriting, and Health Services. Analyzed and presented utilization reports to customers.

1985 to 1987 Senior Research and Statistics Analyst

Vermont Department of Health

Supervised a 5 member unit which provided statistical support for a wide variety of public health efforts, including epidemiology, health care utilization studies, and population estimation and projection. Designed and developed the statewide hospital discharge information system.

Education

B.S. Communication, Rensselaer Polytechnic Institute, 1974

M.P.A. University of Vermont, 2003. Winner, Marshall Dimock award for outstanding student. Member, Pi Alpha Alpha

Graduate, Vermont Leadership Institute, 2007

Awards

BiState Primary Care Association – Public Service Award, Vermont, 2006

Technical Proposal/Program Specifications

Section 1. Exchange Operations/Business Functions

1.A. Call Center

An important goal of the ACA is to facilitate an online, consumer friendly application and enrollment process, but many clients need or prefer human assistance navigating through the eligibility, enrollment and ongoing maintenance processes of acquiring health insurance. This may be especially relevant for those who have never been insured. In the interests of administrative efficiency, the State's unified call center should be tied to advanced, easy-to-use web and IVR customer service modalities. The three modalities are intimately inter-related. Wakely will assess and recommend changes in all three modalities for efficient, effective and responsive customer service.

The ACA directs states to provide a toll free number and the exchange call center to be operational mid-2013, in advance of open enrollment that begins October 1, 2013. Many of the services provided by existing Medicaid/State program call centers will be required with the implementation of the ACA. These include assistance with eligibility questions, enrollment in health plans, and member data maintenance. There are new services and skillsets that the state's call center must offer, such as how to support small businesses and brokers, new eligibility and enrollment rules, and the information technology to support eligibility determination using data from the federal data hub run by USHHS. A thorough review of Vermont's existing call center contractual services, related to people, process and technology, is required to identify and recommend a path to assure full compliance with the ACA exchange requirements and guarantee world-class experience for the consumer.

Individual consultants on this project worked together for several years at the Massachusetts Health Connector, including working with the existing Medicaid call center vendor to define the operational requirements, technology support and staffing to create a call center that complied with the state's health care reform law passed in 2006. Wakely will pull from that experience and incorporate the ACA knowledge gained from work with other states to assist Vermont in capturing what will be required of Vermont's call center to be ready for 2014. Our call center operations experience ranges from high level policy and technology requirements definition to working with the call center operations staff on a daily basis to implement customer service, enrollment, billing and collections services. Based on this experience, we identify some key issues below.

The Vermont call center will need to clarify roles and responsibilities in order to seamlessly transfer information between other state coverage programs QHPs, Medicaid, brokers, employers, Navigators and, of course, potential enrollees. The call center will need to triage member calls in a new world that includes the challenges of working with eligibility information from a federal verification hub, enrollment support from Navigators, members

transferred from a QHP call center, small employer billing and collections issues, and questions related to premium tax credits.

The open enrollment period in 2013 will be a major milestone for the exchange and the call center performs a critical role. To be successful, the exchange will need to develop a coordinated plan with the call center vendor as they will be responsible for supporting the calls, mail, web traffic that will result at the onset of open enrollment. A few of the areas to focus on include website modifications, IVR changes, potential staff augmentation, training and coordination with QHPs and Navigators. Peak volume and confusion should be anticipated for October 2013 through February 2014, and then annually thereafter. Assuming that Vermont chooses January 1st as the annual effective date for non-group coverage, staffing and other operational planning must routinely handle high volume and overflow capacity at year-end.

Staffing levels and organization will be driven by the number of people using the exchange, the availability and use of self-service modalities, the different kinds of customers to be served and the degree of specialized knowledge required in the call center for different kinds of customers and programs. For example, the skillset and seasonality of volume for customer service to support small business operations (SHOP) will be assessed against skills and seasonality for existing Green Mountain Care programs, possibly a new Basic Health Program, individuals (both tax-credit eligible and those above 400% FPL) to determine if cross-training can support this new initiative or if a subset of CSRs should be organized into separate business units to focus on specific programs and customer segments. The customer relationship management solutions would need to be integrated to manage the eligibility, premium tax credit and cost sharing subsidies and member management that will occur.

Wakely will leverage our exchange call center experience from Massachusetts along with our understanding of the ACA requirements to assist the state in assessing, identifying modifications and making recommendations to the call center services contract to assure full compliance. We will begin this process by meeting with key stakeholders from State agencies and the call center to understand the processes and technologies that support current programs. In parallel, the analysis continues with collecting and reviewing the existing contract and call center services documentation – or creating new documentation where necessary. Wakely will create a tracking document to detail the contractual call center services, grouped by business or functional area, and will include the supporting staff, technologies and integration points.

This review will be followed by systematic evaluation of the current call center services against the specific ACA call center requirements and our insight on best practices needed to support the individual and small business consumers. We will go into detail on those areas that are out of compliance with the ACA requirements or which require entirely new skill sets in the call center, such as supporting brokers and small employers. (Unless Vermont legislates a ban on the outside small-group market, customer support for small employers and brokers on underwriting, COBRA, HIPAA, premium assistance, mid-year

terms and deletions, claims denials, and a whole host of other issues that small employers delegate to associations and brokers will be a competitive feature required to attract small employers to SHOP.) The deliverable document will include recommendations on the specific areas in need of modifications, either through staffing, process changes or technology enhancements. The deliverable will also include a narrative of potential risks, issues, or roadblocks that could prevent call center operations from being ready mid-2013, prior to open enrollment.

In addition to the final assessment document, Wakely will assist the State in drafting an amendment to the existing call center contract to accommodate the requirements of the ACA.

Call Center Assessment process and deliverables include the following:

1. Scope Definition
 - Kickoff meeting
 - Schedule key SME interviews
 - Data gathering
2. Assess Current Call Center Delivery
 - Complete document review
 - Initiate interview with key organizations
 - Baseline of the “as is” operations
 - Analyze the gaps between the federal requirements, leading practices and the DVHA’s current state
 - Utilize these comparisons to identify specific processes or situations where there are potential opportunities for standardization, simplification or modifications necessary to align with federal requirements
3. Develop Strategy
 - Validation of analysis and assumptions through a stakeholder check-point
 - Develop Gap Analysis
 - Develop Recommendations
 - Stakeholder debriefing
4. Plan and Align
 - Present findings and comparative analysis
 - Current state vs. future alignment
 - Prioritized activities
 - Draft an amendment to current call center contract

1.B. Financial Management

Vermont is seeking a contractor to assess existing and planned financial management policies and reporting capabilities in relation to federal requirements and recommend refinements and/or adaptations as needed and allowed within State. In addition, the state seeks support in refining its financial model to accurately project Exchange operating expenses, and the related revenue requirements, over a five-year period. Finally, as required of the exchange under the ACA, Vermont is seeking support in the development of a sustainability plan that will result in adequate revenue to sustain exchange operations starting in 2015, when the exchange must become financially self-sufficient.

Under Section 1313 of the ACA, related to financial integrity, the Exchange is required to keep an accurate accounting of all activities, receipts, and expenditures, and to submit annually to the Secretary of HHS a report of such accounting. The exchange is also subject to an annual audit by the Secretary of HHS, and the Secretary, in coordination with the Inspector General of HHS, may at any time examine the properties and records of the Exchange and/or require periodic reports in relation to Exchange activities. Once fully operational, the Exchange will be subject to Government Accountability Office (GAO) oversight, and the Comptroller General will initiate an ongoing study of Exchange operations and performance. While not strictly financial in nature, this oversight will require the development and maintenance of robust and reliable data and reporting systems.

In addition, the Exchange must be self-sustaining. As specified under the ACA and further delineated in the Notice of Proposed Rule-Making issued by CMS on July 11, 2011, the state must ensure that its Exchange has sufficient funding in order to support its ongoing operations beginning January 1, 2015 by adopting a revenue source sufficient to support Exchange operations.

Wakely Consulting Group (Wakely) has deep experience in developing budgets, financial analyses, and financial policies in a variety of private and public settings, including for state-based health benefit exchanges. Our team includes the founding CFO, as well as the Manager of Finance, from the Health Connector in Massachusetts, who together developed and managed the budget functions, financial management systems, vendor procurement, and audit preparation protocols for the exchange in Massachusetts from its inception in 2006 through the first four years of its operation. Since the passage of the ACA, Wakely has been actively working on the development of five-year exchange financial models and proposed revenue plans in nine other states.

Assessment and Recommendations on Financial Management and Reporting

Unlike the Health Connector, and many of the other state-based exchanges with which we have been working, which are independent or quasi-public entities, the Vermont Exchange will be a sub-component of the Department of Vermont Health Access, and as such it will be

able to leverage existing accounting and financial systems and practices of the department, which will be compliant with policies and procedures promulgated by the Vermont Department of Finance and Administration and incorporated into the state's GASB-compliant Comprehensive Annual Financial Report (CAFR). However, the Exchange, as contemplated in the ACA, is tasked with performing an array of business and government functions that are unique and often complex, such as: the premium billing, aggregation, collection, and transmission function; SHOP-specific rate development and billing process; and premium tax credit and subsidy determination, data transmission, and integration with billing and collection system.

While in some ways analogous to processes currently administered under Catamount Care and VHAP, other elements are unique to the ACA and will require the development of appropriate process controls, data capture, and integration into reporting and accounting systems. In addition, the multiple financial and data interfaces required to connect the Exchange to federal agencies, vendors, carriers, brokers and eligibility and enrollment systems. Each of these multiple points of external contact must be appropriately managed and controlled. Moreover, the financial reporting and audit protocols required by federal oversight agencies will likely require different and/or additional requirements than currently in place to meet state-based standards.

Our review will build upon work already performed as part of Vermont's exchange planning effort, but will focus on areas unique to the exchange and additional and/or new requirements. We will pay particular attention to practices and structures required to achieve unified, consistent reporting of financial information, internally and externally, to meet federal audit and reporting standards. Our recommendations will also reflect key elements of the entire exchange planning process, such as the expected scale of the exchange. Specific areas of focus will include:

1. The type of accounting and financial reporting systems appropriate to the exchange model under consideration, including expected cost of implementation and reporting structure
2. Premium billing systems, including lockbox functions;
3. Policies and procedures in the areas of financial reporting, accounts payable/receivable, and premium write-off
4. Organizational integration required to track premium collections and reconcile premium tax credits and cost-sharing subsidies
5. Vendor, carrier, and systems interface and reporting relationships
6. Control and management of exchange data and financial information

Five-Year Exchange Budget Estimates

To develop detailed estimates of anticipated expenses during both start-up and operations, as well the revenue required to support such operations, Wakely has developed the Exchange Financial Implementation Model (ExFIM). ExFIM is a proprietary, interactive model of exchange revenue and expenses during exchange start-up and operations. The

model incorporates existing benchmark information on the cost of operating an exchange, but is flexible and customized for each state. It employs state-specific projections for enrollment, premium levels, product distribution (by benefit tier and market segment), administrative cost drivers, staffing levels, and systems configuration in order to develop five-year cost estimates and revenue requirements. Moreover, ExFIM provides the state with a flexible and iterative budget management tool that can be used and modified as policy decisions are made and more refined information becomes available.

Methodologically, our approach is similar to the approach used by Burns & Associates to estimate Exchange expenses, but goes further. Similar to Burns & Associates, Wakely's approach incorporates granular, state-specific information, but it also applies information on operating exchanges drawn from publicly available sources, our own experience operating an exchange in Massachusetts, and our experience working with nine other states on exchange financial modeling. Thus, working with existing estimates for Vermont as a starting point, Wakely will augment and refine the estimated cost of running Vermont's exchange under varying scenarios, and then estimate the level of assessment or alternative revenue source needed to support its administrative functions.

The two primary drivers of administrative cost for the exchange will be staff salaries and benefits (15-20% of costs) and IT and operational systems (60-70% of costs). Staffing levels are affected by, among other things, the scope of functionality to be supported within the exchange, the number of health plans participating in the exchange, and the anticipated membership that will be enrolled through the exchange. Wakely begins by modeling staff costs from the ground-up, using Vermont wage scales, the number of FTE's by functional area and staff level, and then we use a scalable, volume-based mechanism to test the staffing needs by functional area at different levels of complexity and enrollment. While some areas will be inelastic relative to enrollment, others will be more sensitive to membership volume. Wakely will work with State agency staff to determine the appropriate level of staffing by functional area based on our experience, as well as the proposed design of exchange functionality and reasonable volume scenarios for enrollment through the Exchange.

IT and operational systems will comprise a greater portion of exchange administrative costs, and the close integration of Vermont's exchange with existing state programs as well as the State's extensive experience with other publicly subsidized programs will lend an additional level of specificity to the estimates of cost in this area. Vermont's ability to leverage current State systems, as well as the State's participation in the New England Innovator grant, will provide the state with a high degree of system scalability as well as a range of options for ongoing system financing. Although start-up costs for systems development and implementation of the exchange are financed by the federal government, Vermont, like other states, will need to carefully assess and develop cost estimates and financing strategies for ongoing operation of the core systems. It is during the operational phase that the exchange is susceptible to expense overruns and cash flow issues; Wakely can assist in developing risk mitigation strategies, such as vendor contract models and timing of payments to optimize cash flow.

Brokers are an additional element of the revenue requirements picture. While broker compensation, if incorporated into the exchange's business model, should be a pass-through for the exchange, both the level of broker compensation and the share of enrollment driven by this distribution channel, can have a large impact on administrative costs as a percentage of QHP premiums. Modeling this impact and presenting options to the exchange with respect to how broker compensation fits into the overall revenue model of the exchange, or if other options exist for compensating brokers, will be a key aspect of our analysis and recommendations.

Similarly, the role and financing of Navigators is an important Exchange cost issue. Because this program must be fully state funded, and Navigators' services will be especially important prior to operations and premium flows in 2014, developing and sustaining this program can present unique challenges from a budget and cash-flow perspective. Our analysis will also address the potential challenges related to financing this program and propose potential options to resolve them.

Revenue Model Assessment

Vermont currently leverages a variety of funding streams to support its publicly subsidized health care programs, including, in addition to member premiums and federal matching funds, tobacco tax revenues and employer assessments. Market dynamics and program transitions contemplated under the state's health care reform act may provide opportunities to expand or re-purpose some of these revenues. The structure of funding sources selected by Vermont to finance its Exchange will be influenced by current market structure, existing assessments on the health care sector, an increase in insurance coverage and reduction in uncompensated hospital care, and the State's ultimate vision for a universal exchange. Wakely will support the development of a sustainability plan with a refined estimate of exchange operating costs (discussed above), and an evaluation of the pros and cons of various financing options. Relevant considerations when weighing different financing options includes:

1. Anticipated enrollment in the exchange (the non-group and small group markets) and premium levels. As a small state, it is appropriate for Vermont to multiple means of raising revenue, as enrollment in the exchange initially may be insufficient to fully fund the entity's administrative expenses based solely upon an assessment on participating QHPs. Early estimates suggest that anticipated enrollment in the Vermont exchange could be slightly in excess of 100,000.⁴ Exchanges with enrollment below 200,000 can find it challenging to support exchange operations based on QHP assessments lower than 3% of premium.

⁴ Vermont Health Insurance Exchange Planning Task 6.0: Analysis of Exchange Financial Functions Final Report, Including Matrix of Financial and Business Functions with Cost Estimates, August 30, 2011, Burns & Associates, Inc.

2. Political will to provide stable additional sources of revenue sufficient to support exchange operations, particularly in the event of low or unpredictable levels of enrollment.
3. Impact of the ACA's coverage expansion through federal subsidies on existing State funding mechanisms: can Vermont re-purpose existing State revenues dedicated to coverage programs and/or will providers currently shouldering uncompensated care costs bear some responsibility to assist in financing the program?
4. Desire for broad funding source, such as user fee across all health insurance. Given the centrality of the Exchange to Vermont's larger approach to health market transformation and the exchange's position within DVHA, a more broadly defined revenue source may be appropriate for building a universal exchange.
5. The impact of exchange financing method on different market sectors, including plans sold inside and outside the exchange; in the small, non-, and large group insured markets; and on self-insured and government payers and/or providers.

Specific deliverables of our proposed work plan include three primary tasks:

A. Analyze Current System and Assess Financial Management and Reporting Capacity

1. Provide a detailed analysis of state and federal requirements for financial management and reporting.
2. Review existing work performed to date to assess state financial management and reporting capacity as it related to the exchange.
3. Conduct site visits, document and policy review, as well as interviews with key staff to identify and assess existing financial management policies and procedures, as well as information capture and reporting capacity.
4. Develop recommendations for refinement, modification, and/or addition of financial management reporting policies and resources to meet state and federal requirements

B. Exchange One-Year and Five-Year Expense Projections

1. Conduct detailed review of existing expense estimates, including a review of Vermont source information.
2. Develop a range of refined estimates of Exchange expenses during start-up and operations, projected through 2016, and accounting for scenario planning related to key enrollment scenarios and critical policy decision making pathways.
3. Provide written report outlining expense estimates, as well key assumptions and methodological considerations.
4. Provide interactive and iterative expense planning tool that can be inherited, operated, and modified as the state moves down the implementation timeline.

C. Self-Sustainability Plan

1. Using existing data sources and staff interviews, develop baseline information on sources and uses of current Vermont health care financing mechanisms.
2. Using five-year exchange budget projections as a base, and supplemented with market information related to existing funding mechanisms and known revenue streams, develop financial model of exchange sustainability capable of projecting a range of expense and revenue scenarios to support state decision-making and planning processes.
3. Provide written report highlighting a range of potential funding mechanisms, including an impact analysis of each method and review of pros and cons based on considerations of financial sufficiency, market impact, stability/predictability, and impact on existing or anticipated sources and uses of health care revenue initiatives.

1.C. Program Integrity

Section 1313 of the Patient Protection and Affordable Care Act requires the Health Benefit Exchange to implement and administer a number of financial integrity functions. For example, the Exchange is required to keep an accurate accounting of all activities, receipts, and expenditures, and to submit annually to the Secretary of HHS a report of such accounting. The Exchange is also subject to an annual audit by the Secretary of HHS, with a particular focus on systems of internal control to protect against fraud, waste, and abuse. Further, Vermont's Exchange enabling legislation requires that the Exchange have responsibility for all premium collections, including the potentially complicated task of collecting premium payments from multiple employers for one individual for a single plan covering that individual. Finally, as a division of the Department of Vermont Health Access (DVHA), a publicly-accountable, customer-oriented agency, the Exchange will be motivated to exert a high degree of quality-assurance and transparency of operations.

Wakely will work closely with the DVHA to understand the capabilities and limitations of the existing accounting and financial management infrastructure in determining whether it meets the complex transactional and reporting needs of the Exchange. During our time managing the Massachusetts Health Connector, we consistently received unqualified audit opinions from an independent external auditor and successfully prepared for and managed through multiple reviews and audits conducted by the state. Our experience in this area will allow us to assist Vermont in developing the appropriate financial structure to ensure that internal and external management reports are accurate and timely, and that the system of internal control is robust enough to meet the rigors of state and federal audits.

Our recommendations will analyze and address the following;

- The accounting and financial reporting systems needed for Vermont's Health Benefit Exchange, taking into account the Exchange's relationship with the DVHA, as well as how a universal exchange interact with other state and private health programs;
- Policies and procedures in the areas of financial reporting, accounts payable/receivable, and premium write-off;
- Whether current finance and accounting resources at the DVHA could meet the ongoing reporting and auditing needs of the exchange. These recommendations will also reflect key elements of the entire exchange planning process, such as the expected scale of the exchange; and
- An implementation plan for the accounting and reporting functions that includes cost, reporting structure, recommendations for reports, and chart of accounts;

One aspect of preventing fraud, waste, and abuse is the proper control and management of exchange data and financial information. The focus of our review in this area will be on the practices and structures required to achieve unified, consistent reporting of financial information, as well as the proper management and controlled access to critical data

elements, with a focus on proper protocols, policies, and procedures (as distinct from an IT security assessment or more technical review of exchange systems.) We will review existing guidance on HHS auditing and reporting requirements, with a particular focus on how these requirements changing as the Exchange moves from implementation to ongoing operations in 2014.

Another critical component of preventing fraud, waste, and abuse is ensuring the accuracy of information and outcomes of the eligibility determination process and appeals for exemptions from the individual mandate. The ACA assigns the exchange responsibility for implementing a “no wrong door” approach to eligibility and for certifying exemptions from the individual mandate. The exchange will also need to be able to notify employers when an employee qualifies for subsidized coverage through the exchange, thus potentially triggering an employer penalty. Carrying out these politically sensitive tasks efficiently, effectively, and accurately will be necessary to maintain and build public support for the exchange and reform more broadly. Vermont’s Health Benefit Exchange should leverage the experiences and policies of existing state health coverage programs in determining how best to structure its program integrity procedures.

Wakely has considerable experience in the establishment of these protocols. Not only did staff at Wakely build the mandate exemption process for the Massachusetts Health Connector, we have also assisted many state-based exchanges in identifying the proper protections needed for a robust eligibility determination process.

For this project we will:

- Assess current policies and procedures for the prevention of fraud, waste, and abuse at different state agencies and across different programs with a particular focus on Medicaid. This analysis will include an evaluation of the eligibility requirements and appeal needs of each program, and how they crosswalk to the standards required under the Exchange.
- Evaluate innovative prevention procedures in private industry and whether these procedures could apply to the Exchange.
- Develop a multi-year plan for fraud, waste, and abuse prevention procedures for the Exchange, with a focus on how current procedures could be modified over time.
- Wakely will also work closely with the state workgroup tasked to implement the technical components of “no wrong door” eligibility to ensure adequate control functions and protocols are in place.

The team that will be working on this project include Patrick Holland, the founding CFO of the Health Connector, and James Woolman, who together developed and managed the budget functions, financial management systems, vendor procurement, and audit preparation protocols for the exchange in Massachusetts from its inception in 2006 through the first four years of its operation. They will be also be assisted by Kerry Connolly who managed the development of an internal appeals unit at the Health Connector.

1.D. Exchange Staffing

Wakely Consulting has assisted more than 10 states in the development of Exchange organization plans and staffing designs. Our experience in this arena falls into three main categories:

1. Wakely has directly assisted four states in the development of Level I and Level II Exchange Establishment grant requests, a major component of which is the development of a plan for Exchange staff organization, including job descriptions, organizational structure, and hiring timeline.
2. Wakely's ExFIM financial model, as described in section 1 (B) of this proposal, is structured as an iterative model that helps Wakely work with State officials to customize staffing plans to account for state-specific preferences and circumstances.
3. Wakely has advised several states on a hiring sequence, organizational structure, appropriate level and structure of staff compensation and benefits, skill-set requirements by position, and balancing exchange hiring versus contracting for resources to meet aggressive federal timelines and the "rush" of volume as January 1 2014 approaches.

We will draw upon this experience to develop a staffing plan that is appropriate for the structure envisioned by the Vermont Exchange, as follows:

1. Review existing staffing plans and standard Vermont State employee compensation and benefit levels;
2. Develop refined staffing estimates, organizational chart, and recommended sequence of hiring based on the estimated scale of the exchange, functionality included in exchange design, and ability to leverage existing staff and/or functional expertise from within state government.
3. Develop annual staffing cost estimates and place staffing costs into a 5-year financial model, including revenues, to judge "affordability" of staff budget;
4. Work with Deputy Director of DVHA to revise staffing plans, if necessary for achieving self-sustainability; and
5. Finalize staffing plan and develop job descriptions for key staff

1.E. Exchange Evaluation

A key component of exchange planning, establishment, and operations is the development of an evaluation plan for the exchange. Implementing this plan will enable the state to track the performance of the exchange in general, as well as other aspects of health reform

implementation: in particular, health insurance coverage; health care access, quality and affordability; and health outcomes. A robust measurement and evaluation program will provide the state with data to demonstrate success, identify issues needing mid-course correction, continually improve its programs, and identify unmet public health and programmatic needs that should be addressed.

A careful evaluation program should be able to detect both the negative and positive impacts of the exchange, and is an important step to ensure the exchange is meeting its policy goals. It also ensures that the state can quickly recognize and correct any unforeseen and unanticipated effects. For example, to understand the broad impact of the exchange, Vermont will likely want to continue to track coverage trends, including number of insured, number of “underinsured,” rates and characteristics of employer offers of insurance, out of pocket health expenditures, and access to care and services. Vermont will likely also wish to monitor satisfaction with Exchange services, including with application and enrollment, call center performance, and appeals and exemption processes. Given the state’s goal of a single payer system, close monitoring of cost trends (in and out of the exchange) as well as penetration of new payment and delivery systems such as global payments, ACOs, and medical homes will be important for the state.

Wakely will meet with DVHA and exchange staff to understand key goals and indicators that are of particularly important to the state, including especially those related to its plans for transitioning to single-payer and a universal exchange. Wakely will also leverage work that has already been done in Vermont, and measuring the impact of health reform in Massachusetts as well as by the State Health Access Data Assistance Center (SHADAC) work for California. Based on existing evaluation efforts, plus discussion with state officials about unique Vermont goals, Wakely will recommend potential indicators for use in the state.

Once a list of goals and indicators has been defined, Wakely will inventory the indicators that are already being collected in national and state-based datasets. Based on its work in other states, Wakely is already familiar with data collected through relevant national surveys such as Current Population Survey (CPS), American Community Survey (ACS), Medical Expenditure Panel Survey (MEPS), Behavioral Risk Factor Surveillance System (BRFSS), National Health Interview Survey (NHIS), and Survey on Income and Program Participation (SIPP). Vermont also has a tremendous amount of state-specific data, such as that obtained through Vermont Household Health Insurance Survey, Vermont’s recent study of the uninsured and underinsured, and health care utilization and expenditure data from VHCures. Steve Kappel is very familiar with Vermont’s data sources and will work with Wakely on this task.

Wakely will identify which of the key indicators have already been collected and develop a report that summarizes these baseline data. For indicators that are not yet being collected, Wakely will propose strategies for collecting these data. These strategies could include further household surveys, employer surveys, exchange enrollment data, tax data, target program surveys, and health insurance regulatory data requests. Wakely will recommend a strategy for collecting collect each of the indicators, and develop a template for collecting

such data on a specific reporting schedule. We will also provide a timeline for the evaluation plan that identifies the process and intervals for periodic measurement. We recommend that a high-level budget also be developed for the proposed plan, so that State staff can prioritize and triage elements of the plan and Wakely can incorporate the costs of the evaluation plan into multi-year financial self-sustainability projections..

1.F. Level 2 Establishment Grant Application

Wakely has worked with several states on their grant applications, providing project management, drafting, and budget development expertise. Most recently Wakely wrote the project narrative, budget, budget narrative, workplan, and other components for Rhode Island's successful Level 2 application. In our experience, drafting a Level 2 Grant Application is a months-long process involving close coordination with state staff.

One of the challenges in assisting Vermont with its Level 2 Grant Application will be timing of the start and completion of this effort. If Vermont has already made significant progress in pulling together the application by end of January 2012, Wakely can step in to help complete the application by March 2012. However, if the Level 2 application work is to begin after Vermont signs a contract for technical assistance and the consultant meets with agency staff and reviews key documents and data sources, then meeting a March deadline may be problematic. Moreover, some of the work products of this RFP should inform Vermont's level 2 Grant Application.

Wakely's approach to the creation of Vermont's Level 2 Grant application will include a detailed project plan outlining the composition and editing process for each component described above. We recommend that the State assign a small oversight group to this project in order to assist Wakely with the collection of the necessary State-specific data and information we'll need to complete this application. Wakely will report to this group weekly on the application's progress including activities completed, key activities pending, outstanding issues, and an updated project plan. The first product of this project will be a draft work plan. This workplan will drive the creation of the narrative and budget.

Wakely will work closely with state staff, and outside personnel if needed, to create the remaining deliverables that support the application. With such an innovative vision for its Exchange, Vermont will need to track its resources and timelines across multiple programs and agencies. For some staff, the Exchange planning work happens in addition to their normal workload, so we will be judicious with the amount of time requested from state personnel. Wakely will provide a suggested outline of the specific data elements and staff support needed for each of the application's components.

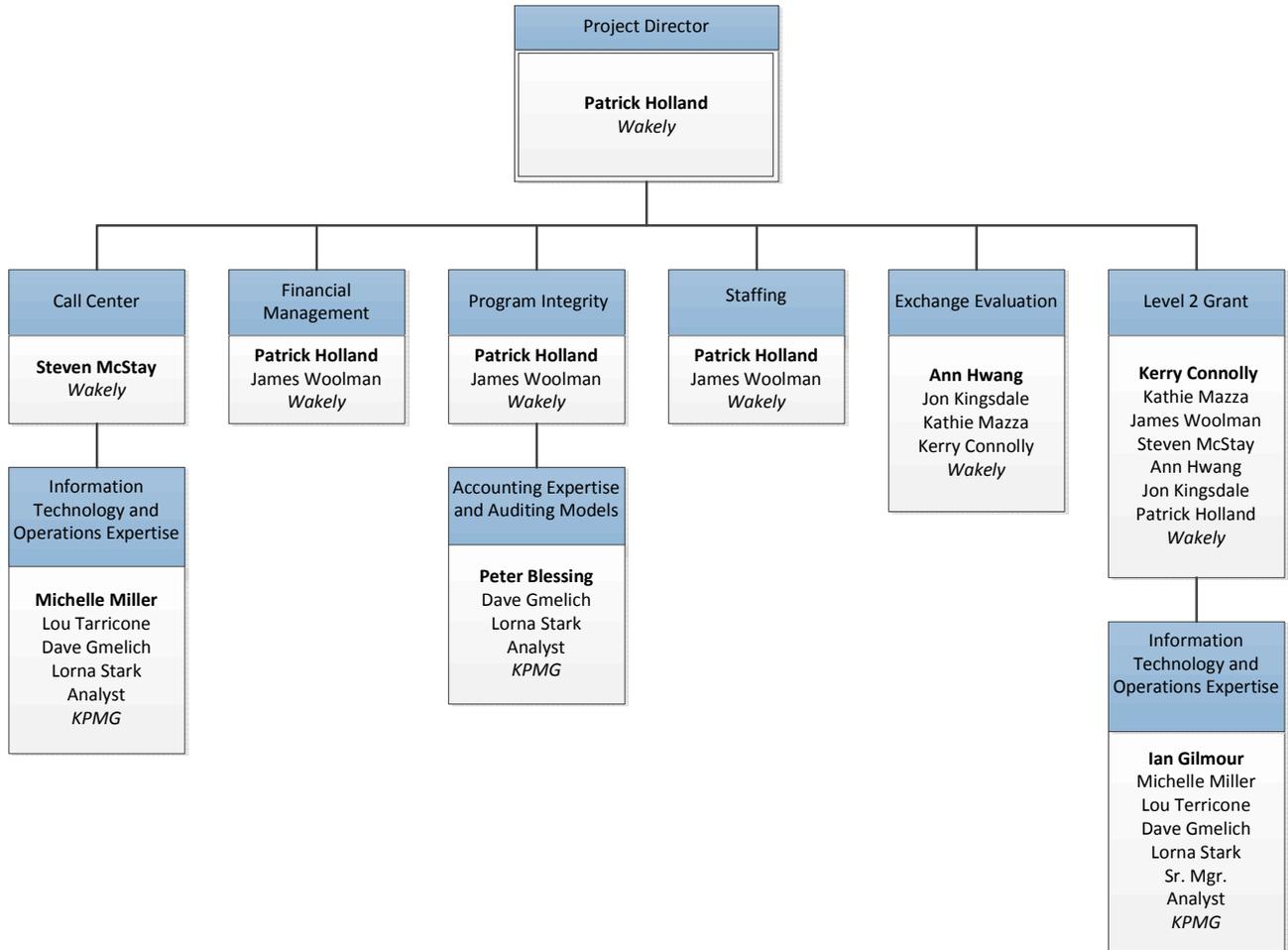
A robust and defensible application requires the coordination of multiple workstreams. For example, in its application, Vermont's IT planning and "build" efforts should explicitly tie back to and support particular business needs of the exchange. To ensure that Vermont's technology vision and planning efforts are accurately described and referenced throughout the application, Wakely staff will work closely with KPMG while drafting the narrative and budget components of the application. Wakely and KPMG have worked together in multiple states to coordinate exchange IT and business planning. KPMG has worked with multiple states, including Missouri and Rhode Island to perform their IT Gap Analysis, develop options for defining and extending the state's exchange architecture, and developing their model IT workplan and budget for inclusion in their Level 1 or Level 2 grant application.

KPMG will review existing IT Gap Analysis and Vermont Exchange Architecture and confirm it aligns to the CMS Exchange Reference Architecture as a baseline before developing the proposed exchange IT budget. KPMG will directly lead the development of the IT workplan and budget, including validating budget assumptions with the states, and providing financial, implementation work schedule, and related detailed backup documentation.

Kerry Connolly will lead the overall project management for the grant application. Kerry has significant project management experience and led Rhode Island in the development of their Level 2 Establishment Grant Application. Also supporting this process will be James Woolman, Ann Hwang and the KPMG team.

Section 1 Organizational Chart

Section 1



Section 2. SHOP/Individual & Employee Responsibility & Enrollment

2.A. SHOP Exchange

The development of a SHOP exchange poses unique challenges for states. While the individual exchange has a clear value proposition for its individual clients -- access to substantial tax credits not available in the commercial market and ease of comparison shopping and enrolling in a matter of minutes -- the value of the SHOP exchange to small employers is less clear. Recent reports from the U.S. Treasury indicate that employer uptake of the small business tax credit has been significantly lower than expected. (And use of these tax credits did not even require eligible small employers to switch their group insurance to SHOP, as it will in 2014.) This suggests that the Exchange's position as the sole distributor of temporary small business tax credits, starting in 2014, will likely not entice many small businesses to the SHOP exchange.

Therefore, Vermont should think strategically about what value the SHOP exchange could add for employers until such time as the state moves to single-payer and a universal exchange. For example, the SHOP Exchange might offer small employers a defined contribution option, expand employee choice, or simplify and standardize administrative functions to take costs out of the small-group market. Vermont will also want to consider how exclusion of the outside market for small employers and for individuals -- other than illegal immigrants, who are barred under the ACA from using the Vermont Health Benefits Exchange -- would work toward a "universal exchange." However, excluding the outside market is not a panacea: it will put more pressure on SHOP to deliver value to small employers.

Wakely will bring its first-hand knowledge of SHOP exchanges, leveraging work the firm is currently performing for Vermont regarding small group policy options, and lessons learned working with CCIIO and other states on SHOP design. For example, it has become clear on SHOP design in other states that close attention must be paid to building into the IT specifications appropriate mechanisms for screening employees for the affordability of ESI. An automated, "easy" way to screen enrollees for ESI affordability should be built into the SHOP business processes, as this screening will likely save money for both employers and lower-wage employees; as such, it represents a "value-add" for the SHOP exchange.

This is just one of several important learnings from our work in other states on employee responsibility and enrollment that Wakely will want to test with staff from DVHA and then (as appropriate) build into business design planning for SHOP.

Working closely with the DVHA staff and with Vermont employers and employees, Wakely will identify priorities for Vermont's SHOP exchange and develop corresponding exchange models. Wakely will organize design meetings with insurers, employers and employees. If given a choice, it is the employer -- not the employee -- who chooses SHOP versus another

buying channel, so design meetings with employers are a priority for developing a SHOP model that will “sell.”

Once a design or set of design options have been developed, Wakely, working with its subcontractor RKM, will develop a moderator guide for focus groups. RKM will develop a market research strategy that includes focus groups and, where appropriate, in-depth interviews with small employers and employees of small businesses, to explore reactions to the proposed models. RKM will summarize findings from this research in a written report to the state. Again, absent the requirement that small employers participate, this kind of market research is crucial for estimating the employer uptake of SHOP, and for refining design.

To help inform decision-making around the SHOP exchange, Wakely will provide an assessment of the budget and operational impacts of carrying out a minimal set of functions versus an expanded set. This will include a high level assessment of the minimum required business processes as well as the business processes associated with optional features or services that the state may wish to offer. We will provide cost estimates, leveraging work from other states where possible, to maximize the efficiency of our work. We will also document the operational procedures needed for the SHOP, including required elements as well as “nice-to-have” features.

2.B. Individual and Employer Responsibility Determinations

Under ACA, exchanges must certify exemptions from the individual mandate for individuals who do not have affordable insurance available to them. While detailed federal guidelines for this process have not yet been released, Wakely is well-versed in the statutory and regulatory guidance that is available to date, and will also be prepared to review any additional guidance that is developed.

With respect to individual determinations, much of the data for eligibility determination will come from the federal data hub and from the individual applicant. However, a particularly challenging subset of data for individual eligibility determination is the applicant's access to employer-sponsored insurance (ESI). Possible approaches range from asking the applicant, checking against multiple, typically incomplete state vendors and data bases on employer and insurance coverage, and random audits. Existing resources for checking on ESI vary considerably among the states, as described below.

In addition, the Exchange must be able to notify employers that one of their employees is eligible for a premium tax credit because the employer does not provide minimum essential coverage or it is not affordable, and as a result, the employer may be subject to a penalty. The exchange must also notify employers of an appeal process on the determination, and in response, the employer can present information to the Exchange for a review of the determination process. Exchanges must also notify an employer if one of their employees ceases coverage under a qualified health plan during the year (including the effective date of such cessation).

These interactions will require the Exchange to develop a process for determining when to impose an employer penalty. Effectively, this process will begin when an applicant applies for a premium tax credit during the eligibility determination process. The applicant will need to provide information on his employment status, employer name and contact information, and information on the availability of affordable minimum essential coverage. The Exchange must have a process in place for obtaining and evaluating any available employer-sponsored coverage, as well as verifying certain other employer data.

For purposes of notifying employers and checking individual eligibility against access to ESI, the Exchange should consider data sources for employer data to avoid unnecessarily burdening the employer with individual employee data verification requests. Wakely has already done some work investigating such data sources in eleven states and would work with Vermont and their State Department of Labor on identifying the optimal source for the Exchange based on criteria Wakely would develop. Possible data sources include the State's premium assistance program (which currently has approximately 8,000 enrollees); coordination of benefit data from the State's program efforts to ensure Medicaid is the payor of last resort; child support data systems; and workforce reporting, including New Hire reporting. Additionally, the Exchange may want to utilize employer specific data that will result from three new ACA reporting requirements: Summary of Benefits and

Coverage; new W2 reporting, and large employer reporting requirements specific to health insurance.

Wakely will work with its subcontractor KPMG to jointly define these business processes, the corresponding reporting requirements and the technology needs to ensure that the ACA mandate for efficient and timely eligibility determinations are realized by Vermonters.

Relative to the appeals functions for both individual and employer responsibility determinations, Wakely will review and document existing appeals functions for various subsidized coverage programs within Green Mountain Care. Wakely and KPMG will also assess the capacity of these existing functions to be leveraged by the Exchange, and business process flows required to do so.

This will include an assessment of staff capacity, IT resources, and the feasibility of integrating specific business functions between Exchange, Medicaid and other Green Mountain Care programs. To inform our assessment, we propose convening and facilitating a series of participatory workshops to review and define the necessary business processes for individual and employer responsibility determinations, and to reach consensus where possible on the suitability of integrating existing resources with exchange operations.

2.C. Enrollment in Qualified Health Plans

Enrolling members in qualified health plans is a fundamental operational function of the exchange. For individuals and small business employers and employees, it will be one of the first transactions with the exchange and will therefore play an important role in determining initial impressions of exchange competency and consumer satisfaction.

Wakely will draw upon two distinct sets of experience. Wakely personnel developed enrollment processes for the Massachusetts Health Connector, both for the subsidized Commonwealth Care program and the unsubsidized Commonwealth Choice program. In its work for other states on exchange design and operational planning, Wakely has assessed the ability to adapt enrollment processes and systems from existing state programs for use by the exchange. Insurers are also a critical stakeholder in the enrollment process and Wakely's practical experience in working for and with insurance carriers will provide an important perspective and linkage to that aspect of the assessment.

In developing our work plan, we will first identify and document the critical path for enrollment in qualified health plans, separately for individuals and employers. Although there are many core exchange business functions that are similar for the individual and small group market, the enrollment function is not one of them. The enrollment process for these two segments is quite different. For example, in the non-group market, enrollment is a relatively straightforward transaction in which the entity making the purchasing decision is also selecting the qualified health plan he/she wishes to enroll in. However, because of the need to coordinate and inform four separate entities on all elements of tax-credit subsidized enrollment—enrollee, health plan, the Exchange and IRS trust fund—even individual enrollment is much more complex under the ACA than it is for the Connector.

Due to the concentration of market share in three health insurance carriers, Vermont can easily work with its major carriers to ensure an efficient and seamless enrollment process for exchange enrollees. Wakely will work closely with the state agencies and carriers to understand the enrollment systems and processes used by each carrier, potential enrollment barriers, and to identify opportunities for standardization and coordination between the carrier and the exchange. For example, due to the ability of an individual enrollee to pay the monthly premium to the exchange or the carrier, there will need to be a bi-directional interface that accommodates either payment flow. Because the exchange will be the authoritative source of information to reconcile individual enrollment in QHPs, premium billing by QHPs or the exchange, eligibility for and advance payment of tax credits, and QHP collection of tax credits and enrollee contributions (direct or through the exchange), the exchange's enrollment and premium payment processes must meet new and extremely rigorous standards for real-time, automated information exchange, accuracy and completeness.

For SHOP, the Exchange will first need to work closely with the employer to create an employer account, including Tax ID, primary business address, upload of employee census

information including payroll data to determine employee annual wages, and premium payment options such as electronic funds transfer (EFT). Examples of subsequent steps in the critical pathway include communicating directly with the employees, establishing online employer and employee accounts, distributing information to employees regarding plan offerings, and, if applicable, documenting why employees have not accepted the employers offer of health insurance (spousal coverage, unaffordable, etc.)

Wakely will then look to component programs in Green Mountain Care, such as Catamount Health, Medicaid and The Vermont Health Access Program, to assess whether such programs have existing processes or systems that could be leveraged for the exchange. Critical elements we will consider include scalability of existing systems, portability of processes and systems to the exchange functions, ability to modify the underlying IT architecture of the systems, and programs policies and procedures. An important dimension of our assessment will be the availability of federal funds to design, build and procure a new system, versus the time and cost to remediate an existing system.

After developing the baseline enrollment functionality and evaluating possible use of existing public programs, Wakely will then develop recommendations concerning enrollment procedures for the individual and small group markets, distinguishing between those procedures which are unique to one segment or the other and those which that can be leveraged for both market segments. An example of the latter is the interface of enrollment data with insurers and back-end reconciliations between the exchange and QHP's. Beyond the two exchange markets, Wakely will also consider how enrollment in other Green Mountain Care coverage can eventually be integrated into a universal exchange.

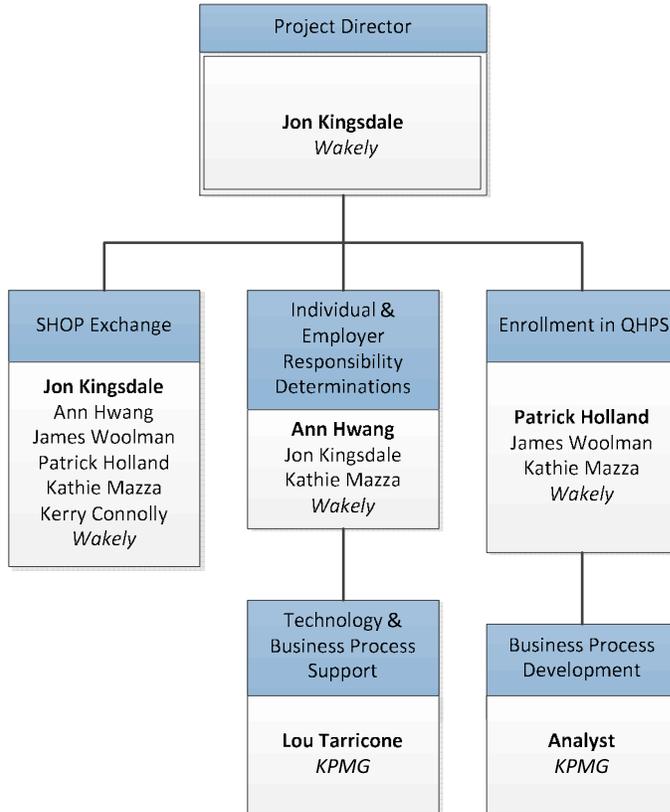
Another critical function directly related to enrollment is design of the exchange premium billing system. An important policy decision regarding premium billing in the SHOP exchange is whether to provide for list- or composite-billing, utilizing the "reference plan" model as allowed under previously released IRS regulations. This question has direct implications on the recommended enrollment process and Wakely will assist the state in assessing the implications to the SHOP exchange of both models.

In the individual market, there is an equally important question regarding the desirability and cost of developing a premium billing system for individuals. Under the ACA, individuals can elect to pay their premium to the exchange or directly to insurers. Wakely will evaluate the pros and cons to the exchange in developing this functionality.

Data gathered during our assessment on these key design questions and preliminary design concepts will also be shared during interviews with insurers, brokers, small employers, employees, and staff of existing Vermont subsidized coverage programs (such as Catamount) to gain their reactions and input. Acquiring information from these stakeholders will be an important element in finalizing our recommendations for the state.

Section 2 Organizational Chart

Section 2



Section 3. Health Insurance Market Reform

3.A. Analysis of the Impact of the Exchange on the Outside Market

We understand that the hours associated to this portion of the Vermont RFP are dependent on issues that arise during the 2012 Vermont legislative session and anticipate that they will be related to topics such as:

- The size of groups allowed in the Exchange, specifically the groups with 51-100 employees and large groups with over 100 employees
- Groups that are currently part of associations
- The range of products, including supplemental insurance and self-insured products, that will be available outside the Exchange and how that market may impact the Exchange

Wakely's responses will be supported with Vermont specific data, or with other relevant data when Vermont data is not available. A key step in this support will be to review the work completed by the existing actuarial firm and their estimates.

The two sources of Vermont data that we anticipate using are the 2010 revenue and claims data and the all payer claims database (APCD). Through another engagement for Vermont, Wakely is familiar with the claims and revenue database compiled by Steve Kappel, of Policy Integrity, containing 2010 data from Vermont's three major insurers for approximately 90% of the market. Wakely is familiar with the information contained in this data, as well as its limitations, so that we can pull required information from it quickly. (Of course, Steve Kappel is also teaming with us on this proposal.)

Wakely will work with the APCD as a potential source of information for answering questions arising out of the legislative session. Wakely has worked with other comprehensive databases such as the New Hampshire APCD and has the analytical capabilities for loading, verifying, and summarizing data for use in understanding impacts of benefit design and contract changes. Having clients with a wide range of focus – Medicaid, Medicaid expansions, Medicare, high-risk pools, and commercial – we have worked with many different data sources associated with various covered and uninsured populations. An integral part of our reform work has been the incorporation of publicly available data such as the American Community Services (ACS) data, Current Population Survey (CPS) data, and information regarding the Massachusetts Connector. In the event the Vermont APCD is not available in time for data extraction to assist in responding to legislative questions under this scope of work, or if it does not contain information necessary for a particular analysis needed, we can access other sources, including those listed above.

Our approach to providing responses to legislative questions will be to objectively evaluate the issue at hand, providing sensitivity analyses and limitation disclosures where warranted. In addition, we will support all findings with actuarial communications as required by the Actuarial Standards of Practice.

3.B. Risk-Leveling Programs

Wakely has developed a widely cited general analysis of the reinsurance, risk corridor and risk adjustment programs under a grant from the Robert Wood Johnson Foundation⁵. Of course, the issues specific to Vermont, with its association plans that include small and large employers, use of academic medical centers just across the borders in New Hampshire and New York, and intent to move to single-payer (including multiple existing risk pools) would need special attention in considering the application of the “3Rs” under the ACA. Wakely is uniquely qualified to analyze the issues covered in the Wakely paper in the context of Vermont’s specific insurance market and health insurance exchange structure. Because we have worked through these issues at such a deep level, we can be very efficient in providing this support.

Program design options (covered below) would help identify any necessary changes in state law. One of the most common areas where changes may be necessary is use of data (e.g. Vermont’s APCD⁶) and authority to collect additional information (e.g. detailed premium information, rating factors, etc.). In addition to state law, there may be regulation changes that could be incorporated, making the rate review process more informed and transparent, and if so chosen, more restrictive. For example, Vermont could implement regulations that require rate filings to display the risk scores used in pricing the 1.0 premium rates, and calculations as to how exactly those risk scores were used in pricing. Wakely actuaries have years of experience submitting rate filings in several states on behalf of commercial carriers, and we could assist Vermont in supplying additional items they may want to consider requiring within future rate filings as they pertain to risk adjustment and reinsurance.

Key design options covered in the Wakely RWJ paper and (soon to be released) work plan present key design options for Vermont, including the following:

- 1) Pros/cons of federal versus state administered risk adjustment program
- 2) If state administered, what state agency will administer the program
- 3) If state run risk adjustment, which risk adjustment tool to use
- 4) If state run risk adjustment, what premium rates to use, rating factors, etc.
- 5) If state run risk adjustment, data collection schedule and other stakeholder interaction
- 6) Federal or state reinsurance parameters
- 7) If state parameters, methodology for determining the factors, including health plan data collection and necessary analysis

⁵ “Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment”
<http://www.rwjf.org/coverage/product.jsp?id=72682>

⁶ Our understanding through our work with NORC for CCIIO is that the Vermont APCD could be used for the reinsurance and risk adjustment programs without legislative changes.

8) Specifics of the risk adjustment and reinsurance audit programs

The full list of design questions is very long, but the items above are some of the most critical. The timing of release of the Federal risk adjustment model and reinsurance program (October 2012) and requirement to file state specific parameters shortly thereafter (November 2012), make it critical for states to aggressively prepare for these programs in advance.

The work plan lays out several different scenarios under which the programs would be set up that reflect key structural differences including the following:

1. The state's access to detailed claims data through an All Payers Claims Database (APCD). States that have implemented or are in the process of implementing an APCD would most likely have access to detailed claims data, as long as the APCD was not developed for a specific, different intent with limitations on possible uses. Timing regarding when data in an APCD could be extracted is also a key consideration. States without an APCD may also have access to data through a specific data request to issuers.⁷
2. The state's interest in exploring an alternative to the federal risk adjustment model ("state alternative");
3. The state's interest in developing reinsurance parameters different than the federal parameters;
4. The number of issuers participating in a state's individual and small group commercial markets
5. Available funding for risk adjustment and reinsurance analysis, stakeholder engagement, and simulations; and
6. Issuers' willingness to provide data under a centralized approach or to model results under a distributed approach.

It is critical that issuers (health insurance companies) in the individual and small group markets receive information in 2013 so that their pricing for 2014 will appropriately consider the impact of reinsurance and also risk adjustment transfers. Wakely would leverage the work plan to assess the specifics of the Vermont insurance market and health insurance exchange structure to develop a Vermont specific work plan including a timeline for key steps.

Wakely will also provide administrative cost estimates for various design and governance options. Wakely has developed administrative cost models for full Exchange and related program administration based on our work in other states. Drawing on our experience in Massachusetts, as well as assisting a number of states on their Level 1 and Level 2 grant applications and five-year exchange financing models, Wakely has developed a fulsome database to develop a range of exchange expense estimates based on various enrollment and design scenarios. Additionally, working closely during the past year with KPMG, we

⁷ Our understanding through our work with NORC for CCIIO is that the Vermont APCD could be used for the reinsurance and risk adjustment programs without legislative changes.

also have a rich source of data to develop or corroborate IT design, build and ongoing operational forecasts.

Because the risk corridor program will be federally administered with no state discretion, less consideration needs to be given to this program as compared to the reinsurance and risk adjustment programs. However, it will be important to coordinate the risk corridor program with minimum loss ratio requirements and other department of insurance functions which appear to be outside the scope of this project. Therefore, we would expect to provide minimal support on the risk corridor program and then only to the extent some state support for data transmission will need to take place.

3.C. Certification of Qualified Health Plans (QHPs)

The Vermont Health Benefit Exchange is seeking a contractor to support the identification and development of criteria for certification, decertification, and recertification of Qualified Health Plans (QHPs) participating in the Exchange. The state seeks support in analyzing state and federal laws and other guidance pertaining to QHP certification and the development of criteria that incorporates these state and federal requirements. In addition, the state seeks support in developing the processes and procedures for certifying health plans, an estimate of the resources required to support this process, and assistance in developing the information requests and model contract for issuers participating in the Exchange.

Under the ACA, the Exchange is required to consider certain criteria regarding the issuer of a QHP as well as regarding the QHP benefit plan itself when making determinations related to QHP certification. Federal HHS has provided minimum criteria states will need to review during the certification process. Beyond these minimum criteria, states have the ability to include additional criteria that they deem to be in the “best interest of qualified individuals and qualified businesses.” Under minimum federal criteria, issuers of QHPs must:

- Be licensed and in good standing in the state in which it is proposing to offer coverage
- Offer at least one QHP at the Silver level and one at the Gold level, a child-only plan for each tier in which they participate, and uniform pricing in and outside the exchange
- Comply with ACA rating band requirements and family tier product offerings (individual, two adult, one adult/one child, and family)
- Comply with ACA quality improvement and reporting initiatives
- Comply with state and ACA marketing rules and requirements
- Participate in ACA-based risk adjustment programs
- Be accredited by an entity recognized by HHS
- Segregate funds for abortion services

Relating to QHPs themselves, the ACA and current federal guidance from HHS requires that QHPs meet the following criteria:

- Rates must be set for an entire benefit or plan year and submitted to the exchange
- Issuers must submit justifications to the exchange for annual rate increases, which must be considered by the exchange in relation to rate increase activity outside the exchange
- QHPs must meet service area and geographic coverage requirements

- QHPs must demonstrate adequate network adequacy, including a sufficient number of essential community providers, and provide detailed provider network information to the exchange
- Enrollment processes, periods, and termination of coverage must be in accordance with federal requirements and those specified by the Exchange
- Issuers must demonstrate coverage transparency to the Exchange, HHS, and the Insurance Bureau
- QHPs must meet minimum coverage standards, cover all essential health benefits and adhere to cost limits outlined in the ACA
- QHPs must be non-discriminatory

Under Act 48, Vermont’s Exchange-enabling legislation, the Exchange must minimally consider the following when granting QHP certification:

- Affordability
- Promotion of high-quality care, prevention, and wellness
- Promotion of access to health care
- Participation in the state’s health care reform efforts
- Such other criteria as is deemed appropriate by the Commissioner

In addition, QHPs must meet existing state standards for participation in the Blueprint for Health as provided in 18 V.S.A. chapters 13, use the uniform enrollment forms and descriptions of coverage provided by the DVHA and the BISHCA, and comply with rate review and rate justification processes overseen by BISHCA.

Working within this framework, Wakely will help translate state and federal requirements into certification specifications for Vermont QHPs that supports Vermont’s unique vision for single-payer. Wakely will recommend a certification process and contracting instrument to effectively and efficiently review QHP qualifications, assess health plan adherence to the principles outlined in Vermont’s legislation, and engage carriers in the larger health care market changes envisioned by the states enabling legislation. A number of other important considerations will be critical to successful certification process, such as:

1. The potential impact of “Multi-state Health Plans designated by the Federal Office of Personnel Management (OPM) to participate across all states. As specified in the ACA, the OPM will designate at least two carriers who will be deemed as QHPs across all states once they meet state-based criteria for licensure and participation. Given the small market and limited number of carriers currently participating in Vermont, the potential introduction of new carriers will be a significant development, not necessarily conducive to the development of a single-payer

system in Vermont. Wakely will seek ways to reconcile or mitigate such disruption in crafting QHP criteria for certification, re-certification and de-certification.

2. The impact that QHP criteria will have on carriers and products sold both inside and outside the exchange. If Vermont elects to retain a market outside the exchange, the impact that certification criteria for plans and product designs sold inside and outside the exchange will be an important consideration, particularly in their impact on the relative risk profile of plans sold in the two markets. For this reason, the Exchange will need to work closely with BISHCA to ensure that certification criteria used for the exchange and possible new legislation or insurance regulations applicable to the non-exchange market harmonize and coordinate offerings in and outside the exchange to the maximum extent possible.
3. The level of choice in plans and/or products offered through the exchange, as well as the degree to which benefit designs sold inside and outside the exchange are standardized, per specifications provided by the Exchange. While the ACA allows states wide latitude in establishing product offering requirements as a condition for QHP certification, Vermont's RFP (pp. 33 and 34) indicates that its Exchange intends to develop standardized benefit/cost-sharing designs for Silver, Gold and Platinum offerings. This raises the question of developing certification criteria that constrain commercial offerings at the Bronze and catastrophic levels, too. Standardizing QHP offerings at the Silver, Gold and Platinum levels and legislation tying offerings outside the exchange to those inside it—or banning the outside market--will significantly affect Vermont's progress toward a universal exchange that serves a single-payer vision for Green Mountain Care.
4. Finding the appropriate balance in working with carriers as both a business partner and as a component of state government. Health insurers create the products that the Exchange will be selling, so developing a productive working relationship should be an important goal for any certification process. In Vermont, where the Exchange is seen as a stepping stone toward a larger, market-wide end-game, engaging carriers in a commonly-held, longer term vision will be particularly important. Vermont has ample experience managing similar state-carrier collaborations for its other subsidized programs, and given the limited number of carriers and market dominance of BCBS, this process will necessarily focus on a few key relationships. (Some states, such as neighboring New Hampshire, Massachusetts and Maine have sought new entrants, but allowing new carriers to enter Vermont will challenge single-payer.) It will be especially important to develop inter-operability standards and linkages between QHPs and the Exchange to achieve administrative savings and move toward a universal exchange eventually, so how to build that into QHP certification criteria will be a focus of Wakely's efforts.
5. How can the Exchange use the certification process to advance important health goals enshrined in the enabling legislation, including payment reform and the transition to a unified market in 2017? What levers does the Exchange have? While

state and federal laws provide wide discretion to state exchanges on which criteria to include in plan certification, the Exchange as defined under ACA may not “set” prices for exchange products, as it operates within the (potentially) larger community-rated small and non-group market. Using the certification process to address affordability, access, and quality concerns in the interim may require creative ways for the Exchange to engage carriers around such developments as bundled or even global payment methods, support of ACO development, linkages to Special Needs Plans for dual-eligibles, and payment for quality improvement.

6. The integration of the Exchange with existing public programs, and the need to manage potential discontinuities in coverage as enrollees migrate between Medicaid/CHIP and tax-credit eligibility. Vermont has a rich array of existing public programs, some of which will be replaced by Exchange tax credits. Managing the certification process to effect this integration and harmonize the coexistence of Medicaid/CHIP and commercial products sold through the exchange will be an important consideration as the state moves towards a more unified health care market.

Wakely’s work developing an effective and efficient certification process will draw upon extensive knowledge and experience in developing health plan procurements for both subsidized and non-subsidized programs for the Massachusetts Health Connector, contract negotiations with health insurance carriers and provider systems, development of incentive-based procurements and contracts, extensive experience and knowledge with the new provisions of ACA, and practical experience in working for health insurance carriers. In addition, our recent and ongoing work to assist two other states grapple with the complex issues related to QHP certification will directly benefit the exchange in Vermont.

Specific elements of our proposed scope of work include the following:

1. Provide Vermont with an in depth analysis outlining state and federal requirements and criteria for QHP certification. This will provide the baseline information upon which the state will establish its own detailed QHP criteria.
2. Interview staff within BISHCA, DVHA, and other relevant state agencies and review relevant documents and policies to assess existing state capacity and activity related to rate review, licensure, and other oversight activities. We will use this information to develop a recommended certification process that leverages and complements existing processes to maximize efficiency and coordination while minimizing market confusion.
3. Facilitate discussions with Vermont officials to delineate short and long term state goals and priorities for the certification process. Alongside elements highlighted in Vermont’s enabling legislation, identifying specific goals the state hopes to achieve through the certification process, and how these relate to the larger project envisioned in Vermont’s health reform legislation, will be a critical determining factor in the development of recommended QHP criteria.

4. At the request of the state, interview key stakeholders to identify priorities, concerns, and issues with direct relevance to the QHP certification process, including a discussion of both content as well as regulatory process issues. This will enhance state information related to carrier priorities, and provide additional perspective on the development of an efficient, streamlined, and non-duplicative certification process.
5. Based upon our analysis of state and federal policy, assessment of existing processes, and information gathering from state officials and carriers, we will develop recommendations related to QHP criteria, as well as a process structure that will most effectively and efficiently meet state goals.
6. Draft model contract instrument to memorialize state goals, meet state and federal standards, and address other issues, concerns, and priorities identified during our review.

Specific deliverables for this project will include the following:

- A. A written report to include the following elements:
 - Analysis of State and Federal QHP Requirements
 - Findings related to existing regulatory and oversight capacity
 - Suggested QHP Criteria to include in the certification process
 - Suggested process structure for the certification process, and estimated resource requirements to implement this process.
- B. Information request and data collection templates to support Exchange and/or BISHCA review of carrier and QHP qualifications
- C. A model contract instrument the state may utilize to contract with QHPs for participation in the Exchange

3.D. Consumer Satisfaction Surveys

Our work will address section 1311 of the ACA, which requires each state to gather customer satisfaction data from enrollees for each qualified health plan with at least 500 enrollees and report that information on the Exchange's website to provide individuals and employers with information about how each plan is rated by its members. RKM Research and Communications is a full-service marketing and communications research firm specializing in custom-designed quantitative and qualitative research services. Among many engagements with health plans, providers and state clients, RKM has experience working with Wakely consultants on the Commonwealth Connector in Massachusetts and the State of Rhode Island.

Working in close cooperation with Wakely, RKM will be responsible for the following steps to enable the exchange to conduct periodic consumer satisfaction surveys and post the survey results on the website for general viewing:

1. Provide a set of recommendations for designing and implementing an appropriate customer satisfaction system, including standards and recommendations based on existing HEDIS/CAHPS survey questionnaires, as well as other measurement systems. RKM has extensive experience conducting customer satisfaction, customer loyalty and customer advocacy surveys, and believe their experience will bring significant value to this assignment.
2. Provide a comprehensive outline of the possible survey design options (including telephone, online, mail and mixed-mode, as well as a careful review of the costs of each one, and the methodological advantages and disadvantages of each one). RKM will also make recommendations for an appropriate sample size needed for members enrolled in each qualified health plan.
3. RKM will work closely and collaboratively with project staff from Wakely and DVHA to provide technical assistance and recommendations toward the development of an appropriate questionnaire. Based on input from Wakely and DVHA, RKM will draft a copy of the questionnaire. This draft will be submitted to Wakely and DVHA for review, revision and modification. Based on comments and suggestions from Wakely and DVHA, RKM will draft a revised questionnaire and will re-submit for further review, revision and modification. This iterative process will be repeated until a final version of the questionnaire is approved by DVHA.

RKM has extensive experience designing questionnaires. They also have extensive experience with the CAHPS survey, and will be able to provide expert counsel to ensure that the final instrument is: 1) consistent with regulatory requirements; 2) using best-in-practice measurement techniques. Questionnaire design is one of the most important components of any survey research project

- and it is essential that detailed attention is given to each question to ensure that it provides accurate and useful information. RKM uses a three-step process to build questionnaire reliability. First, their extensive first-hand experience provides a depth of knowledge about the types of questions and response options that work best, and why. Second, they follow a set of systematic recommendations for addressing wording and context effects outlined in the academic literature. And third, they pre-test each survey instrument to ensure ease of administration and clarity of question wording after it is tested in their cognitive lab.
4. Provide recommendations for the development of procedures and oversight for the effective implementation and monitoring of the customer satisfaction survey on an on-going basis. Based on years of experience managing an active field unit of interviewers from RKM's out-bound call center, they will be able to provide expert counsel on the practical, day-to-day management of on-going tracking research. They will also provide an estimated budget for what the costs will likely be to conduct the research and post the results.
 5. Provide counsel regarding options for posting the customer satisfaction survey results on the Exchange's website. RKM has direct experience managing a web portal for the surveys they conduct for their clients, and they are in an excellent position to provide counsel on all the options available for making the research results available for public review.

3.E. QHP Plan Designs

The tasks outlined in this section fall into two distinct pieces of work: (1) An analysis of Vermont's mandated benefits in relation to the as-yet undefined federal Essential Health Benefits package; and (2) a survey of existing benefit plan designs sold in Vermont and assessment of the level of variation in these benefit designs. For this proposal, we will discuss each of these larger pieces of work separately.

I. Essential Health Benefits Analysis

The Affordable Care Act (ACA) requires the Secretary of Health and Human Services to define the Essential Health Benefits (EHB) package that will establish the minimum covered benefits for products sold through the state based Exchanges as well as in the non-Exchange commercial insurance market for individuals and small groups. In addition to defining a minimum level of coverage for insurance products, among other things, the EHB package will create the basis upon which federal premium tax credits will be provided on a sliding scale to individuals purchasing through the Exchange with incomes between 139% and 400% of FPL. If policies sold through the Exchange cover benefits above and beyond the EHB package, they must be paid for with state dollars (enrollee premium contributions are limited by the ACA to a percent of the individual's income based on a sliding scale between 3% and 9.5% of annual income). Whether the state retains existing mandates that exceed the EHB package, and if so, how such mandates will be funded, are critical decisions the state will need to make as it prepares to fully implement the ACA. More immediately, the state is required to provide a report to the legislature due in February outlining a proposed minimum benefits package for the Exchange by February 15, 2012.

To assist in Vermont in this decision-making process, the state is seeking a contractor to perform these four main tasks:

1. Complete a comparison of State mandates to the federally-defined EHB package

The Affordable Care Act specifies 10 broad categories of benefits that must be included in the EHB package, but specific definition from the Secretary has not yet been issued as to what the EHB will include. An actual comparison between Vermont mandates and benefit covered under the EHB package will obviously not be possible until such guidance is obtained from the federal HHS. Until such time as guidance is provided, we will need to compare Vermont's mandates to a proxy of what the final EHB is likely to include. The Institute of Medicine, in its report on this subject released in October, 2011, recommends that the Secretary balance the breadth of the selected benefits with affordability, and recommends, in addition to the 10 specified coverage outlined in the law, that the Secretary initially anchor the EHB package on benefit plans currently available in the market, including some flexibility for state variations. This recommendation is consistent with the emphasis that the ACA places on affordability. We would anticipate that EHB's, at least initially, will be a consistent a benefits package

that is representative of small group and individual policies nationally. In lieu of receiving detailed federal guidance, our initial effort will focus on comparing Vermont's 13 mandated benefits to benefit plans that are representative of what is currently available nationally in the small-group insurance market to identify which mandated benefits are likely to be included or excluded from EHB. This work will be based on our work evaluating health plan benefits in states across the country.

2. Complete an actuarial analysis of the cost to the State of maintaining existing mandates that are not included in the EHB package

Based on the comparison completed in task 1 noted above, Wakely will analyze the instances where Vermont's 13 mandated benefits are greater than the EHB (or proxy EHB if the regulations have not been released in time). Pricing for the mandates will be based on three main sources of information:

- Wakely's actuarial pricing model, calibrated to Vermont's market. This pricing model has been utilized in four different states (Colorado, Illinois, Rhode Island, and Delaware) specifically for the purpose of analyzing the impact of essential health benefit requirements. Calibration and adjustments to our pricing model are necessary in order to incorporate state-specific considerations, and we would do so in order to make the model appropriate for Vermont.
- Reviewing prior analyses related to mandates. Often times, states will perform a financial analysis to determine the estimated cost impact of proposed state mandates prior to incorporation of the mandates. If such estimates were performed by Vermont, Wakely would take those estimates into account as well.
- Rate filings. When mandates are initially incorporated, carriers often times document the premium rate changes they feel are necessary in order to compensate for the additional costs associated with the mandated benefit. This documentation may be found in rate filings available.

3. Research other states to determine which states have similar mandates, and whether they intend to retain or eliminate these mandates, and the research behind these decisions

Vermont is not the only state wrestling with this issue; to provide Vermont with an overview of how other states are grappling with this issue, Wakely will survey related efforts in the dozen other states in which Wakely is working to generate a broad baseline of information on which mandates exist and, at a high level, how states plan to adapt to the requirements in the ACA. Wakely will conduct in depth follow-up with a those states which are most similar to Vermont in the type of mandates in force and overall approach to health care reform to provide more detailed, useful insight into the approach being taken or contemplated in other states. In the past year, Wakely Consulting Group has worked with more than a dozen other states on the implementation of health care reform and the development of state-based Exchanges,

and is actively working in at least 10 states. This deep client experience and our many relationships with state policy makers charged with implementing the ACA will allow us to quickly and effectively populate a “control group” from which to provide Vermont with in-depth insights from other similarly situated states.

4. Identify potential funding sources for retention of the State mandates

Wakely has extensive experience in both state health care program financing, benefit valuation, and their intersection, as well as in finding creative solutions for financial challenges related to subsidized benefit programs. In the past six months, we have been engaged by half a dozen other states to help identify options for Exchange financing, an exercise requiring the detailed analysis of a given state’s existing health care financing and assessment environment to identify both broad-based and narrowly defined financing solutions. Options explored in other states include: assessment on provider revenue (e.g., for those providing services included in the mandates); assessment upon participating QHP’s (if one is contemplated); inclusion of this cost within the mechanism employed to fund the exchange (e.g., another broad based financing source).

Our extensive knowledge of how other states are grappling with this issue and our actuarial and analytical capacity can help Vermont Vermont’s decision making process in tackling this challenge..

II. Analysis of Variation in Existing Benefit Designs

In addition to the analysis of state-mandated benefits in relation to the EHB package, Vermont seeks help evaluating the variation in existing product designs, to support the State’s intent to develop standardized benefit and cost sharing designs offered through the Exchange. Identifying the existing range of product choice and which designs are most prevalent in Vermont will help determine how many plan designs would need to be offered through the Exchange to approximate existing levels of market choice, which product designs are most popular in their target market segments, and the impact of limiting product choice -- across the market or, if an outside market is retained, on the competitive dynamics between the Exchange and other distribution channels. An important consideration related to this analysis is the question of what type of choice is meaningful – i.e., plan type (HMO, PPO, POS, indemnity), benefit design, breadth and depth of network, or other features such as wellness programs.

Wakely is performing this type of analysis for another state, and can bring both a qualitative and quantitative approach used there to this evaluation. As part of this project, Wakely developed a carrier and broker interview protocol and a data call template that can be re-purposed for Vermont’s needs. BISHCA has issued a data call that may be somewhat useful in supplying relevant data, but Wakely will need to review the data to see if it is sufficiently detailed for assessing the variation in existing plan designs, or whether a new

data call would be needed. As the most recent benefit design trends are the most relevant in any case, it may be prudent to supplement older data with new data for 2012.

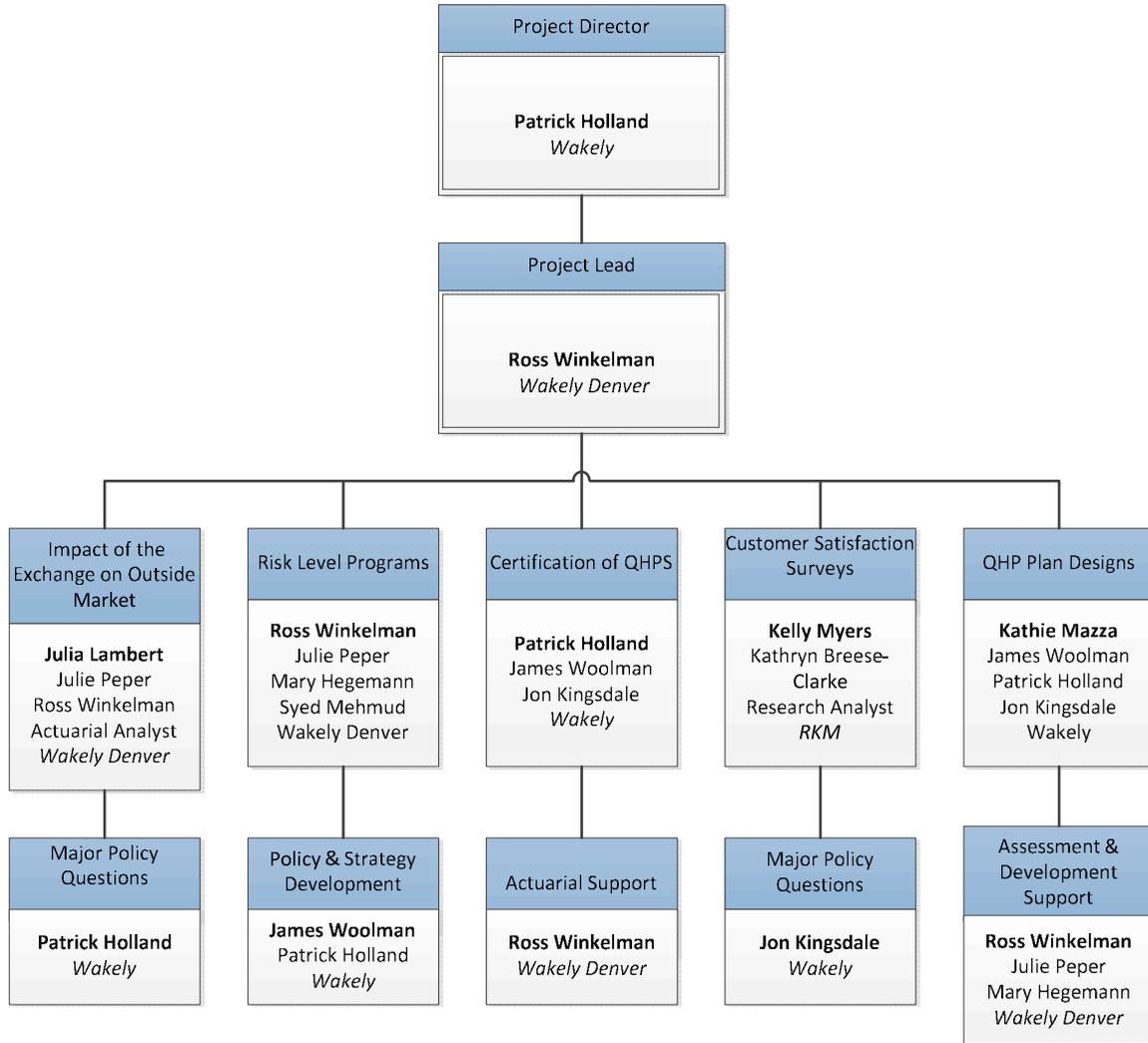
While our project for Vermont will be primarily focused on the qualitative aspects of the present market dispersion in plan designs, it will include an assessment of the overall market distribution by actuarial value tier and level of dispersion across the actuarial spectrum. This will provide an important level of detail for Vermont to consider as it weighs its options related to product standardization. In order to assign actuarial values to the current plans in the market, Wakely will input plan design specifications into the Wakely actuarial pricing model, which outputs the associated actuarial value by plan. We envision that plan design specifications will come from either information already obtained through prior data calls, a new data call to carriers, or possibly through information provided by carriers in rate filings. In the past year, we have performed similar analyses for states in which we performed a specific data call related to gathering plan design information and in doing so, have worked efficiently with the carriers in gathering the most useful information while minimizing the burden on them by not requesting an overabundance of data.

Of course, employer, employee and individual purchasers' input on potential plan features is important. In light of the requirement to report to the legislature by February 15, 2012 on recommended benefits, Wakely suggests a "quick and dirty" approach may be most useful in the short run, supplemented later in 2012 with a more rigorous and statistically credible approach to determining market input. For the short-term, Wakely has found that in-depth interviews with agents/brokers (and knowledgeable staff from employer associations) provides a very good way to identify a limited set of the most popular plan designs in another state. We propose structuring a set of such interviews in Vermont in January, in order to be able to describe the most popular offerings in non-group and small-group, roughly ascribe actuarial values to them, and provide input to the February 15th report.

This qualitative analysis will also provide important insight into the design of a more rigorous data collection effort through a formal data call from BISHCA to Vermont's three major carriers later in the project timetable.

Section 3 Organizational Chart

Section 3



Section 5. Program Integration

Act 48, signed into law in May 2011, promotes a streamlined and simplified organizational structure of existing health programs in the state by incorporating some (or all) responsibility for the populations served by those programs to the Exchange. Populations impacted by this organizational restructuring include individuals covered under private insurance, Medicaid eligibles, Medicaid- Medicare dual eligibles, associations, and State and municipal employees.

Vermont envisages a much more unified, integrated and simplified health insurance system on the path to a possible single payer system. Unification, integration and simplification are strategies to help bend the curve in health care expenditures and to achieve more cost effective health outcomes.

The implementation of a Health Benefit Exchange provides an excellent opportunity to migrate the Vermont health care system to a more integrated set of health care coverages and more cost effective administrative processes. By its very nature, the Exchange will bring together:

- A diverse range of target populations in the group and non-group markets
- The full range of Federal and State health insurance programs
- A wide range of insurance coverages from carriers and plans in the Vermont market.

Designing the business and operating model of an Exchange exposes potential overlaps and gaps in coverages for target populations and significant administrative inefficiencies in the current siloed delivery of public and private health care to health insurance consumers in the group and non-group markets. In addition to addressing administrative inefficiencies associated with overlapping coverages such as Medicare-Medicaid dual eligibles, Vermont plans to go beyond payer-patient transactions mediated by an Exchange to look at administrative inefficiencies in other relationships such as administering payer-provider transactions including insurer coding, claims adjustment and payment. The program Integration work proposed is meant to address and mitigate any such inefficiencies.

We discuss separately below the challenges of addressing Integration and Simplification, but these two subsections are so inter-connected that we propose a single approach and set of activities further on to address both Integration and simplification.

5.A. Integration of Existing Coverage Groups

Wakely and KPMG have considerable experience with a number of States who are using the implementation of their Health Benefit Exchanges to rationalize overlapping health care coverages and to integrate business processes to help manage transactions among a range of health insurance sector participants. Vermont has similar overlapping coverage issues and inefficiencies in business processes in providing health insurance, but has more ambitious goals than most. Vermont's goal to aggressively integrate all public and private health insurance markets will require interaction and analysis across a broader group of programs and constituents.

To rationalize its own overlapping coverages and program delivery functions, Vermont requires an integration strategy to:

- 1 Rationalize existing coverage groups across:
 - Public programs including Medicaid and Medicare
 - Private insurance in the group and non-group markets
 - Coverages for State and municipal employees
 - Overlapping coverages for target populations such as Medicaid-Medicare dual eligibles
- 2 Leverage the Exchange to integrate business processes to manage coverage transactions among:
 - Providers of public programs
 - Department of Vermont Health Access,
 - Department of Human Resources,
 - Department of Children and Families
 - Private and non-profit sector carriers
 - Insurance consumers in the group and non-group markets
 - Public program clients.

Integration of coverage groups may not be permitted under existing legislation so this subproject must identify statutory constraints and required policy changes. In addition, the Exchange provides a significant opportunity to reduce process siloes in program delivery by having the Exchange support, for example, the delivery of current DVHA functions and Medicaid eligibility functions performed by DCF. Therefore, the deliverables of this subproject include:

- 1 A cross program integration strategy to rationalize coverage groups and options
- 2 Identification of potential statutory changes required to implement the integration strategy
- 3 An integration plan to integrate the Exchange business processes with current program functions including DVHA functions and DCF Medicaid eligibility functions.

5.B. Administrative Simplification

The process design work in the coverage integration workshops focused primarily on transactions between public or private payers and insurance consumers in the individual and group markets, mediated by an Exchange. A broader administrative simplification strategy must also look at additional players in the health insurance market including health care providers and health insurance regulators such as the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA). Such a strategy goes beyond the role of the Exchange in coverage eligibility, enrollment and payment transactions to take a much broader look at the administration of the broader health insurance market.

There is strong evidence that the current complexity in administrative procedures, in particular, is adding significant transaction costs to health care providers in the United States. Wakely and KPMG have considerable experience with a number of States who are using the ACA and the implementation of their Health Benefit Exchanges to simplify administrative processes. There is a risk that potentially competing state initiatives may have the unintended consequence of further complexity rather than achieving the goal of reduced costs through simplification.

In addition, KPMG can call upon its global health care practice to bring insight and administrative simplification experience from other health care systems, as required by Vermont, including single payer jurisdictions.

To achieve the desired cost reduction outcomes from its own efforts, including its Medicaid-Medicare dual-eligibles project, Vermont requires an administrative simplification plan that leverages:

- Its own past and current simplification work and the work of other jurisdictions
- The insights of health care providers in the State.

At the same time, Vermont must ensure that any simplification opportunities align with applicable Federal and State statutes and regulations. Therefore, the deliverables of this subproject include:

- 1 An assessment of past and current administrative simplification efforts, including projects in Vermont, other states and national research
- 2 An administrative simplification strategy, business case and implementation plan including long-term savings, program development costs and required statutory or regulatory changes or waivers.

Integration and Simplification Challenges

There are significant challenges to achieving the desired program integration outcomes including coverage group integration, program function integration and administrative simplification. These include:

- The complexity of multiple programs (public and private), multiple coverage options and multiple target populations and coverage needs
- Existing policy constraints to program integration and administrative simplification at the Federal and State level
- Concerns of current program managers regarding the capability and capacity of a newly implemented Exchange operation to integrate existing business processes
- Simultaneously managing the new ACA population and coverage programs
- Ensuring the readiness of health system participants including public programs, private insurers, regulators and health care providers to accept and implement the required changes.

Integration and Simplification Activities

To meet these challenges and achieve Vermont's integration and simplification goals, KPMG and Wakely propose the following activities:

- 1 An environmental scan of the integration practices and simplification projects of, and lessons learned from, other jurisdictions including early innovators and implementers of existing Exchanges as well as other health care systems, including single payer jurisdictions as required
- 2 A policy scan of potential statutory and regulatory enablers and constraints at the Federal and State level to the achievement of program integration and administrative simplification goals
- 3 A preliminary analysis of current coverage groups, public programs, private plans, coverage options and coverage groups in the Vermont health insurance market
- 4 A polling and analysis of key health care system stakeholders that will be affected by program integration and administrative simplification (including public program managers, private insurers, health insurance regulators, health care providers, and health care consumers in the individual and group markets) to understand their needs and concerns and their preferences and priorities for integration and simplification
- 5 A set of integration design workshops to involve the appropriate stakeholders in the design and planning of:
 - Possible coverage group integration options
 - Process integration options based on the implementation of the Vermont Exchange
 - Administrative simplification
- 6 Development of the program integration strategy and implementation plan report

- 7 Development of the administrative simplification strategy, business case and implementation plan.

Using Reference Models to Cut through Complexity

To deal with the complexity of potentially overlapping coverage options and coverage groups, KPMG will provide a set of business reference models to potentially simplify coverage group patterns by showing:

- Different public program and private plan coverage options
- Different target populations and health coverage needs
- The value propositions of the types of public and private coverage options in meeting the needs of the target populations.

To deal with the issue of functional and administrative complexity and to ensure completeness of analysis, KPMG will leverage three relevant functional reference models:

- 1 A Medicaid operating model based on the business process model from the Medicaid IT Architecture (MITA)
- 2 An Exchange operating model based on the CMS Exchange Reference Architecture (ERA) guidance
- 3 An Integrated Medicaid and Exchange service delivery network that shows possible integration and simplification points between the Exchange and existing Medicaid or human service programs (e.g., SNAP and TANF), existing insurance regulation and risk management programs, and planned ACA programs in the individual and small group markets.

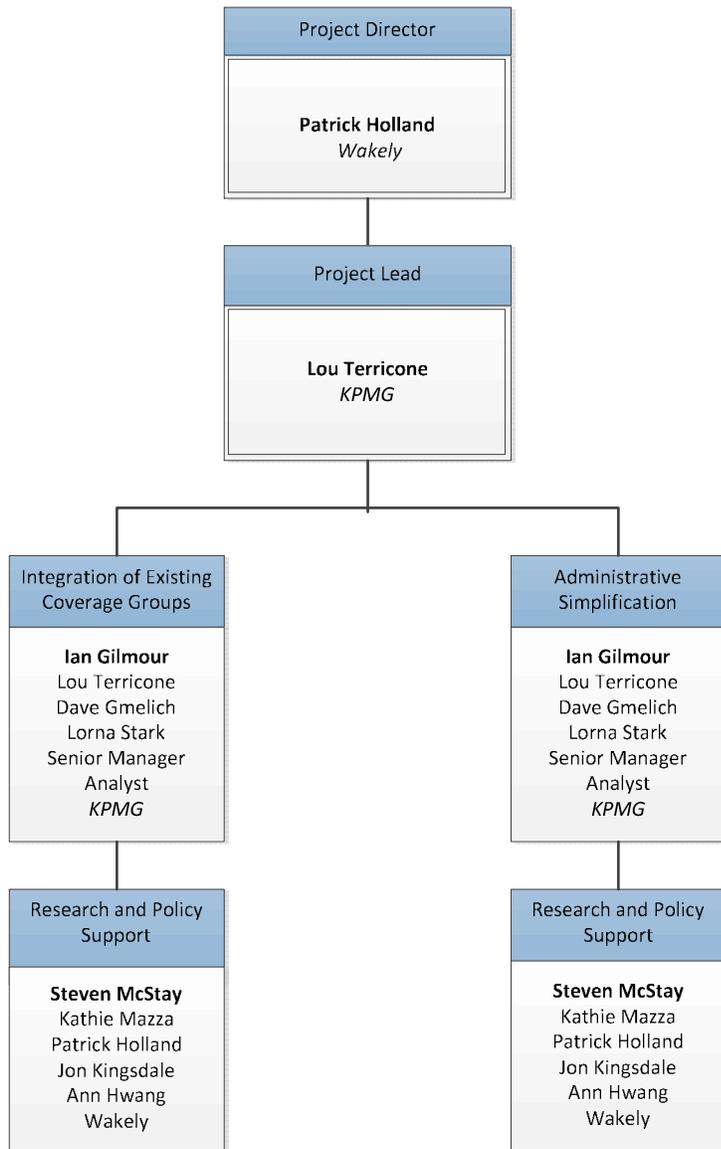
Using Stakeholder Design Workshops to Build Stakeholder Support

KPMG will use these reference models to support stakeholders in the integration design and administrative simplification workshops. The design of the workshop series and the interests of the stakeholders will determine which stakeholders participate in which of the workshops. As a result Vermont will also have a clear sense of market and stakeholder readiness to integrate coverages, integrate business processes and simplify administration in the health insurance market and the health care system. We expect that this work can be completed primarily off-site and validated in five or fewer 2-4 hour workshops with key individuals.

Based on the workshops devoted to program integration, Vermont will receive a report that documents the coverage and process integration approach, the statutory gaps and recommendations to integrate Exchange operations with existing program functions using the model analysis discussed above. Based on the workshops devoted to administrative simplification and management input, Vermont will receive a report documenting a simplification approach and business case based upon the model selected, the potential statutory gaps, and the recommendations for next steps.

Section 5 Organizational Chart

Section 5



Section 6. Quality & Wellness

6.A. Quality Program & Rating System

Inventory existing quality programs and initiatives in the State

Wakely's partner Freedman HealthCare will inventory existing quality programs and initiatives in Vermont. This includes reaching out to the Vermont Program for Quality in Healthcare (VPQ), which serves as the principle statewide resource for expertise, leadership and technical assistance in healthcare quality improvement and measurement in the state. In addition, Freedman HealthCare will compile a list of measures and programs used by healthcare organizations in Vermont, including NCQA/HEDIS, CAHPS, Bridges to Excellence, Vermont state quality programs, Leapfrog, among others.

Freedman HealthCare will develop a spreadsheet that includes all of the quality measures and programs that are available and in use.

Develop a plan for incorporating quality programs in the Exchange, including coordination with existing quality programs outside the Exchange

Freedman HealthCare recognizes that Vermont's stakeholder community must be fully engaged in the planning process for developing a quality program and rating system. Our aim is to understand the expectations and attitudes of individuals, groups and institutions regarding the best design of and expected outcomes from the Exchange's quality program. Engaging both internal stakeholders (within state government) and external stakeholders will be important to the success of the quality program.

Freedman HealthCare feels face-to-face engagement with stakeholders is critical, and has therefore budgeted monthly visits to Vermont to convene a quality stakeholder group. To prepare participants, Freedman Healthcare will develop a short briefing paper that summarizes the importance of quality measurement, quality reporting, and rating systems, and will present the advantages and disadvantages of various models. Freedman HealthCare will then convene the following stakeholders:

- Vermont Department of Health
- Vermont Medical Society
- Vermont Association of Hospitals and Health Systems
- Vermont Association of Mental Health
- Vermont Department of Banking, Insurance, Securities and Health Care Administration
- BCBS of Vermont/Catamount Health
- MVP HealthCare

- Vermont Program for Quality in Health Care
- Vermont Cardiac Network
- VRHA (Vermont Rural Health Alliance)

Freedman HealthCare envisions meeting monthly with the VT stakeholder group, with intermittent conference calls and email contact.

Based on Freedman HealthCare's inventory and their understanding of Vermont's goals, they will develop a series of recommendations for what should exist within the Exchange and what should be borrowed from outside the Exchange for an overall quality program.

Analyze federal guidance and regulations on quality rating

Freedman HealthCare will monitor the release of the federal government formal guidance on quality standards for use by exchanges. We understand, based on principles and priorities that will inform federal funding and technical support exchanges must promote efficiency; therefore, Vermont's benefit exchange must be mindful of cost and quality. While federal requirements will be integral to Vermont's quality rating system, much can be done to inventory current programs and mobilize stakeholders prior to requirement release. Upon release, Freedman HealthCare will thoroughly review requirements, develop a briefing paper for the stakeholder group, and will develop an action plan for incorporation of said requirements into Vermont's quality rating system.

Upon release of the Federal Guidance, Freedman HealthCare will develop a briefings report to distribute.

Develop a quality rating system for the Exchange that includes federally-required quality standards, as well as any standards the State wishes to include

Freedman Healthcare will develop a quality rating system that builds off other initiatives in the state, especially the Blueprint. Pending Federal guidance on quality, the Freedman HealthCare team compile quality measures in use in Vermont, whether from national (CMS, NCQA/HEDIS, etc.) or local (state of Vermont, Vermont health plans, collaborative, and community efforts). This compilation will include a roster of measures, level of analysis (health plan vs. provider organization vs. community etc.), whether they are NQF endorsed, whether they are widely used, whether they are publicly reported, and other relevant details (data sources, in use in VT now or planned, cost, etc. They will focus on care coordination and primary care (as emphasized in the Blueprint), and identify priorities for measures.

The likely candidates are health-plan-specific care coordination or transition of care measures such as HEDIS appropriate follow-up after a behavioral health hospital admission, readmission rates, network availability of Advanced Primary Care Practices, CAHPS survey responses, selected preventive measures (particularly those that require coordination across institutions or provider types) such as colorectal cancer screening.

Our team will consider novel sources of data to inform this, such as DocSite-Covisint patient registry, as well as CMS data from Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. These are dependent upon appropriate patient protection safeguards and having data use agreements in place.

Depending upon Federal guidance, Freedman HealthCare will propose alternate approaches including minimum thresholds (must have X or perform above min. benchmark, or be excluded), simple scoring (1 point for each of X criteria. Must score a Y or better) or more sophisticated methods (weighted average and risk-adjusted scores compiled for each plan).

Freedman HealthCare will work with Wakely to provide specific recommendations for what will be included in the ratings, proposed methods for calculating the ratings, with pros and cons for each. Our team will also advise on how to display on website, as well as explain to consumers.

Propose a method for displaying ratings that will be easily understandable by the general public

Freedman HealthCare will work with Vermont to create a reporting vision that explores what other states done so far in terms of reporting quality data, as well as the strengths of different measures.

Once this foundation is established, Freedman HealthCare will develop a Reporting Vision that builds an infrastructure that permits increasingly detailed health care transparency. Freedman HealthCare will work with Vermont to develop a formal statement of reporting goals to help build consensus, and allow stakeholders to become oriented to dataset and reporting tasks. This process enables stakeholders to develop confidence in the analysis and reporting process, while setting out what will be produced as well as associated resource needs. Freedman HealthCare will provide specific examples and samples from other states, anticipated breadth of reports and an expected timeline.

In addition, Freedman HealthCare will explore additional sources of data and measures that will enhance Vermont's quality initiative. Additional data may include hospital discharge data, vital statistics, All Payor Claims Database data, among others.

Develop a plan for rewarding health plans that achieve quality goals

Drawing on Freedman HealthCare's experience with Pay for Performance (P4P) and design measures, the team will create principles for programs in domains: patient experience, clinical quality (process and outcomes), and inpatient and outpatient care. Freedman HealthCare will add to these domains as other measures become available, such as home care, dialysis, and behavioral health, among others.

Freedman HealthCare and Wakely will provide specific recommendations that lay out the pros and cons of different approaches, with a preliminary set of options. Upon presenting a draft version to Vermont, we will utilize feedback to present our final recommendations.

6.B. Wellness Programs

Research existing programs in the State and other states, including programs designed by insurers and employers

Given that the state of Vermont envisions that a substantial program of wellness and health promotion will be a precondition of certification, Freedman HealthCare will conduct the necessary steps to ensure this is in place as part of the Exchange. Freedman HealthCare will begin by conducting research to inventory state-based wellness programs including those offered by insurers and employers, including work site wellness programs. They will identify programs provided by the Department of Health and/or other communities and organizations in Vermont. The Freedman HealthCare team will also look nationally at the range of programs that are offered.

Freedman HealthCare has identified the following wellness program components as desirable in an integrated wellness initiative:

- Health Risk Assessment
- Biometric screenings (such as blood pressure and cholesterol levels)
- Action planning that supports changes that addresses risk factors or personal goals
- Health education
- Smoking cessation programs
- Preventative screening (such as colon or breast cancer screening).
- Flu and other vaccines
- Exercise programs
- Nutritional education and counseling
- Weight management
- Stress management and mental health
- Changes to the built environment, such as designs that encourage exercise, placement of walking and bike paths, access to bike racks)
- Policy changes, such as healthier foods in vending machines

Freedman HealthCare will explore programs that are delivered through a variety of vehicles, including online, by telephone or in person by a clinician, educator or health coach. We anticipate programs will include access to educational materials and tools that support and track behavioral change and progress.

The Freedman HealthCare team will use evidence based literature to seek the most effective programs and interventions. It should be noted Freedman HealthCare considers wellness and health promotion to be distinct from disease management programs. While wellness and health promotion programs can address the underlying causes of or improve health status with respect to chronic conditions (for example, exercise and weight loss can actually cure type II diabetes), such programs are distinct from disease management programs, which help individuals manage their conditions.

Freedman HealthCare’s research will include the context of the programs, for example, whether incentives/disincentives (cash rewards for completing HRA or participation, discounted or increased health care premium) are offered, participation rates and fall-off, likelihood of persistent lifestyle changes, and the role of design changes.

Freedman HealthCare will also review the federal grant program available to small businesses (100 or fewer employees) to establish new comprehensive workplace wellness program and how employers can access free federal technical assistance in shaping their program so that consideration can be given to how this may fit with Vermont’s overall efforts.

Freedman HealthCare will also explore initiatives out of the newly created National Prevention, Health Promotion and Public Health Council, called for by the Affordable Care Act, and that may inform our research process. As we understand it, this Council has been tasked with providing coordination and leadership at the federal level and among all executive agencies regarding prevention, wellness, and health promotion practices.

Freedman HealthCare will develop a findings report that includes:

- Inventory of programs in Vermont and other states
- Analysis of trends and gaps in programs

Review evidence based research on wellness programs

Freedman HealthCare understands that wellness efforts have varied broadly in their success. However, studies have shown that investments in wellness and health promotion can reduce medical costs and improve health.

Freedman HealthCare has identified the following variables that are known to impact success:

- Ability to engage individuals in the program (including the ability to customize to the individual’s needs)
- Ability to sustain engagement
- Incentives/disincentives
- Ability to achieve persistent lifestyle changes
- Social, community and environmental support
- Benefit design changes

Freedman HealthCare will research those wellness components found to be effective, their impact in cost savings, absenteeism, and productivity, as well as their impact on the individual’s overall health and wellbeing. They will summarize the research showing the evidence for both hard and soft ROI when possible. (Hard ROI measures savings in direct medical costs and “soft ROI” includes such benefits as productivity gains).

Freedman HealthCare will develop a findings report that includes:

- Analysis of strengths and challenges of evidence based wellness programs
- Summary of wellness program elements, factors and design with best evidence basis
- Annotated Bibliography

Design a wellness program component to be included in the Exchange, including an implementation plan, timeline and cost

In designing a wellness program component to be included in Vermont's Exchange, Freedman HealthCare will work with the state and identified stakeholders to create a shared definition of wellness program. Their consensus process will be informed by the results of our research, which we will present in an actionable findings report.

Freedman HealthCare will propose components to be included in wellness programs based upon the evidence showing reduction in short or long term health costs, reduced absenteeism, improved productivity, and improvements in overall health and well-being. Their recommendations will also be informed by the national Behavioral Risk Factor Surveillance System, focusing on those key areas for which Vermont has not met the Healthy People targets. For example, while Vermont's obesity rate may be lower than the US average according to the most recent data (23.9 vs. 27.3, respectively), Vermont has experienced increasing rates of obesity when comparing 2000 figures against 2008 figures (18.4 vs. 23.9). Given that more and more Vermont residents are facing the challenges of obesity, as well as associated health risk factors, recommendations will consider wellness programs that incorporate an obesity prevention/reduction component.

Freedman HealthCare's team will explore with Vermont stakeholders which wellness and health promotions programs make sense to include as part of the package of benefits in order for a health plan to be certified as a qualified health plan in Vermont; what components make sense to deliver through the Department of Public Health; and what makes sense to be offered by the Exchange itself.

For the Exchange-based program, Freedman HealthCare will identify action steps, implementation timeframes, and an associated budget for each component. They will also develop minimum specifications programs must meet to qualify for inclusion in the VT Exchange.

Freedman HealthCare will also advise Vermont on how best to encourage employers to offer their own programs and promote healthy work environments. This will include developing a findings report that summarizes the federal grant program available to small businesses (100 or fewer employees) that do not currently have a workplace wellness program, how to apply for a federal grant to establish a comprehensive workplace wellness program and how employers can access free federal technical assistance in shaping their program. Freedman HealthCare will propose suggested approaches to measurement that plans can adopt to report on the success of their programs.

Freedman HealthCare will develop a Wellness Program Plan that includes:

- Recommendations for programming
- Operations Plan
- Budget
- Implementation Plan/Timeline
- Analysis of trends and gaps in programs

Develop an integration plan for the Exchange's wellness programs and any programs that exist outside of the Exchange

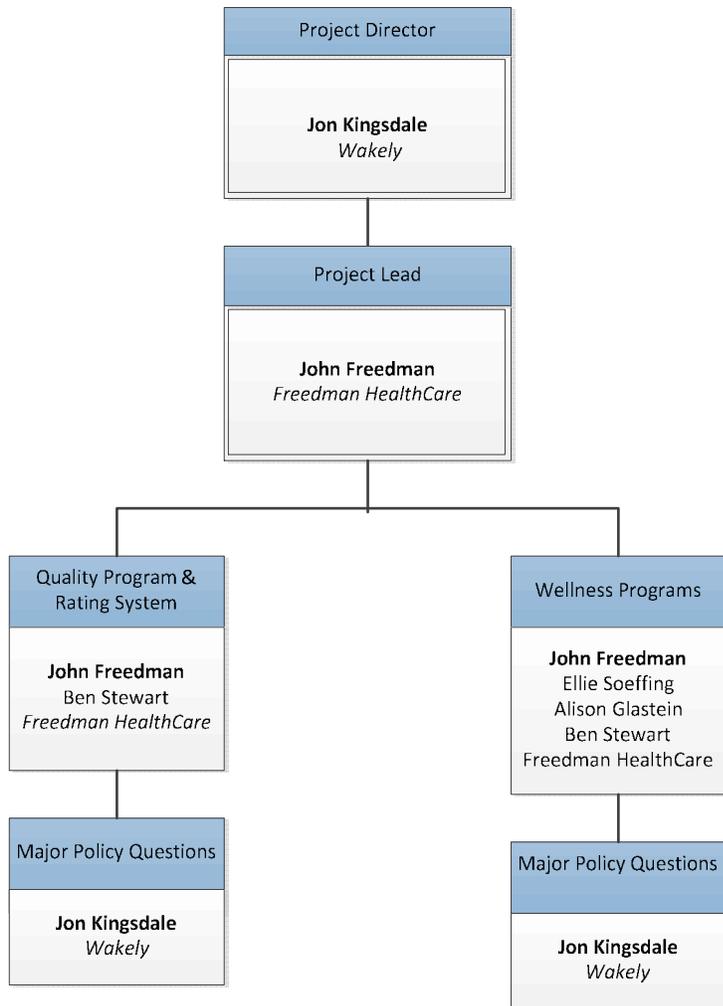
Freedman HealthCare will review the availability of programs and propose a plan to organize the efforts such that duplication is avoided; that programs work to complement and support each other and to the extent possible provide every individual access to a basic package of wellness and health promotion regardless of their location within Vermont.

They will develop an Integration Plan that includes:

- Recommendations for opportunities for coordination/collaboration/integration
- Steps the HIX can take to assist users (individuals) to find Wellness Programs they could participate in, whether coordinated within the HIX or outside it.

Section 6 Organizational Chart

Section 6



Section 7. Payment Reform

Overview

Under authorization granted by Act 48, Vermont intends to adopt an all-payer rate setting system that will moderate health care cost increases, enhance system equity across payers and providers, simplify reimbursement, and support innovative approaches to payment reform and quality improvement. In planning for this effort, the state seeks a contractor that will support this transition through the application of analytics and policy planning to: (a) assess current payment practices and dispersion in the state, (b) model the potential impact of various options for all-payer rate setting, and (c) recommend a phased-in approach to implementation that advances Vermont's desired outcomes and integrates seamlessly with existing delivery-system, coverage expansion, and payment reforms. Specifically, the four critical tasks to be performed by the contractor include:

- Document current payment levels used by commercial and public payers, payment methodologies, and variation in payments, both across payers and across providers within Vermont.
- Assess potential approaches to implementing all-payer rates by identifying the scope of rate setting methodologies to be used, and any necessary phase-in approaches that would need to be employed
- Model the impact of implementing all-payer rates within the Exchange, which approximate the cost of services delivered and minimize cost-shifting among payers, and applying those rates to public payers outside the Exchange. The modeling should quantify costs or savings to the State, to private payers, and to specific types of providers, individual institutions, or geographic areas.
- Develop a plan for coordinating the all-payer approach with Medicare payment policies and innovations in Medicare payment

Recommended approaches and solutions should be developed in a manner that is consistent with the larger policy effort in Vermont to reform health and reflect core health care system values specific to Vermont such as competition, innovation, value, quality, rationality, and equity.

Vermont has already embarked on an ambitious agenda of payment and delivery system reform. The state's Blueprint for Health, initiated in 2006, has made significant progress towards expanding the Integrated Health Services model throughout the state and securing the participation of both a significant number of practice sites as well as a wide range of public and private payers. The Integrated Health Service model, based on the Advanced Primary Care Practice model integrated with Community Health Teams, has made strides

towards transforming primary care as the locus of care management. With the inclusion of Vermont in CMS's Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration project starting in 2011, Vermont has the opportunity to fully integrate all covered populations in this project and to evaluate its overall impact on delivering more effective, efficient health care.

With the passage of Act 48, the state plans to build upon the foundation established under the Blueprint for Health by moving forward with more broad-reaching payment reform. The Act directs DVHA to implement payment reform pilot projects under the policy direction of the Green Mountain Care Board. Such pilots should be developed across payers and coverage types with the goal of managing the costs of the health care delivery system, improving health outcomes for Vermonters, and providing a positive health care experience for patients and health care professionals. Although not prescriptive, Act 48 clearly contemplates the development of global budgets and/or comprehensive capitation payments designed to manage health care utilization and improve quality outcomes. As spelled out in Act 48, these new payment models must be integrated with and supportive of the delivery system reforms incorporated into the Blueprint for Health.

Within this context, all-payer rate setting should complement the state's efforts to reform the delivery and payment of health care services by controlling cost, rationalizing provider reimbursement, and promoting equity and consistency across payers and providers. By focusing on a reimbursement element – the contracted unit price – that is not directly addressed through either the Blueprint for Health or the movement to global budgets, the state will develop a comprehensive approach to enhancing value in the health care system, including utilization, quality, and unit cost.

The two primary drivers of Total Medical Expenses for a given population are unit price (i.e., the average cost for each discrete unit of service) and utilization (i.e., the number of units delivered). Three variables drive average unit price: (1) the contracted price between payer and provider for each unit of service; (2) the mix of services, which reflects the overall intensity and type of services delivered; and (3) the provider mix, which reflects the site of care and/or the use of more or less expensive providers (e.g., academic vs. community hospitals). While always difficult to unpack and differentiate these factors, Vermont's existing and contemplated reform efforts under global-budgeting aim primarily at managing the absolute number of units consumed (e.g., by reducing hospital admissions), the mix of services delivered (e.g., by encouraging less intense service use), or the mix of providers utilized (e.g., by encouraging care to be delivered in a community-based setting or incenting at-risk physician groups to utilize more efficient hospitals).

All-payer rate setting, on the other hand, focuses on rationalizing and controlling the absolute level and rate of increase in the contracted unit cost across payers and providers, to achieve reimbursement required to sustain and support efficient delivery of care. Experience in Maryland, the only state currently employing an all-payer rate regulation system, indicates that such a system can be successful in controlling the increase in unit price, but that overall cost management requires the integration of rate regulation with

other strategies to manage the use of services and appropriate setting for care. In Maryland, hospital rates for all payers, including Medicare, under a waiver granted by CMS, have been regulated by the state's Health Services Cost Review Commission (HSCRC) since 1976. Between 1977 and 2009, the cumulative increase in casemix-adjusted cost per admission was lower in Maryland than in any other state, with average cost per admission increasing in 2009 at a rate less than half that of the rest of the country (2% vs. 4.5%).⁸

However, the focus on unit cost alone cannot yield the type of integrated quality and cost-efficiency desired in Vermont. While Maryland's unit costs were under control, its hospital admissions grew between 2001 and 2007 at an annual average rate of 2.7% versus an average annual rate nationally of 1%.⁹ In analyzing options for Vermont's approach to all-payer rate setting, one of our primary goals will be to link our recommendations with the larger effort to transform the delivery system in order to provide a pathway for a tightly integrated, rational, and efficient delivery of health care services.

In addition to its intersection with delivery system changes, the transition to all-payer rate setting will overlap with contemplated changes in health care coverage as of 2014. Currently, hospitals' and other providers' financial results are deeply impacted by the payer mix of patients utilizing their services. One of the opportunities under all-payer rate setting is to clarify cross-subsidization among payer types and account for differences in levels of uncompensated care and service to public programs, among other important cost factors such as case-mix and graduate medical education. In 2011, DSH payments to hospitals in Vermont totaled \$37 million, while budgeted levels for 2007 hospital uncompensated care and bad debt at community hospitals totaled approximately \$70 million, according to BISHCA's 2007 report to the House Committee on Health Care and the Senate Committees on Health & Welfare and Finance. Our analysis of potential options for all-payer rate setting will take careful account of the intersection of rate-setting with coverage dynamics..

Project Plan

Our approach to this project is in four parts, as follows:

1. Develop Baseline Qualitative and Quantitative Information on Payment Methodologies and Relative Payment Levels

During this phase we will develop a baseline of both qualitative and quantitative information and establish the claims datasets necessary to simulate the impact of alternative rate setting scenarios on key stakeholders and market segments. Key tasks in this phase will include:

⁸ John A. Kastor, MD and Eli Y. Adashi, MD, MS, "Maryland's Hospital Cost Review Commission at 40: A Model for the Country." JAMA, 2011; 306(10); 1137-1138.

⁹ Robert Murray, "Setting Hospital Rates To Control Costs and Boost Quality: The Maryland Experience", Health Affairs, 2009; 28(5); 1395-1405.

- (1) Conduct interviews with payers, providers, and state officials to develop a qualitative catalog of existing payment methodologies used in Vermont. This will provide a detailed understanding of the types of existing payment arrangements as well as important contextual information as we prepare the quantitative components of our analysis.
- (2) Compile a baseline dataset of current payment practices and reimbursement rates, standardized to a common benchmark. This dataset will allow us to analyze the existing dispersion of payment rates for services across payers, providers, and market segments. To perform this step, we plan to utilize information held within the VHCURES all-payer claims database as well as the Vermont Uniform Hospital Discharge Data Set (VUHHDS). Our focus will be primarily on hospital and physician rates (including free-standing diagnostic and surgical facilities, if any), which together account for more than 90% of non-pharmacy acute-care claims. A critical component of this step will be to benchmark existing payment levels to a common benchmark. Where possible, we plan to anchor our analysis on the Medicare level of payment. For hospital and physician claims, this will involve re-pricing claims to the CMS Hospital Prospective Payment System and RBRVS intensity-weighted physician payment system. Wakely's actuarial team has expertise re-pricing claims at Medicare levels, having performed such analyses often within the last year for various types of clients considering alternative payment strategies.
- (3) Perform a baseline analysis of the existing dispersion in payment levels and methodologies across payers and providers. Using the baseline dataset described in item (2), above, we will analyze the current market state, including an assessment of payment levels across carriers, providers, and market segments. For example, we will describe the range around median payment rates for high and low reimbursement rates by different payers for the same unit of service and provider, as well as the range of reimbursement levels across providers for any given unit of service and payer. This analysis will provide an important starting point for modeling the impact of alternate all-payer rate setting approaches on these groups.

2. Develop Catalog of Existing Models of Rate Setting and Assess Applicability to Vermont

During this phase, we will develop a catalog of existing rate-setting models and provide detailed information related to their reimbursement methodologies, impact on cost and utilization, and contribution to the enhancement of quality and value to assess their potential applicability in Vermont. Some potential reimbursement methodologies to include in this review are listed below:

- a. Maryland Health Services Cost Review Commission. As the only state currently utilizing an all-payer rate setting framework, Maryland will provide a highly

- relevant example of how such a system may be approached, from both a technical/methodological as well as a policy perspective. As indicated earlier, this system has succeeded in managing the overall increase in unit price, and has also provided a vehicle for the state to finance uncompensated hospital care and, by incorporating rates paid by Medicare and self-insured employers, to address the issue of payer cross-subsidization. The Maryland system is dependent upon the state's waiver agreement with the federal government; whether to pursue a similar arrangement in Vermont will be an important consideration explored in our analysis.
- b. Medicare. Medicare's size and wide adoption as a standard method make it an obvious model to examine. The Medicare prospective hospital payment system is based upon bundling groups of services related to a single admission or episode of care and providing a single, prospective payment for the bundle based on the level of service intensity. Payments are further adjusted for regional wage indices and other cost factors. Similarly, Medicare's physician payment system provides physicians with a fee-for-service payment based on the estimated resource requirements of the service. The prospective nature of the payment methodology encourages efficient use of resources within a single instance of care (e.g., within a single admission). For payers employing a percent of charges or per-diem based payment methodology, implementing a Medicare-like DRG- or APC-based system can present a number of technical and methodological challenges that should be considered prior to adopting this type of reimbursement model. As outlined in Phase 1, above, grounding our analysis in the current basis of payment will help us highlight potential challenges and opportunities in moving towards a more standardized reimbursement system.
 - c. Vermont Medicaid. Because Act 48 envisions the coordination of the all-payer system with the state's public programs (including Medicaid), it will be important to examine the Medicaid rate-setting methodology and process. For hospitals, the state currently employs a DRG-based system, in which a hospital average base rate is adjusted by the relative weight of each DRG. As in Medicare, provisions are made for special types of cases (outliers, transfers), and the state incorporates standards for the compensation of out-of-state facilities (e.g., teaching hospitals in New Hampshire). DRG weights are developed based on Vermont-specific experience and both base rates and DRG weights are updated periodically (at least every four years).
 - d. Quality-based. A primary goal for Vermont's payment reform is to enhance the value of services for patients. This emphasis is incorporated into the reimbursement structure for the Blueprint for Health, which is based on fee-for-service reimbursement with payment enhancements for meeting practice qualifications and PCMG criteria. Our analysis will incorporate a review of this and other payment models structured to incent quality improvements, including both "P4P" fee-for-service or bonus-based systems as well as efforts to

incorporate quality standards into global budget arrangements, such as the Alternative Quality Contract (AQC) employed by Blue Cross Blue Shield of Massachusetts.

- e. Global Budget/Shared Savings. Significant national attention is being paid to payment reform efforts that incent greater quality, care integration, and population health management through the adoption of global budgets and/or capitated payments. CMS's Medicare Shared Savings model provides guidelines for the development of Accountable Care Organizations and payment methods to compensate integrated delivery systems participating in the program based on shared program savings. Massachusetts has been actively developing a global budget payment model for several years, and private carriers throughout the region and the country are experimenting with global budgets and the integration of cost management and value enhancement through capitated payments and increased levels of care coordination and integration. Our review of alternate models will include both an examination of how these models may support and intersect with all-payer rate regulation.

The examples cited above primarily focus on the mechanism of payment itself. Another important dimension of all-payer rate regulation has to do with the process of standard-setting and schedule for implementation, as well as the mechanism by which rates will be regulated. For example: will the state require adherence to a standard reimbursement mechanism and establish payment rates for all hospitals and physicians, or instead provide corridors or guidelines as to the acceptable range of provider reimbursement by payer type? (For example, payment rates to any hospital for inpatient care can be allowed to vary no more than a certain percentage above the median payment rate for a similar set of services across the state.) Will rates be uniform across payer types and over what period would uniformity be phased-in, or will existing differentials be maintained and/or only moderated? How quickly will changes take effect, and for whom? How will the state elect to coordinate their payment method with Medicare – by requiring the adoption of a Medicare proxy payment methodology, or, as in Maryland, by reaching an agreement with CMS as to the reimbursement mechanism and level of payment received in Vermont for Medicare beneficiaries? The state's decisions in each of these areas – as well as many others – will materially affect the impact on payers, providers, and the market as a whole and are offered as illustrative examples of the issues that will be incorporated into our review of available options.

3. Simulate results of transitioning current market to new rate setting method

Relying upon the baseline data set developed in phase 1, we will simulate the impact of various rate-setting methodologies and implementation approaches and assess the anticipated impact on a range of stakeholders, including public payers, private payers, self-insured employers, community and academic hospitals, primary care and specialty physicians, other providers, consumers in different health insurance markets, and the

uninsured. Evaluating the impact on stakeholders will be a critical component to developing an implementation plan to transition efficiently and fairly towards all-payer rate setting in a way that maximizes the positive impacts of such a policy, while minimizing market disruption.

In addition to the impact on payment rates and methodologies, this assessment will also incorporate an analysis of the impact on changed payment methodology on overall administrative costs related to reporting, regulatory structures, and potential cost savings from administrative simplification and rationalization. Other critical considerations will include the intersection of provider payments with coverage expansion initiatives and other important provider cost drivers, such as graduate medical education, public program participation, uncompensated care, and bad debt.

4. Provide Options and/or Recommendations on how to transition towards all payer rate setting

Outside of the technical and empirical aspects of evaluating Vermont's options related to rate setting, Wakely will provide recommendations and options related to the implementation and structure of rate setting. Act 48 provides relatively wide latitude in the mechanism adopted by the Green Mountain Care Board to establish provider rates, and does not mandate that the board establish rates for all provider types. Among the critical considerations facing the board from an implementation and planning perspective include (1) the sequencing of implementation relative to different payer groups (2) the integration of this effort with Vermont's overall health care reform initiatives and (3) how to coordinate state rate-setting initiatives with the Medicare program.

One approach to sequencing would be to begin the implementation of all-payer rate regulation within the Exchange. Such an approach could have several potential advantages. For example, the small initial scale would minimize any negative effects on provider reimbursement and would require less of an initial offsetting increase in Medicaid reimbursements. At the same time, the potential for more competitive provider rates in the Exchange would allow for competitive premium rates within the Exchange and could cushion any potential impact to small-group rates resulting from the implementation of ACA.

Integrating all-payer rate setting within the Exchange would also necessitate a number of important considerations, including:

- Would such a strategy be feasible without requiring all small groups and individuals to purchase insurance through the Exchange?
- How would such a policy impact Exchange enrollment? What impact would this approach have on small group and individual premium rates?
- What impact would this policy have on Association Health Plans or hybrid groups like the Vermont Education Health Initiative?

- Perhaps most importantly: what impact would this approach have on other payer classes, particularly fully insured and self-funded large groups? Since one goal of the all-payer system would be to mitigate or eliminate payer class cross subsidization, the state, when piloting this approach, will need to take care to set rates for this population that most closely approximate true “all payer” rates; i.e., in a way that will minimize or avoid short term rate increases for commercially insured groups or other public programs.

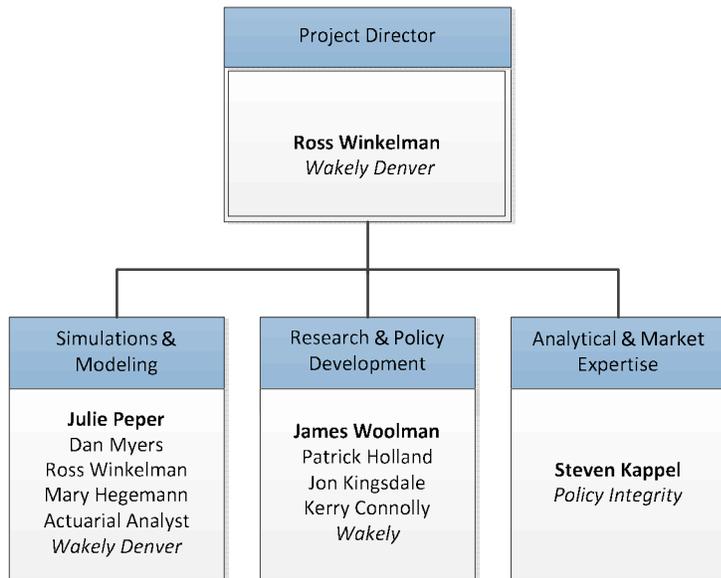
Expanding beyond the Exchange, the state will likely next look to the population enrolled in Medicaid and other state-subsidized coverage, as well as the state’s public employee benefits plan. A third level of participation could expand rate setting to non-Exchange commercial insured plans as well as self-insured employers. A fourth and final component could incorporate the state’s Medicare beneficiaries. The state has a variety of options with respect to coordinating an all-payer system with Medicare, examples of which include: (1) the state could adopt a Medicare-based rate setting methodology as the basis for all-payer rate regulation; (2) the state could seek a waiver from CMS along similar lines to the one underlying Maryland HSCRC; (3) the state could adopt newly published CMS ACO standards under the recently announced shared savings program, and require that hospitals and non-Medicare payers participate in an arrangement based upon integrated delivery systems that qualify for participation in this program. In some ways, this last approach would mirror the one taken by the Blueprint for Health and expand the concept to incorporate hospitals, with federal ACO guidelines as well as current PCMH guidelines providing qualifying criteria for program participation.

We will work closely with the state to identify key goals and strategic considerations inherent in each proposed option, as well as to ensure that the implementation of all-payer rate setting is closely coordinated with and integrated with Vermont’s broader efforts related to coverage expansion, delivery system change, and payment reform. For example, by developing a mechanism to ensure that the “true” unit cost – inclusive of shared-savings, settlement, and quality payments – of global budget arrangements is in line with the level of payment contemplated in the all-payer rates, and that incentive programs, if included, are consistent and mutually complementary between the all-payer structure and the states other reform initiatives. Given the complex and interrelated nature of the various strands of health care reform unfolding in Vermont, ensuring that various aspects work with and complement developments occurring in parallel will be critical to achieving the state’s goal of a more streamlined, efficient, and unified health care delivery, coverage, and payment system.

Finally, our simulation results and empirical analysis will help to identify the impact of potential payment reform models on particular provider and payer groups. Arming the state with detailed assessment of these expected impacts will allow the state to identify specific considerations, protections, and/or adjustments to make to account for special circumstances or needs. Examples of such considerations, as outlined in Act 48, include the impact of payment reform on certain types of specialized or unique provider systems, as well as the impact of reform on access to care in under-served or under-resourced areas.

Section 7 Organizational Chart

Section 7



Section 8. Universal Exchange

Overview

Section 8 of the RFP lays out a variety of important issues related to moving to a Universal Exchange serving all Vermonters. This entails identifying which Exchange functions can be shared with large employers and other coverage programs; developing options as to how the Exchange can leverage buying power to improve quality of care, reform payment and cut costs; and modeling the resulting impact on claims costs, administrative costs and therefore premium requirements of fully integrating different coverage programs. We divide these various tasks into four distinct categories for our deliverables:

A. Reforming Insurance: Our team will work collaboratively with state agencies to articulate a vision of the universal exchange, in conformance with Act 48 of 2011 and the single-payer program envisioned for Green Mountain Care. We will develop options for how the exchange can integrate processes and reform payment to improve health care quality and costs. The universal exchange must play an active and aggressive role to achieve a high degree of integration and reform.

We will begin by summarizing the extensive literature on past approaches by both the private and public sector to improve quality and control costs through insurance market structures, such as Medicare pilots to pay for performance and bundled or global provider reimbursement. We will also describe the particulars of the Vermont medical sector and which strategies might make the most sense for this state in terms of reorganizing care to maximize quality and minimize costs. For example, can the Universal Exchange be a vehicle for developing global budgets for geographic communities within the state, organized and served by discrete Accountable Care Organizations?

Working with RKM, we will test the perceptions of employer groups offering, and consumers presently receiving, coverage in the large, small-group and individual markets. The outline below offers a stepwise set of changes to achieve Vermont's vision for single-payer. Some of these changes definitely involve NOT letting people keep their current coverage, so it will be important to test perceptions and receptivity in advance to the key elements of change, such as global payment, limited or no choice of carriers, limited or no choice of cost-sharing levels, coordination of care through a Patient Centered Medical Home. Attitudes toward these new elements of coverage should be tested in context, and RKM will use focus groups to probe for reactions to new ideas and ways of buying coverage and delivering care.

Working directly with provider groups and individual stakeholders, we will also provide opportunities for their input on which operational features of an exchange they find most and least appealing and where they believe administrative savings are truly possible. And, as referenced in Section 5B, we will also work with RKM to interview key personnel at

provider and carrier organizations in-depth about the opportunities for meaningful administrative simplification.

Dr. Gruber and Dr. Kingsdale will work together to assess the policy options for the exchange in this realm.

B. Modeling Work: Quantifying the cost impact under the options identified in segment "A" above requires modeling the population that would be reached by the universal exchange. This work builds on the work that Wakely's partner Jonathan Gruber did as part of his support of the Hsiao report.

For this work Gruber relied on the Gruber Microsimulation Model (GMSIM), which computes the effects of health insurance policies on the distribution of health care spending and private and public sector health care costs. This model has been used over the past decade by a wide variety of state and federal policy makers to analyze the impacts of health insurance reforms. The core of GMSIM is an approach for turning policy changes into a set of price changes facing individuals and firms. These price changes are then run through a detailed set of behavioral assumptions about how changes in the absolute and relative price of various types of insurance affect individuals, families, and businesses. The key concept behind this modeling is that the impact of tax reforms on the price of insurance continuously determines behaviors such as insurance take-up by the uninsured and insurance offering by employers.

In doing this type of analysis, a number of assumptions must be made about how individuals will respond to tax subsidies, through their effect on the price of insurance. These assumptions have been developed based on the available empirical evidence from the health economics literature, to which Dr. Gruber is a major contributor. One of the most important features of GMSIM is its transparency. Due to the proprietary nature of such models, many other modelers are unwilling to share in detail the underlying assumptions that are so critical to the analysis. Dr. Gruber has made it a clear feature of all of his engagements that all assumptions that underlie the analysis are publicly available and that he is willing to engage in any necessary "sensitivity analyses" around those assumptions.

For this engagement, Dr. Gruber proposes to update the modeling effort done with Dr. Hsiao of a single-payer option for Vermont, to reflect the latest available data for the state. This would include updating the underlying data on individuals and firms that comes from the Current Population Survey (CPS), as well as the data on premiums in the group and non-group market in Vermont. He will work with Steve Kappel on updating data sources. The revised updates would apply to the following original modeling.

The effect of the Patient Protection and Affordable Care Act (ACA), including:

- The expansion of Medicaid
- The introduction of tax credits for low income families

- The individual mandate – incorporating both penalties and the affordability exemption
- Tax credits for small businesses
- Penalties for businesses whose employees get federal tax credits
- Reformed insurance markets with modified community rating and guaranteed issue with no preexisting conditions exclusions
- Regulations on minimum insurance coverage, such as mandated benefits, maximum deductibles for small businesses, and out of pocket maximums
- Regulations on insurers, such as mandates for dependent coverage, and coverage of preventive care with no patient cost sharing
- The introduction of a state insurance exchange

System reform: under system reform, we modeled the impact of savings reductions in the delivery on health care premiums, out-of-pocket costs, and government spending on public insurance programs. This had the result of encouraging ESI offering and improved benefit packages, lower premiums in the exchange, lower out-of-pocket costs, and lower Medicaid costs for both the Federal and State government.

Single payer reforms: under single payer reform, he assumed that the entire private insurance market would be dissolved, and the entire population would be covered under the single payer system. The single payer system was financed by the combination of Federal health care spending under the ACA, and a state payroll tax.

This updated modeling work would inform several of the planning and design tasks specified in the RFP, including:

1. learning the health care coverage characteristics of the Vermont population
2. modeling the impacts of combining risk pools
3. quantifying how the exchange could contain costs through payment and systems reform

For example, we would use the model to first document the health care coverage characteristics of the Vermont population, focusing (as requested) on those outside of the individual and small group market. We will determine the demographic characteristics of these groups, as well as the distribution of their incomes, health insurance coverage, health insurance premiums, and out of pocket medical costs. Dr. Gruber would also work with Wakely Actuarial to model the impact of combining risk pools on premiums, and the resulting feedback effects on insurance enrollment. This will parallel work that Dr. Gruber and Wakely Actuarial have recently completed for the state of Colorado.

C. Transitioning the Exchange to Single-Payer: A third category of issues relates to the practical steps and stakeholder perceptions and reactions to moving along a path toward single-payer. In order to perform many of the tasks set forth in Section 8 – determine the nature and timing of intergovernmental actions required to integrate disparate coverage

programs in the Exchange, test the perceptions of the employers and enrollees in programs outside non-group and small-group coverage (including state and municipal workers), test operational features of the exchange with a broad set of stakeholders, and explore how the exchange could help introduce and manage delivery system and payment reform -- it will first be necessary to develop some concrete options for transitioning to a single-payer system under the ACA by 2017 (or some later date, if preferred), using the Vermont Health Benefits Exchange as a vehicle for incorporating the maximum number of coverage programs into an integrated whole. Therefore, based on extensive consultation with staff in DVHA, BISHCA, DoR and other relevant agencies in state government, Wakely proposes to develop a “roadmap” to single-payer, as a tool for organizing key policy decisions.

The “roadmap” will consist of at least two options – expedited and deliberate – for transitioning to single-payer, based on expanding the exchange’s functions as permissible under the ACA, and culminating in a comprehensive waiver proposal under section 1322 of the ACA. The roadmap will describe the key steps required, year-by-year to reach the goal of developing the necessary programmatic elements for a comprehensive waiver proposal for single-payer.

Below we present a purely hypothetical implementation outline, meant simply to suggest the breadth of change necessary to build a single-payer system on the base of “universal exchange” in Vermont. As a starting point, it will guide the specific analyses proposed under Section 8 determining law changes, testing perceptions, comparing existing coverages to more restricted options, exploring how the exchange could promote delivery systems and payment reform, and develop broader stakeholder processes.

An expedited implementation schedule might include such steps and program features as outlined below. Although presented as a series of steps, this outline more accurately represents a set of questions as to whether, when and how to take each of these seemingly necessary steps toward a universal exchange:

2014:

- 1. Take on all the risk adjustment functions allowed to states under PPACA*
- 2. Merge non-group and small-group markets in VT, effective 1/1/2014 (<51 ‘ees)*
- 3. Eliminate external market in VT for N-G/S-G, as of employers’ or individual’s first private plan anniversary date in 2014*
- 4. Using Catamount Health or other vehicle establish a single health plan as VT’s Basic Health Program*
- 5. Establish one standard benefit package and cost-sharing formula for all QHPs in each actuarial value in the exchange (Platinum, Gold, etc.)*
- 6. Encourage through the certification criteria all QHPs to contract on a bundled/global payment basis with all willing hospitals and physicians that have applied for Medicare designation as an ACO.*

2015:

1. *Develop all-payer, bundled FFS rates for QHPs in the exchange to use, and that would also apply to Catamount, Medicaid, Dr. Dynasaur, etc.*
2. *Expand definition of small-group market to <101 employees and ban reinsurance for ASO arrangements for employers <101 'ees*
3. *Transition all small-employer plans during 2015 to a January 1, 2016 anniversary date*
4. *Exchange (or other state agency) to develop global budgets for state's ACOs, tied to risk-adjustment, all-payer fee schedule, and utilization targets*

2016:

1. *All exchange QHPs and Green Mountain Care plans transition to paying providers on the basis of global budgets*
2. *Encourage QHP issuers to use the state's global payment arrangement as an alternative to the state FFS schedule outside the exchange as well*
3. *Move all state/municipal ESI to a January 1, 2016, anniversary date, using one of the standardized benefit specifications in the exchange that is expected to operate under single-payer and using the global budgeting rates established by the state*
4. *Apply for federal waiver under section 1322 of PPACA to substitute single-payer for multi-payer exchange as of 1/1/2017*
5. *Develop new payroll and individual tax policies, forms, processes, etc. for tax collections effective 1/1/2017*
6. *State issues RFP for one carrier to run the exchange plan(s), a Medicare Advantage Plan, Medicaid/CHIP and a Special Needs Plan for dually eligibles*

2017:

1. *Payroll tax effective on all firms of VT-resident employees, except that self-insured firms offering essential health benefits and paying VT providers for VT residents on the basis of VT-established global budgets, adjusted for benefit levels, may claim their private health plan contributions as a credit against their share of the payroll tax, and all such employees may claim their employee contributions as a credit against their payroll taxes*
2. *Under federal waiver, move all exchange enrollees on January 1, 2017 into the single exchange/Medicaid/Medicare-Advantage and Special Needs Plan carrier, and eliminate BHP, CHIP and any other Medicaid acute-care coverage*
3. *Eliminate "unwanted" benefit levels from the exchange (catastrophic, bronze, silver and gold?)*
4. *Open the exchange to all large insured employers and consider closing off the private market off the exchange*
5. *All dually-eligibles enrolled in the state-contracted Special Needs Plan*

6. *All ASO employers, FEHBP, CHAMPUS, TriCare, etc. plans given the option to buy into the state's single-payer system on a risk-adjusted basis*

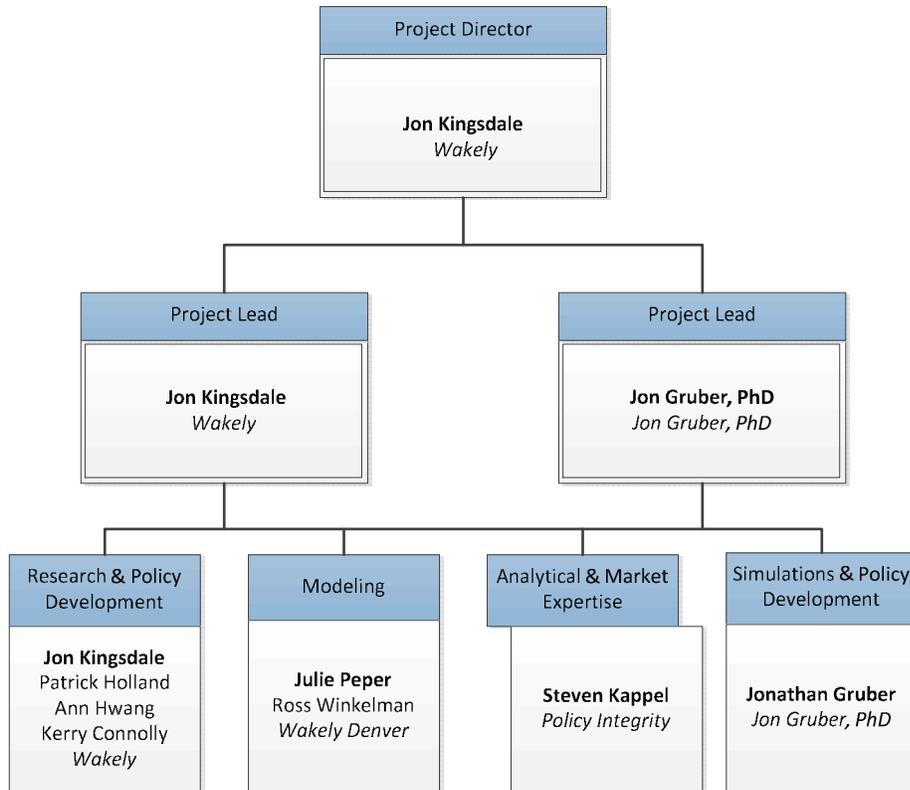
This sample “roadmap” highlights the multiplicity of important decisions facing Vermont as the state transitions to a universal exchange. Our team has the ability to identify the challenges and options that must be confronted – and to analyze potential solutions. For example, consider the issues related to the second step in the process outlined above i.e., the question of whether and how to merge the individual and small group insurance markets in 2014? In the long run, for a universal exchange to support Vermont’s vision of single payer, these two markets (and other insurance risk pools) will be merged. But the preferred timing for the merger is an important decision that depends on a number of factors – such as the relative morbidity of enrollees and premiums in the two markets, the number of enrollees in each market, the impact of temporary federal reinsurance and stop-loss, etc. We will use actuarial and economic modeling to understand the implications of timing such a market merger earlier versus later in the transition process. Drs. Kingsdale and Gruber will lead this effort.

D. Staffing, Sustainability and Business Operations for a Universal Exchange: As Wakely has done similar work for a half-dozen state exchanges—including some that are projected to be larger than the population of Vermont. We will use the proprietary ExFIM model for projecting staffing, other costs, a full year-by-year budget and revenue sources. This is a flexible model of operating costs and revenues that is scalable and specifies diverse sources of revenue, including a commission on premiums, user fees, premium taxes and/or broader bases such as a payroll tax.

In order to make meaningful projections of expenses, Wakely will develop a high-level plan of operations for the exchange through the first full year of operating a single-payer system. This will include staffing, key job descriptions, compensation levels, and other expense items, financial management and accounting requirements, and all IT systems. Incorporating both the modeling by Jon Gruber and Wakely actuaries, plus the year-by-year projections of exchange enrollment volume and functions, and the high-level plan of operations, Patrick Holland and James Woolman will develop a comprehensive operating budget through the first full year of single-payer status in the exchange.

Section 8 Organizational Chart

Section 8



Program Costs

Budget Overview

With over thirty years of corporate experience and approaching nearly \$7 million in gross revenues, Wakely Consulting (Wakely) has a strong track record in fiscally managing contracts comparable in scope, size, and complexity to the Department of Vermont Health Access, Health Benefits Exchange Planning and Implementation RFP, requisition number 03410-103-12.

Wakely works with a diverse client base including national, regional and local health insurance carriers, provider organizations, and federal and state governments. Contracts range from short-term market or policy studies or research papers to long-term business planning and implementation, strategic, actuarial, and financial management consulting. As a result, Wakely has experience in managing many types of contracts such as time and materials or fixed deliverable, as well as contract durations of one month, one year, or longer.

Additionally, many of the subcontractors in which Wakely has proposed to work with in Vermont have direct recent experience working with each other further minimizing contract risk to Vermont. For example; Wakely and KPMG have worked, or currently working together on large exchange planning and implementation projects in Oregon, Rhode Island, and Missouri; Wakely and RKM Research and Communications have been working together in Rhode Island; and Wakely and Jon Gruber have worked together in Colorado and Rhode Island.

Supported by our centralized finance department in Clearwater Florida, Wakely will work closely with the State of Vermont to ensure this contract is carefully managed fiscally and will work with its direct personnel assigned to this contract, as well as our subcontractors to ensure thorough recordkeeping and timely invoicing. Additionally, Wakely is willing and able to work with the State of Vermont on any specialized reporting that may be needed to ensure proper management of the contract.

Schedule A- Summary of Program Costs/ Rate Chart

Personnel	Fully-Loaded Hourly Rates (1)&(2)	1A	1B	1C	1D	1E	1F	Total 1	2A	2B	2C	Total 2												
Wakely Consulting	\$	18,560	\$	56,720	\$	19,080	\$	14,695	\$	43,855	\$	117,706	\$	270,616	\$	108,670	\$	35,060	\$	28,360	\$	167,090		
Jon Kingsdale	\$	361.00	\$	-	\$	-	\$	-	\$	9,025	\$	5,776	\$	14,801	\$	21,660	\$	7,220	\$	-	\$	-	\$	28,880
Patrick Holland	\$	361.00	\$	28,880	\$	14,440	\$	5,415	\$	-	\$	3,610	\$	52,345	\$	10,830	\$	-	\$	14,440	\$	-	\$	25,270
Ross Winkelman / Julia Lambert	\$	395.00	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Julie Peper / Mary Hegemann	\$	375.00	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Ann Hwang	\$	232.00	\$	-	\$	-	\$	-	\$	13,920	\$	6,960	\$	20,880	\$	27,840	\$	18,560	\$	18,560	\$	-	\$	46,400
James Woolman	\$	232.00	\$	-	\$	-	\$	9,280	\$	-	\$	27,840	\$	69,600	\$	18,560	\$	-	\$	4,640	\$	-	\$	23,200
Kathie Marza	\$	232.00	\$	27,840	\$	4,640	\$	9,280	\$	6,960	\$	30,160	\$	37,120	\$	9,280	\$	9,280	\$	9,280	\$	-	\$	27,840
Steve McStay	\$	232.00	\$	-	\$	-	\$	-	\$	-	\$	18,560	\$	37,120	\$	-	\$	-	\$	-	\$	-	\$	-
Kerry Connolly	\$	155.00	\$	-	\$	-	\$	-	\$	13,950	\$	24,800	\$	38,750	\$	15,500	\$	-	\$	-	\$	-	\$	15,500
Dan Myers	\$	245.00	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Syed Mehmud / Luke Rodgers / Mick	\$	275.00	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Actuarial Analyst	\$	175.00	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Subcontractor - Freedman Healthcare	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
John Freedman	\$	288.75	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Alison Glastein	\$	236.25	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Ellie Soeffing	\$	225.75	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Ben Stewart	\$	131.25	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
TBD	\$	252.00	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Subcontractor - KPMG	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Lorna Stark	\$	336.00	\$	64,019	\$	42,126	\$	-	\$	-	\$	161,805	\$	267,950	\$	-	\$	6,720	\$	6,510	\$	-	\$	13,230
Dave Gmelich	\$	336.00	\$	1,344	\$	2,016	\$	-	\$	-	\$	1,344	\$	4,704	\$	-	\$	-	\$	-	\$	-	\$	-
Peter Blessing	\$	262.50	\$	5,376	\$	6,720	\$	-	\$	-	\$	5,376	\$	17,472	\$	-	\$	-	\$	-	\$	-	\$	-
Lou Tarricone	\$	162.75	\$	5,376	\$	26,880	\$	-	\$	-	\$	-	\$	26,880	\$	-	\$	-	\$	-	\$	-	\$	-
Ian Gilmore	\$	-	\$	-	\$	-	\$	-	\$	-	\$	6,720	\$	12,096	\$	-	\$	6,720	\$	-	\$	-	\$	6,720
Michelle Miller	\$	157.50	\$	47,040	\$	-	\$	-	\$	-	\$	49,728	\$	49,728	\$	-	\$	-	\$	-	\$	-	\$	-
TBD - Senior Manager	\$	-	\$	-	\$	-	\$	-	\$	-	\$	45,696	\$	92,736	\$	-	\$	-	\$	-	\$	-	\$	-
TBD - Senior	\$	262.50	\$	-	\$	-	\$	-	\$	-	\$	6,720	\$	6,720	\$	-	\$	-	\$	-	\$	-	\$	-
TBD - Analyst	\$	-	\$	4,883	\$	6,510	\$	-	\$	-	\$	46,221	\$	57,614	\$	-	\$	-	\$	-	\$	-	\$	6,510
Subcontractor - Steve Kappell	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Steve Kappell	\$	157.50	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Subcontractor - Jonathan Gruber	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Jon Gruber	\$	262.50	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Subcontractor - RKM Research & Comm.	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Kelly Meyers	\$	262.50	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Kathryn Breesse-Clarke	\$	210.00	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Research Analyst	\$	78.75	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-
Total Budget	\$	82,579	\$	56,720	\$	61,206	\$	14,695	\$	43,855	\$	279,511	\$	538,566	\$	108,670	\$	41,780	\$	34,870	\$	-	\$	180,320

Personnel	Fully-Loaded Hourly Rates (1) & (2)	3A	3B	3C	3D	3E	Total 3	5A	5B	Total 5	6A	6B	Total 6	Total 7	Total 8	Total Labor	Travel
Wakely Consulting		\$ 54,460	\$ 57,143	\$ 46,060	\$ 7,220	\$ 248,660	\$ 413,543	\$ 69,605	\$ 65,480	\$ 135,085	\$ 7,220	\$ 3,610	\$ 10,830	\$ 476,505	\$ 98,295	\$ 1,571,964	\$ 14,550
Jon Kingsdale	\$ 361.00	\$ -	\$ -	\$ 7,220	\$ 7,220	\$ 3,610	\$ 18,050	\$ 10,830	\$ 3,610	\$ 14,440	\$ 7,220	\$ 3,610	\$ 10,830	\$ 21,660	\$ 45,125	\$ 153,786	\$ -
Patrick Holland	\$ 361.00	\$ 3,610	\$ 2,888	\$ 21,660	\$ -	\$ 7,220	\$ 35,378	\$ 5,415	\$ 10,830	\$ 16,245	\$ -	\$ -	\$ -	\$ 28,880	\$ 10,830	\$ 168,948	\$ -
Ross Winkelman / Julia Lambert	\$ 395.00	\$ 11,850	\$ 11,850	\$ 7,900	\$ -	\$ 31,600	\$ 63,200	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 29,625	\$ 7,900	\$ 100,725	\$ -
Julie Peper / Mary Hegemann	\$ 375.00	\$ 30,000	\$ 26,250	\$ -	\$ -	\$ 75,000	\$ 131,250	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 150,000	\$ 12,000	\$ 299,250	\$ -
Ann Hwang	\$ 232.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 18,560	\$ 4,640	\$ 23,200	\$ -	\$ -	\$ -	\$ 27,840	\$ 16,240	\$ 106,720	\$ -
James Woolman	\$ 232.00	\$ -	\$ 9,280	\$ 9,280	\$ -	\$ 13,920	\$ 32,480	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 153,120	\$ -
Kathie Mazza	\$ 232.00	\$ -	\$ -	\$ -	\$ -	\$ 18,560	\$ 18,560	\$ 11,600	\$ 11,600	\$ 23,200	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 106,720	\$ -
Steve McKay	\$ 232.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 23,200	\$ 34,800	\$ 58,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 95,120	\$ -
Kerry Connolly	\$ 155.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 15,500	\$ 6,200	\$ 75,950	\$ -
Dan Myers	\$ 245.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 98,000	\$ -	\$ 98,000	\$ -
Syed Mehmud / Luke Rodgers / Mick	\$ 275.00	\$ 5,500	\$ 6,875	\$ -	\$ -	\$ 55,000	\$ 67,375	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 67,375	\$ -
Actual Analyst	\$ 175.00	\$ 3,500	\$ -	\$ -	\$ -	\$ 43,750	\$ 47,250	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 105,000	\$ -	\$ 152,250	\$ -
Subcontractor - Freedman Healthcare		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 930
John Freedman	\$ 288.75	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 82,898	\$ 101,708	\$ 184,606	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 184,606	\$ -
Alison Gastein	\$ 236.25	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 49,954	\$ 17,325	\$ 67,279	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 67,279	\$ -
Ellie Soeffing	\$ 225.75	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,363	\$ 9,450	\$ 11,813	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 11,813	\$ -
Ben Stewart	\$ 131.25	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 60,060	\$ 60,060	\$ 60,060	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 60,060	\$ -
TBD	\$ 252.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 30,581	\$ 9,844	\$ 40,425	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 40,425	\$ -
Subcontractor - KPMG		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5,040
Lorna Stark	\$ 396.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 90,258	\$ 64,775	\$ 155,033	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 436,212	\$ 18,050
Dave Gmelich	\$ 396.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,344	\$ 672	\$ 2,016	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 6,720	\$ -
Peter Blessing	\$ 262.50	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,064	\$ 6,720	\$ 14,784	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 32,256	\$ -
Lou Taricone	\$ 162.75	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 26,880	\$ -
Ian Gilmour	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 6,720	\$ 6,720	\$ 13,440	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 32,256	\$ -
Michelle Miller	\$ 157.50	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 20,160	\$ 13,440	\$ 33,600	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 83,328	\$ -
TBD - Senior Manager	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 92,736	\$ -
TBD - Senior	\$ 262.50	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 13,440	\$ 10,080	\$ 23,520	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 30,240	\$ -
TBD - Analyst	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 21,000	\$ 15,750	\$ 36,750	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 36,750	\$ -
Subcontractor - Steve Kappell		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 95,046
Steve Kappell	\$ 157.50	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,938	\$ -	\$ 3,938	\$ -	\$ -	\$ -	\$ 3,938	\$ 7,875	\$ 15,750	\$ -
Subcontractor - Jonathan Gruber		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 91,875	\$ 930
Jon Gruber	\$ 262.50	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 91,875	\$ -
Subcontractor - RKM Research & Comm.		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 620
Kelly Meyers	\$ 262.50	\$ -	\$ -	\$ -	\$ 15,435	\$ -	\$ 15,435	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 15,435	\$ -
Kathryn Breeze-Clarke	\$ 210.00	\$ -	\$ -	\$ -	\$ 10,500	\$ -	\$ 10,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 10,500	\$ -
Research Analyst	\$ 78.75	\$ -	\$ -	\$ -	\$ 3,360	\$ -	\$ 3,360	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,360	\$ -
Total Budget		\$ 54,460	\$ 57,143	\$ 46,060	\$ 22,655	\$ 248,660	\$ 432,916	\$ 159,863	\$ 130,255	\$ 290,118	\$ 90,118	\$ 105,318	\$ 195,436	\$ 480,443	\$ 198,045	\$ 2,315,842	\$ 35,080

Notes:
 1. Subcontractors fully-loaded hourly rates include a 5% administrative fee payable to the Prime Contractor, Wakely Consulting.
 2. Fully-loaded hourly rates are applicable to all sections and subsections.

Schedule B – Detail of Expenses

As a professional consulting firm, Wakely develops a salary and benefit structure that is reflective of the need to recruit and retain excellent personnel, while at the same time maintain competitive billing rates for our clients. Wakely does not have a

standard corporate protocol in determining figures in the areas of salary, benefits, phone, mileage, buildings and facilities, but is sensitive to the need to be efficient and cost effective in order to maintain our competitive rates.

Schedule C – Allocation of Expenses

Wakely does not develop indirect cost factors or separately determine fringe and overhead rates. Our professional billing rates are all inclusive of such costs and reflective of our most competitive billing rates to government entities and are similar to those provided to other government entities for similar services.

Schedule D – Related Party Disclosure

Wakely is not aware of any related party disclosures.

Summary of Funds

Organization Name: Wakely Consulting Group
 Federal Tax ID #: 59-3554482

Summary of funds received during current fiscal year: January 1, 2011 to December 31, 2011 (not an all-inclusive list, but representative of work similar to the scope of work in the State of Vermont RFP.)

Source of Funds	Contract/Grant Total Award	Briefly describe activities supported by these funds
State of Oregon	\$552,625.	Provide exchange planning and implementation to the state including financial mgmt./self-sustainability; business operations; assessment of state resources and an IT Gap analysis.
State of Washington	\$600,000.	Provide exchange planning and implementation to the state including financial mgmt./self-sustainability; business operations; assessment of state resources.
State of New York (subcontractor to Urban Institute)	\$124,050.	Financial modeling for exchange and business operations blueprint.
State of Missouri (subcontract to Urban Institute)	\$210,000.	Consultative advice on exchange design and development, actuarial modeling for Medicaid/Exchange integration strategy program, SHOP exchange specifications, development of procurement strategy options.
Missouri Health Care Foundation	\$60,000.	Five-year financial model for exchange and development of a Level 1 federal grant application.
State of Missouri (subcontractor to Covington & Burling)	\$250,000.	Worked closely with our subcontractor KPMG to perform an IT gap analysis, vendor interviews, and development of a state IT strategy.
Academy Health	\$30,000.	Technical assistance to various states on exchange and health insurance topics.
Robert Wood Johnson Foundation	Maximum amount of \$700,000.	Technical assistance to ten states on various exchange strategic, financial and operational issues.
State of Rhode Island	Not to exceed \$1,350,000.	Provide exchange planning and implementation to the state including financial mgmt./self-sustainability; business operations; assessment of state resources and an IT Gap analysis.
State of Maryland	\$225,000.00	Developed a five year budgeting model and options for self-sustainability and developed options for certification of qualified health plans.
State of Colorado	\$250,000.	Worked closely with Jon Gruber on actuarial, economic and population impact of ACA and exchanges. Also developed a five-year budgeting model.

		Length of contract: January 15, 2012 to September 9, 2012		Actuarial																
				35 weeks; 9 months																
				Fully Loaded		Section 2 - A		Section 2 - B		Section 2 - C		Section 2 - Total								
		Title		Hourly Rate		SHOP Exchange		Individual & Employer Responsibility Determinations		Enrollment in Qualified Health Plans		SHOP, Indiv. & Employ resp, enrollment (A-C)								
				Avg. Cost per 2 day Trip		Hours		Hours		Hours		Hours		Hours		Hours		Hours		
						Cost		Cost		Cost		Cost		Cost		Cost		Cost		
BUDGET SUMMARY																				
Personnel																				
Wakely Consulting																				
	Jon Kingsdale	Managing Director	\$361.00	\$485.00	430.00	103,670.00	140.00	35,060.00	100.00	28,360.00	670.00	167,090.00								
	Patrick Holland	Managing Director	\$361.00		60.00	\$21,660.00	20.00	\$7,220.00	40.00	\$0.00	80.00	\$28,880.00								
	Ross Winkelman / Julia Lambert	Managing Director	\$395.00		30.00	\$10,830.00		\$0.00		\$14,440.00	70.00	\$25,270.00								
	Julie Peper / Mary Hegemann	Senior Consulting Actuary	\$375.00		-	\$0.00		\$0.00		\$0.00	-	\$0.00								
	Ann Hwang	Sr. Consultant	\$232.00		120.00	\$27,840.00	80.00	\$18,560.00		\$0.00	200.00	\$46,400.00								
	James Woolman	Sr. Consultant	\$232.00		80.00	\$18,560.00	40.00	\$9,280.00		\$0.00	100.00	\$23,200.00								
	Kathie Mazza	Sr. Consultant	\$232.00		40.00	\$9,280.00		\$0.00		\$0.00	120.00	\$27,840.00								
	Steve McStay	Sr. Consultant	\$232.00		-	\$0.00		\$0.00		\$0.00	-	\$0.00								
	Kerry Connolly	Analyst	\$155.00		100.00	\$15,500.00		\$0.00		\$0.00	100.00	\$15,500.00								
	Dan Myers	Actuarial Consultant	\$245.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Syed Mehmud / Luke Rodgers / Mickell	Consulting Actuary	\$275.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Actuarial Analyst	Actuarial Analyst	\$175.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Subcontractor - Freedman Healthcare			\$310.00		\$0.00		\$0.00		\$0.00	-	\$0.00								
	John Freedman	Principal	\$288.75			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Alison Glastein	Vice President	\$236.25			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Ellie Soeffing	Sr. Consultant	\$225.75			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Ben Stewart	Analyst	\$131.25			\$0.00		\$0.00		\$0.00	-	\$0.00								
	TBD	Subject Matter Expert	\$252.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Subcontractor - KPMG			\$601.67		\$0.00		\$6,720.00	20.00	\$6,510.00	40.00	\$13,230.00								
	Lorna Stark	Partner	\$336.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Dave Gmelich	Director	\$336.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Peter Blesing	Director	\$336.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Lou Tarricone	Sr. Manager	\$336.00			\$0.00		\$6,720.00	20.00	\$0.00	20.00	\$6,720.00								
	Ian Gilmore	Assoc. Partner	\$336.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Michelle Miller	Sr. Manager	\$336.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	TBD - Senior Manager	Sr. Manager	\$336.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	TBD - Senior	Sr. Associate	\$262.50			\$0.00		\$0.00		\$0.00	-	\$0.00								
	TBD - Analyst	Associate	\$162.75			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Subcontractor - Steve Kappell			\$310.00		\$0.00		\$0.00		\$0.00	-	\$0.00								
	Steve Kappell		\$157.50			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Subcontractor - Jonathan Gruber			\$310.00		\$0.00		\$0.00		\$0.00	-	\$0.00								
	Jon Gruber		\$262.50			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Subcontractor - RKM Research & Comm.			\$310.00		\$0.00		\$0.00		\$0.00	-	\$0.00								
	Kelly Meyers	President & Dir. Research	\$262.50			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Kathryn Breese-Clarke	Director of Operations	\$210.00			\$0.00		\$0.00		\$0.00	-	\$0.00								
	Research Analyst	TBD	\$78.75			\$0.00		\$0.00		\$0.00	-	\$0.00								
TOTAL DIRECT LABOR					430	\$103,670.00	160	\$41,780.00	140	\$34,870.00	730	\$180,320.00								

Length of contract: January 15, 2012 to September 9, 2012		Actuarial		35 weeks; 9 months																
BUDGET SUMMARY		Fully Loaded		Avg. Cost per		Section 3 - A		Section 3 - B		Section 3 - C		Section 3 - D		Section 3 - E		Section 3 - Total				
Personnel	Title	Hourly Rate	2 day Trip	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	
Wakely Consulting	Managing Director	\$361.00	\$485.00	160.00	\$4,460.00	173.00	\$7,143.00	140.00	46,060.00	20.00	7,220.00	900.00	248,660.00	1,393.00	413,543.00					
Jon Kingsdale	Managing Director	\$361.00		10.00	\$3,610.00	8.00	\$2,888.00	60.00	\$21,660.00	20.00	\$7,220.00	10.00	\$3,610.00	50.00	\$18,050.00					
Patrick Holland	Managing Director	\$395.00		30.00	\$11,850.00	30.00	\$11,850.00	20.00	\$7,900.00		\$0.00	80.00	\$31,600.00	98.00	\$35,378.00					
Ross Winkelman / Julia Lambert	Senior Consulting Actuary	\$375.00		80.00	\$30,000.00	70.00	\$26,250.00		\$0.00		\$0.00	200.00	\$75,000.00	160.00	\$63,200.00					
Julie Peper / Mary Hegemann	Sr. Consultant	\$232.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Ann Hwang	Sr. Consultant	\$232.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
James Woolman	Sr. Consultant	\$232.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Kathie Mazza	Sr. Consultant	\$232.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Steve McStay	Analyst	\$155.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Kerry Connolly	Actuarial Consultant	\$245.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Dan Myers	Consulting Actuary	\$275.00		20.00	\$5,500.00	25.00	\$6,875.00		\$0.00		\$0.00	200.00	\$55,000.00	245.00	\$67,375.00					
Syed Mehmod / Luke Rodgers / Mickel	Actuarial Analyst	\$175.00		20.00	\$3,500.00		\$0.00		\$0.00		\$0.00	250.00	\$43,750.00	270.00	\$47,250.00					
Subcontractor - Freedman Healthcare	Principal	\$288.75	\$310.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
John Freedman	Vice President	\$236.25			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Alison Glastein	Sr. Consultant	\$225.75			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Ellie Soeffing	Analyst	\$131.25			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Ben Stewart	Subject Matter Expert	\$252.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
TBD					\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Subcontractor - KPMG	Partner	\$336.00	\$601.67		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Lorna Stark	Director	\$336.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Dave Gmelich	Director	\$336.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Peter Blessing	Sr. Manager	\$336.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Low Tarricone	Assoc. Partner	\$336.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Ian Gilmore	Sr. Manager	\$336.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Michelle Miller	Sr. Manager	\$336.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
TBD - Senior Manager	Sr. Associate	\$262.50			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
TBD - Analyst	Associate	\$162.75			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Subcontractor - Steve Kappell		\$157.50	\$310.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Steve Kappell		\$157.50			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Subcontractor - Jonathan Gruber		\$262.50	\$310.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Jon Gruber		\$262.50			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Subcontractor - RKM Research & Comm.	President & Dir. Research	\$262.50	\$310.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Kelly Meyers	Director of Operations	\$210.00			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Kathryn Breese-Clarke	TBD	\$78.75			\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
Research Analyst					\$0.00		\$0.00		\$0.00		\$0.00		\$0.00		\$0.00					
TOTAL DIRECT LABOR				160	\$54,460.00	173	\$57,143.00	140	\$46,060.00	96	\$33,660.00	900	\$248,660.00	1,494	\$432,915.50					

Length of contract: January 15, 2012 to September 9, 2012		Actual																	
		35 weeks: 9 months																	
BUDGET SUMMARY		Fully Loaded		Section 5 - A		Section 5 - B		Section 5 - Total		Section 6 - A		Section 6 - B							
Personnel	Title	Hourly Rate	Avg. Cost per 2 day Trip	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost
Wakely Consulting	Managing Director	\$361.00	\$485.00	275.00	69,605.00	260.00	65,480.00	535.00	135,085.00	20.00	7,220.00	10.00	3,610.00	10.00	3,610.00				
Patrick Holland	Managing Director	\$361.00		30.00	\$10,830.00	10.00	\$3,610.00	40.00	\$14,440.00	20.00	\$7,220.00	10.00	\$3,610.00						
Ross Winkelman / Julia Lambert	Managing Director	\$395.00		15.00	\$5,415.00	30.00	\$10,830.00	45.00	\$16,245.00	-	\$0.00	-	\$0.00						
Julie Peper / Mary Hegemann	Senior Consulting Actuary	\$375.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Ann Hwang	Sr. Consultant	\$232.00		80.00	\$18,560.00	20.00	\$4,640.00	100.00	\$23,200.00	-	\$0.00	-	\$0.00						
James Woolman	Sr. Consultant	\$232.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Kathie Mazza	Sr. Consultant	\$232.00		50.00	\$11,600.00	50.00	\$11,600.00	100.00	\$23,200.00	-	\$0.00	-	\$0.00						
Steve McStay	Sr. Consultant	\$232.00		100.00	\$23,200.00	150.00	\$34,800.00	250.00	\$58,000.00	-	\$0.00	-	\$0.00						
Kerry Connolly	Analyst	\$155.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Dan Myers	Actuarial Consultant	\$245.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Syed Mehmud / Luke Rodgers / Mickel	Consulting Actuary	\$275.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Actual Analyst	Actuarial Analyst	\$175.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Subcontractor - Freedman Healthcare	Principal	\$288.75	\$310.00	-	\$0.00	-	\$0.00	-	\$0.00	416.00	\$82,897.50	461.00	\$101,708.25						
John Freedman	Vice President	\$236.25		-	\$0.00	-	\$0.00	-	\$0.00	173.00	\$49,953.75	60.00	\$17,325.00						
Alison Glastein	Sr. Consultant	\$225.75		-	\$0.00	-	\$0.00	-	\$0.00	10.00	\$2,362.50	40.00	\$9,450.00						
Elise Soeffing	Analyst	\$131.25		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Ben Stewart	Subject Matter Expert	\$252.00		-	\$0.00	-	\$0.00	-	\$0.00	233.00	\$30,581.25	75.00	\$9,843.75						
TBD				-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Subcontractor - KPMG	Partner	\$336.00	\$601.67	348.00	\$90,258.00	242.00	\$64,774.50	590.00	\$155,032.50	-	\$0.00	-	\$0.00						
Lorna Stark	Director	\$336.00		4.00	\$1,344.00	2.00	\$672.00	6.00	\$2,016.00	-	\$0.00	-	\$0.00						
Dave Gmelich	Director	\$336.00		24.00	\$8,064.00	20.00	\$6,720.00	44.00	\$14,784.00	-	\$0.00	-	\$0.00						
Peter Blessing	Director	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Lou Tarricone	Sr. Manager	\$336.00		20.00	\$6,720.00	20.00	\$6,720.00	40.00	\$13,440.00	-	\$0.00	-	\$0.00						
Ian Gilmour	Assoc. Partner	\$336.00		60.00	\$20,160.00	40.00	\$13,440.00	100.00	\$33,600.00	-	\$0.00	-	\$0.00						
Michelle Miller	Sr. Manager	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
TBD - Senior Manager	Sr. Manager	\$336.00		40.00	\$13,440.00	30.00	\$10,080.00	70.00	\$23,520.00	-	\$0.00	-	\$0.00						
TBD - Senior	Sr. Associate	\$262.50		80.00	\$21,000.00	60.00	\$15,750.00	140.00	\$36,750.00	-	\$0.00	-	\$0.00						
TBD - Analyst	Associate	\$162.75		120.00	\$19,530.00	70.00	\$11,392.50	190.00	\$30,922.50	-	\$0.00	-	\$0.00						
Subcontractor - Steve Kappell		\$157.50	\$310.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Steve Kappell		\$157.50		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Subcontractor - Jonathan Gruber		\$262.50	\$310.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Jon Gruber		\$262.50		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Subcontractor - RKM Research & Comm.		\$262.50	\$310.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Kelly Meyers	President & Dir. Research	\$210.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Kathryn Brees e-Clarke	Director of Operations	\$210.00		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
Research Analyst	TBD	\$78.75		-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00	-	\$0.00						
TOTAL DIRECT LABOR				623	\$159,863.00	502	\$130,254.50	1,125	\$290,117.50	436	\$90,117.50	471	\$105,318.25						

Length of contract: January 15, 2012 to September 9, 2012		Actuarial 35 weeks; 9 months		-		\$0		1,475.00		\$382,625		52.00		\$19,900		2,552.00		\$711,600	
BUDGET SUMMARY	Personnel	Title	Fully Loaded Hourly Rate	Avg. Cost per 2 day Trip	Section 6 - Total Quality & Wellness (A-B)		Section 7 - Total Payment Reform		Section 8 - Total Universal Exchange		Total Labor All Sections		Travel						
					Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost	# of Trips	Cost					
	Wakely Consulting	Managing Director	\$361.00	\$485.00	30.00	10,830.00	1,835.00	476,505.00	317.00	98,295.00	5,926.00	\$1,571,964.00	30.00	\$14,550.00					
	Jon Kingsdale	Managing Director	\$361.00		30.00	\$10,830.00	60.00	\$21,660.00	125.00	\$45,125.00	426.00	\$153,786.00							
	Patrick Holland	Managing Director	\$395.00		-	\$0.00	80.00	\$28,800.00	30.00	\$10,830.00	468.00	\$168,948.00							
	Ross Winkelman / Julia Lambert	Managing Director	\$375.00		-	\$0.00	75.00	\$29,625.00	20.00	\$7,900.00	255.00	\$100,725.00							
	Julie Peper / Mary Hegemann	Senior Consulting Actuary	\$232.00		-	\$0.00	400.00	\$150,000.00	32.00	\$12,000.00	782.00	\$293,250.00							
	Ann Hwang	Sr. Consultant	\$232.00		-	\$0.00	-	\$0.00	70.00	\$16,240.00	460.00	\$106,720.00							
	James Woolman	Sr. Consultant	\$232.00		-	\$0.00	120.00	\$27,840.00	-	\$0.00	660.00	\$153,120.00							
	Ka thie Wazza	Sr. Consultant	\$232.00		-	\$0.00	-	\$0.00	-	\$0.00	460.00	\$106,720.00							
	Steve McStay	Sr. Consultant	\$232.00		-	\$0.00	-	\$0.00	-	\$0.00	410.00	\$95,120.00							
	Kerry Connolly	Analyst	\$155.00		-	\$0.00	100.00	\$15,500.00	40.00	\$6,200.00	490.00	\$75,950.00							
	Dan Myers	Actuarial Consultant	\$245.00		-	\$0.00	400.00	\$98,000.00	-	\$0.00	400.00	\$98,000.00							
	Syed Mehmud / Luke Rodgers / Mickell	Consulting Actuary	\$275.00		-	\$0.00	600.00	\$165,000.00	-	\$0.00	245.00	\$67,375.00							
	Actuarial Analyst	Actuarial Analyst	\$175.00		-	\$0.00	-	\$0.00	-	\$0.00	870.00	\$152,250.00	3.00	\$930.00					
	Subcontractor - Freedman Healthcare	Principal	\$288.75	\$310.00	877.00	\$184,605.75	-	\$0.00	-	\$0.00	877.00	\$184,605.75	-	-					
	John Freedman	Vice President	\$236.25		233.00	\$67,278.75	-	\$0.00	-	\$0.00	233.00	\$67,278.75	-	-					
	Alison Glastein	Sr. Consultant	\$225.75		50.00	\$11,812.50	-	\$0.00	-	\$0.00	50.00	\$11,812.50	-	-					
	Ellie Soeffing	Analyst	\$131.25		266.00	\$60,049.50	-	\$0.00	-	\$0.00	266.00	\$60,049.50	-	-					
	Ben Stewart	Subject Matter Expert	\$252.00		308.00	\$40,425.00	-	\$0.00	-	\$0.00	308.00	\$40,425.00	-	-					
	TBD				20.00	\$5,040.00	-	\$0.00	-	\$0.00	20.00	\$5,040.00	-	-					
	Subcontractor - RPMG	Partner	\$336.00	\$601.67	-	\$0.00	-	\$0.00	-	\$0.00	1,630.00	\$436,212.00	30.00	\$18,050.10					
	Lorna Stark	Director	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	20.00	\$6,720.00	-	-					
	Dave Gmellich	Director	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	96.00	\$32,256.00	-	-					
	Peter Blessing	Director	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	80.00	\$26,880.00	-	-					
	Lou Tarricone	Sr. Manager	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	96.00	\$32,256.00	-	-					
	Ian Gilmour	Assoc. Partner	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	248.00	\$83,328.00	-	-					
	Michelle Miller	Sr. Manager	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	276.00	\$92,736.00	-	-					
	TBD - Senior Manager	Sr. Manager	\$336.00		-	\$0.00	-	\$0.00	-	\$0.00	90.00	\$30,240.00	-	-					
	TBD - Senior	Sr. Associate	\$262.50		-	\$0.00	-	\$0.00	-	\$0.00	140.00	\$36,750.00	-	-					
	TBD - Analyst	Associate	\$162.75		-	\$0.00	-	\$0.00	-	\$0.00	584.00	\$95,046.00	-	-					
	Subcontractor - Steve Kappel			\$310.00	-	\$0.00	25.00	\$3,937.50	50.00	\$7,875.00	100.00	\$15,750.00	-	\$0.00					
	Steve Kappel		\$157.50		-	\$0.00	25.00	\$3,937.50	50.00	\$7,875.00	100.00	\$15,750.00	-	-					
	Subcontractor - Jonathan Gruber			\$310.00	-	\$0.00	-	\$0.00	350.00	\$91,875.00	350.00	\$91,875.00	3.00	\$930.00					
	Jon Gruber		\$262.50		-	\$0.00	-	\$0.00	350.00	\$91,875.00	350.00	\$91,875.00	-	-					
	Subcontractor - RKM Research & Comm.			\$310.00	-	\$0.00	-	\$0.00	-	\$0.00	76.00	\$15,435.00	2.00	\$620.00					
	Kelly Meyers	President & Dir. Research	\$262.50		-	\$0.00	-	\$0.00	-	\$0.00	40.00	\$10,500.00	-	-					
	Kathryn Breese-Clarke	Director of Operations	\$210.00		-	\$0.00	-	\$0.00	-	\$0.00	16.00	\$3,360.00	-	-					
	Research Analyst	TBD	\$78.75		-	\$0.00	-	\$0.00	-	\$0.00	20.00	\$1,575.00	-	-					
	TOTAL DIRECT LABOR				907	\$195,435.75	1,860	\$480,442.50	717	\$198,045.00	8,959	\$2,315,841.75	68	\$35,080.10					
														\$2,350,921.85					

Vermont Health Benefit Exchange Planning and Implementation DRAFT Workplan, January 15, 2012 - September 9, 2012* (*all dates subject to change based on project start date and feedback from Vermont project leadership)		Q1 2012			Q2 2012			Q3 2012		
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Section 1: Exchange Operations/Business Functions										
Project A: Call Center		Project Lead: Steven McStay (Wakely)								
Tasks	Deliverables									
Interview key State stakeholders on current call center functions, needs, and overall satisfaction			X							
Interview call center vendor to understand processes and technologies			X							
Review existing call center vendor contract and all call center services documentation	Tracking Document		X	X						
Evaluate existing call center capabilities against the ACA requirements and best practices	Gap Analysis			X						
Develop recommendations for modifications to existing infrastructure	Final Report			X						
Create roadmap for full call center operability by mid-2013	Final Report				X					
Draft amendment to existing call center contract	Contract Amendment						X			

Project B. Financial Management		Project Lead: Patrick Holland (Wakely)	
Assessment of Financial Management and Reporting Capacity			
Tasks	Deliverables		
Review State and Federal requirements for financial management and reporting	Report on Findings	X	
Review work performed to date by the state to assess state financial management and reporting capacity as it relates to the Exchange		X	
Interview key state staff, conduct site visits, and collect appropriate financial documentation		X	
Assess existing financial management policies and procedures, information capture, and reporting capacity		X	
Develop recommendations for refinement, modification, and/or addition of financial management reporting policies and resources to meet state and federal requirements. Include cost projections for implementation.	Final Report - PPT	X	
Exchange Five-Year Expense Projections			
Conduct detailed review of existing expense estimates, including a review of Vermont source information		X	
Building off of work already completed by the state, develop a range of refined estimates of Exchange expenses during start-up and operations, projected through 2016		X	
Outline expense estimates, as well key budget assumptions and methodological considerations	Final Report	X	
Create excel-based interactive and iterative expense planning tool that can be inherited, operated, and modified as the state continues to move toward implementation timeline	Financial Model	X	
Self-Sustainability Plan			
Interview key staff and evaluate existing data sources on Vermont health care financing mechanisms		X	
Develop Self-Sustainability model	Financial Model	X	X
Assess a range of potential funding mechanisms, including an impact analysis of each method and review of pros and cons	Final Report		X

Project C. Program Integrity		Project Lead: Patrick Holland (Wakely)																			
Tasks	Deliverables																				
Identify the accounting and financial reporting needs for Vermont's Exchange, and all requirements/guidance from HHS	Report on Findings									X											
Assess existing fraud, waste, and abuse protections in Vermont state government and current "best practices" in private industry										X											
Identify organizational positions to support regulatory compliance and reporting requirements										X											
Identify areas for exchange audit processes for all major program operations	Memorandum										X										
Provide recommendations on accounting, financial management, and reporting controls	Policies and Procedures										X										
Create multi-year plan for the development of fraud, waste, and abuse prevention procedures for the Exchange, including how current procedures could be modified over time.	Final Report & Timeline									X											
Provide assistance to other Vermont projects on meeting program integrity standards												X								X	
Project D. Exchange Staffing		Project Lead: James Woolman (Wakely)																			
Tasks	Deliverables																				
Work with state staff to identify the organizational and staffing vision for Vermont's Exchange										X											
Develop organizational structure of Exchange	Org. Chart										X										
Identify key staff needed for the exchange by functional area	Job Descriptions											X									
Create a hiring timeline for Exchange staff that is directly tied to operational readiness plan and financial model	Timeline												X								
Provide recommendations on the appropriate level and structure of staff compensation and benefits, skill-set requirements, and striking the appropriate balance between internal staff hires and contracted employees	Staffing Plan												X								
Work with state staff to refine staffing plan over time														X						X	X

Project E. Exchange Evaluation		Project Lead: Ann Hwang (Wakely)									
Tasks	Deliverables										
Interview staff to understand key goals and indicators important to the											
Identify other indicators that may be important to Vermont	Goals & Findings Report										
Identify data being collected and indicators being measured nationally											
Summarize baseline data on indicators already being collected											
Provide recommendations on strategies for collecting data on indicators not yet being measured	Evaluation Plan										
Develop reporting templates for Exchange and possible budget	Evaluation Plan										
Establish reporting timelines with the process and intervals for periodic	Evaluation Plan										
Project F. Level 2 Establishment Grant Application		Project Lead: Kerry Connolly (Wakely)									
Tasks	Deliverables										
Create detailed project plan for the composition and editing of each component of the grant application	Project Plan										
Review previous grant application and other Exchange project documents											
Conduct weekly status meetings in advance of grant submittal	Project Status Reports										
Review other state grant proposals and budgets											
Coordinate with other state workgroups, consultants, or vendors on any data or materials needed											
Draft grant components including project abstract, narrative, budget narrative, and other supporting materials	Grant Proposal										
Establish plan for final review by all key stakeholder identified by Vermont											
Provide final review of full proposal to ensure it meets HHS requirements	Grant Proposal										

Section 2: SHOP Exchange, Individual and Employer Responsibility, and Enrollment									
Project A. SHOP Exchange		Project Lead: Jon Kingsdale (Wakely)							
Tasks	Deliverables								
Identify priorities for Vermont's SHOP Exchange								X	
Assess potential SHOP models of other state								X	
Model different SHOP exchange options for Vermont (development will include the pros and cons of each model)	Slide Deck							X	
Conduct stakeholder meetings on SHOP models (optional)								X	
Develop moderator guide for focus groups with small employer and	Interview Guide							X	
Synthesize findings from all market research	Strategy Paper							X	
Determine the business requirements specific to the SHOP exchange and evaluate the budgetary and operational impact of these functions									X
Complete recommendations for Vermont's SHOP	Final Report								X
Project B. Individual and Employer Responsibility Determinations		Project Lead: Ann Hwang (Wakely)							
Tasks	Deliverables								
Review and document existing appeals functions in Vermont with a focus on Medicaid and other public programs	Findings report							X	
Conduct workshops with state staff to review and refine the business processes for individual and employer responsibility determinations									X
Assess the staff capacity and IT resources of existing functions									X
Assess the feasibility and desirability of integrating specific business functions between Exchange and Medicaid									X
Provide recommendations on whether existing state resources and	Final Report								X

Project C. Enrollment in Qualified Health Plans	Project Lead: James Woolman (Wakely)	Tasks	Deliverables																
Identify and document the critical path for enrollment in qualified health plans for individuals and employers		Interview state staff and carrier representatives to understand current enrollment systems and processes, and identify areas for coordination/standardization																	
Assess whether the existing processes of public health programs in Vermont could be leveraged by the Exchange		Assess the availability of federal funds to design, build and procure a new system, versus the time and cost to remediate an existing system																	
Conduct stakeholder interviews on potential enrollment design concepts		Develop recommendations for individual and small group enrollment procedures, including the design of a billing model to support the recommendations																	

Section 3. Health Insurance Market Reform											
Project A. Analysis of the Impact of the Exchange on the Outside Market		Project Lead: Julia Lambert (Wakely)									
Tasks	Deliverables										
Size of groups in the Exchange, pending legislative session outcomes				X	X	X	X	X	X	X	X
Treatment of associations, pending legislative session outcomes				X	X	X	X	X	X	X	X
Supplemental product choice, pending legislative session outcomes				X	X	X	X	X	X	X	X
Project B. Risk-Leveling Programs		Project Lead: Ross Winkelman (Wakely)									
Tasks	Deliverables										
Provide summary of federal law and important considerations	Paper	X									
Present potential design options for Vermont	Paper		X								
Provide administrative cost estimates for various design options and governance decisions			X	X							
Assess Vermont's insurance market and Exchange structure to determine implementation plan	Workplan			X							
Develop an implementation plan for the chosen reinsurance and risk adjustment program models	Paper				X						
Risk corridor data coordination with BISHCA	Paper					X					
Project C. Certification of Qualified Health Plans (QHPs)		Project Lead: Patrick Holland (Wakely)									
Tasks	Deliverables										
Analyze state and federal requirements and criteria for QHP certification				X							
Interview key staff at the BISHCA, DVHA, and other agencies on existing state activity related to rate review, licensure, and other oversight activities				X							
Facilitate discussions with Vermont officials to delineate short and long term state goals and priorities for the certification process				X							
Interview key stakeholders to identify priorities, concerns, and issues with direct relevance to the QHP certification process (optional)					X						
Develop recommendations for QHP certification criteria, certification process structure, and estimated resource needs	Final Report				X						
Identify the information request and data collection needs to support Exchange and/or BISHCA review of carrier and QHP qualifications	Data Collection Templates					X					
Draft model contract instrument to memorialize state goals, meet state and federal standards, and address other issues, concerns, and priorities identified during review	Contract Instrument						X				

Project D. Consumer Satisfaction Surveys	Project Lead: Kelly Myers (RKM)								
Tasks	Deliverables								
Provide recommendations for designing and implementing a customer satisfaction system									X
Outline possible survey design options	Memorandum								X
Draft survey questionnaire	Questionnaire								X
Provide recommendations for the development of procedures and oversight for implementation and monitoring of the customer satisfaction survey on an on-going basis	Final Report								X
Create an estimated budget for research and analysis	Final Report								X
Evaluate options for posting survey results to the Exchange website									X
Project E. QHP Plan Designs	Project Lead: Kathie Mazza (Wakely)								
Essential Health Benefits Analysis									
Tasks	Deliverables								
Evaluate likely benefits that will be included in the Essential Health Benefits package									X
Compare Vermont's mandated benefits to the likely EHB benefits and to benefit plans currently available in the national market									X
Calculate the price impact of each mandated benefit									X
Conduct a survey of mandated benefits in other states and, where applicable, how states plan to adapt to the ACA requirements									X
Identify select states for more in depth research on their approach to EHB									X
Provide counsel in advance of legislative report	Report								X
Analyze the existing healthcare financing and assessment environment in Vermont, as well as state revenue requirements									X
Develop potential financing solutions to keep Vermont's mandated benefits									X
Synthesize research and evaluation into report on impact of Essential Health Benefits in Vermont	Final Report								X

Analysis of Variation in Existing Benefit Designs											
Tasks	Deliverables										
Collect benefit information from carriers	Template										
Analyze existing market offerings in Vermont and determine the most utilized plan designs											
Model the actuarial level of benefit plans offered in Vermont											
Assess overall market distribution by actuarial value tier and level of dispersion across the actuarial spectrum											
Solicit feedback on finding from key stakeholders	Slide Deck										
Provide recommendations on product standardization and estimated premium costs for different plan designs	Final Report										
Section 5: Program Integration (the activities for this Section are shown separately but will be administered as one integrated set of activities)											
Project A. Integration of Existing Coverage Groups		Project Lead: Ian Gilmour (KPMG)									
Tasks	Deliverables										
Assess existing public programs and private insurance options											
Identify overlapping coverages for target populations											
Conduct an environmental scan of the integration projects of, and lessons learned from, other state Exchanges and health care systems, including single payer jurisdictions as required											
Inventory the current business processes of these programs and identify efficiencies											
Conduct integration workshops with key stakeholders											
Develop a cross program integration strategy to rationalize coverage groups and options	Paper										
Identify potential statutory and regulatory enablers and constraints at the Federal and State level to the achievement of integration strategy											
Produce an integration plan to integrate the Exchange business processes with current program functions including DVHA functions and DCF Medicaid eligibility functions	Final Report										

Project B. Wellness Programs		Project Lead: Ellie Soeffing (Freedman Healthcare)									
Tasks	Deliverables										
Inventory and analyze state-based wellness programs including those offered by the Department of Health, insurers, and employers	Findings Report	X	X								
Identify and Analyze other national wellness programs (8 weeks)	Findings Report	X	X								
Review evidence based research on wellness programs (8 weeks)	Findings Report		X	X							
Conduct stakeholder meetings on possible wellness program designs						X	X				
Develop a Wellness Program Plan that includes operations plan, budget, timeline, and analysis of trends or gaps in programs (8 weeks)	Program Plan					X	X				
Recommendations for opportunities for coordination/collaboration/integration with existing programs outside the Exchange	Integration Plan									X	
Identify steps the Exchange can take to assist users find wellness programs they could participate in (8 weeks)	Integration Plan									X	X

Section 8: Universal Exchange		Project Lead: Jon Kingsdale (Wakely) & Jonathan Gruber									
Modeling Work											
Tasks	Deliverables										
Update modeling efforts conducted to date to reflect latest available data		X									
Model the impact of combining risk pools on premiums, and the resulting feedback effects on insurance enrollment				X							
Reforming Insurance Markets											
Summarize literature on past approaches by both the private and public sector to improve quality and control costs through insurance market structure				X							
Identify which strategies might make the most sense for Vermont				X							
Assess the perceptions of groups offering, and consumers presently receiving coverage through payers and programs inside and outside the small-group and individual markets					X						
Model the impacts of combining risk pools on impacted stakeholders						X					
Determine the necessary law changes and intergovernmental actions required to bring the maximum number of existing coverage programs into the Exchange and the timing of such changes								X			
Transitioning the Exchange to Single-Payer											
Conduct extensive interviews and workgroups with staff in DVHA, BISHCA, DoR and other relevant agencies in state government on vision and planning									X		
Develop options for transitioning to a single-payer system under the ACA by 2017										X	
Develop a "roadmap" to single-payer, the key steps required year-by-year to reach the goal of developing the necessary programmatic elements for a comprehensive waiver proposal for single-payer											X
Staffing, Sustainability and Business Operations for a Universal Exchange											
Model projected staffing, operating costs, budget, and revenue sources	Financial Model										X
Develop a high-level plan of operations for the exchange through the first full year of operating a single-payer system	Plan of Operations										X
Develop operating budget for first full year of single-payer status in the exchange	Budget										X

Appendix B: Timeline

ID	Task Name	2012											
		Dec	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter	
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct		
1	Exchange Planning and Implementation												
2	Section 1: Exchange Operations/Business Functions												
3	Project A. Call Center												
4	Interview key State stakeholders on current call center functions, needs, and overall satisfaction												
5	Interview call center vendor to understand processes and technologies												
6	Review existing call center vendor contract and all call center services documentation												
7	Evaluate existing call center capabilities against the ACA requirements and best practices												
8	Develop recommendations for modifications to existing infrastructure												
9	Create roadmap for full call center operability by mid-2013												
10	Draft amendment to existing call center contract												
11	Project B. Financial Management Assessment of Financial Management and Reporting Capacity												
12	Assessment of Financial Management and Reporting Capacity												
13	Review State and Federal requirements for financial management and reporting												
14	Review work performed to date by the state to assess state financial management and reporting capacity as it relates to the Exchange												
15	Interview key state staff, conduct site visits, and collect appropriate financial documentation												
16	Assess existing financial management policies and procedures, information capture, and reporting capacity												
17	Develop recommendations for refinement, modification, and/or addition of financial management reporting policies and resources to meet state and federal requirements. Include cost projections for implementation.												
18	Exchange Five-Year Expense Projections												
19	Conduct detailed review of existing expense estimates, including a review of Vermont source information												
20	Building off of work already completed by the state, develop a range of refined estimates of Exchange expenses during start-up and operations, projected through 2016												
21	Outline expense estimates, as well key budget assumptions and methodological considerations												

ID	Task Name	2012											
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	4th Quart	
22	Create Excel based interactive and iterative expense planning tool that can be inherited, operated, and modified as the state continues to move toward implementation timeline.												
23	Self-Sustainability Plan												
24	Interview key staff and evaluate existing data sources on Vermont health care financing mechanisms												
25	Develop Self-Sustainability model												
26	Assess a range of potential funding mechanisms, including an impact analysis of each method and review of pros and cons												
27	Project C. Program Integrity												
28	Identify the accounting and financial reporting needs for Vermont's Exchange, and all requirements/guidance from HRIS												
29	Assess existing fraud, waste, and abuse protections in Vermont state government and current "best practices" in private industry.												
30	Identify organizational positions to support regulatory compliance and reporting requirements												
31	Identify areas for exchange audit processes for all major program operations												
32	Provide recommendations on accounting, financial management, and reporting controls												
33	Create multi-year plan for the development of fraud, waste, and abuse prevention procedures for the Exchange, including how current procedures could be modified over time.												
34	Provide assistance to other Vermont projects on meeting program integrity standards												
35	Project D. Exchange Staffing												
36	Work with state staff to identify the organizational and staffing vision for Vermont's Exchange												
37	Develop organizational structure of Exchange												
38	Identify key staff needed for the exchange by functional area												
39	Create a hiring timeline for Exchange staff that is directly tied to operational readiness plan and financial model												

ID	Task Name	2012											
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
40	Provide recommendations on the appropriate level and structure of staff compensation and benefits, skill-set requirements, and striking the appropriate balance between internal staff hires and contracted employees												
41	Working with state staff to refine staffing plan over time												
42	Project E. Exchange Evaluation												
43	Interview staff to understand key goals and indicators important to the state												
44	Identify other indicators that may be important to Vermont												
45	Identify data being collected and indicators being measured nationally												
46	Summarize baseline data on indicators already being collected												
47	Provide recommendations on strategies for collecting data on indicators not yet being measured												
48	Develop reporting templates for Exchange and possible budget												
49	Establish reporting timelines with the process and intervals for periodic measurement												
50	Project F. Level 2 Establishment Grant Application												
51	Review previous grant application and other Exchange project documents												
52	Create detailed project plan for the composition and editing of each component of the grant application												
53	Conduct weekly status meetings in advance of grant submittal												
54	Review other state grant proposals and budgets												
55	Coordinate with other state workgroups, consultants, or vendors on any data or materials needed												
56	Draft grant components including project abstract, narrative, budget narrative, and other supporting materials												
57	Establish plan for final review by all key stakeholder identified by Vermont												
58	Provide final review of full proposal to ensure it meets HHS requirements												
59	Section 2: SHOP Exchange, Individual and Employer Responsibility, and Enrollment												
60	Project A. SHOP Exchange												
61	Identify priorities for Vermont's SHOP Exchange												
62	Assess potential SHOP models of other state												

ID	Task Name	2012											
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
63	Model different SHOP exchange options for Vermont (development will include the pros and cons of each model)												
64	Conduct stakeholder meetings on SHOP models (optional)												
65	Develop moderator guide for focus groups with small employer and employees												
66	Synthesize findings from all market research												
67	Determine the business requirements specific to the SHOP exchange and evaluate the budgetary and operational impact of these functions												
68	Complete recommendations for Vermont's SHOP												
69	Project B. Individual and Employer Responsibility Determinations												
70	Review and document existing appeals functions in Vermont with a focus on Medicaid and other public programs												
71	Conduct workshops with state staff to review and refine the business processes for individual and employer responsibility determinations												
72	Assess the staff capacity and IT resources of existing functions												
73	Assess the feasibility and desirability of integrating specific business functions between Exchange and Medicaid												
74	Provide recommendations on whether existing state resources and functions meet the needs of the Exchange. Include integration plan if needed												
75	Project C. Enrollment in Qualified Health Plans												
76	Identify and document the critical path for enrollment in qualified health plans for individuals and employers												
77	Interview state staff and carrier representatives to understand current enrollment systems and processes, and identify areas for coordination/standardization												
78	Assess whether the existing processes of public health programs in Vermont could be leveraged by the Exchange												
79	Assess the availability of federal funds to design, build and procure a new system, versus the time and cost to remediate an existing system												
80	Conduct stakeholder interviews on potential enrollment design concepts												
81	Develop recommendations for individual and small group enrollment procedures, including the design of a billing model to support the recommendations												
82	Section 3. Health Insurance Market Reform												
83	Project A. Analysis of the Impact of the Exchange on the Outside Market												
84	Size of groups in the Exchange, pending legislative session outcomes												

ID	Task Name	2012											
		1st Quarter	2nd Quarter	3rd Quarter	4th Quarter								
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
85	Treatment of associations, pending legislative session outcomes												
86	Supplemental product choice, pending legislative session outcomes												
87	Project B. Risk-Leveling Programs												
88	Provide summary of federal law and important considerations												
89	Present potential design options for Vermont												
90	Provide administrative cost estimates for various design options and governance decisions												
91	Assess Vermont's insurance market and Exchange structure to determine implementation plan												
92	Develop an implementation plan for the chosen reinsurance and risk adjustment program models												
93	Risk corridor data coordination with BISHCA												
94	Project C. Certification of Qualified Health Plans (QHPs)												
95	Analyze state and federal requirements and criteria for QHP certification												
96	Interview key staff at the BISHCA, DVRMA, and other agencies on existing state activity related to rate review, licensure, and other oversight activities												
97	Facilitate discussions with Vermont officials to delineate short and long term state goals and priorities for the certification process												
98	Interview key stakeholders to identify priorities, concerns, and issues with direct relevance to the QHP certification process (optional)												
99	Develop recommendations for QHP certification criteria, certification process structure, and estimated resource needs												
100	Identify the information request and data collection needs to support Exchange and/or BISHCA review of carrier and QHP qualifications												
101	Draft model contract instrument to memorialize state goals, meet state and federal standards, and address other issues, concerns, and priorities identified during review												
102	Project D. Consumer Satisfaction Surveys												
103	Provide recommendations for designing and implementing a customer satisfaction system												
104	Outline possible survey design options												
105	Draft survey questionnaire												
106	Provide recommendations for the development of procedures and oversight for implementation and monitoring of the customer satisfaction survey on an on-going												

ID	Task Name	2012											
		Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
107	Create an estimated budget for research and analysis												
108	Evaluate options for posting survey results to the Exchange website												
109	Project E. QHP Plan Designs												
110	Essential Health Benefits Analysis												
111	Evaluate likely benefits that will be included in the Essential Health Benefits package												
112	Compare Vermont's mandated benefits to the likely EHB benefits and to benefit plans currently available in the national market												
113	Calculate the price impact of each mandated benefit												
114	Conduct a survey of mandated benefits in other states and, where applicable, how states plan to adapt to the ACA requirements												
115	Identify select states for more in depth research on their approach to EHB												
116	Provide counsel in advance of legislative report												
117	Analyze the existing healthcare financing and assessment environment in Vermont, as well as state revenue requirements												
118	Develop potential financing solutions to keep Vermont's mandated benefits												
119	Synthesize research and evaluation into report on impact of Essential Health Benefits in Vermont												
120	Analysis of Variation in Existing Benefit Designs												
121	Collect benefit information from carriers												
122	Analyze existing market offerings in Vermont and determine the most utilized plan designs												
123	Model the actuarial level of benefit plans offered in Vermont												
124	Assess overall market distribution by actuarial value tier and level of dispersion across the actuarial spectrum												
125	Solicit feedback on findings from key stakeholders												
126	Provide recommendations on product standardization and estimated premium costs for different plan designs												
127	Section 3. Program Integration												
128	Project A. Integration of Existing Coverage Groups												
129	Assess existing public programs and private insurance options												
130	Identify overlapping coverages for target populations												

ID	Task Name	2012											
		1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct		
131	Conduct an environmental scan of the integration projects of, and lessons learned from, other state Exchanges and health care systems, including single payer jurisdictions as required												
132	Inventory the current business processes of these programs and identify efficiencies												
133	Conduct integration workshops with key stakeholders												
134	Develop a cross program integration strategy to rationalize coverage groups and options												
135	Identify potential statutory and regulatory enablers and constraints at the Federal and State level to the achievement of integration strategy												
136	Produce an integration plan to integrate the Exchange business processes with current program functions including DVHA functions and DCF Medicaid eligibility functions												
137	Project B. Administrative Simplification												
138	Provide an assessment of past and current administrative simplification efforts, including projects in Vermont, other states and national research												
139	Survey key health care system stakeholders that will be affected by program integration and administrative simplification to understand their needs, concerns, preferences												
140	Identify potential statutory and regulatory enablers and constraints at the Federal and State level to the achievement of integration strategy												
141	Conduct simplification workshops with key stakeholders												
142	An administrative simplification strategy, business case and implementation plan including long-term savings, program development costs and required statutory or regulatory changes or waivers												
143	Section 6: Quality & Wellness												
144	Project A. Quality Program & Rating System												
145	Inventory existing quality programs and initiatives in the State (4 weeks)												
146	Conduct stakeholder meetings on quality rating and reporting												
147	Develop recommendations for what quality programs should exist within the Exchange, and what should be borrowed from outside the Exchange (4 weeks)												
148	Analyze federal guidance and regulations on quality rating and plan for integration into Vermont's quality rating system (2 weeks)												
149	Analyze existing state quality initiatives and measurements												

ID	Task Name	2012											
		1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct		
150	Develop recommendations for a quality rating system for the Vermont Exchange (8 weeks)												
151	Work with staff to establish reporting goals and vision for quality data												
152	Develop formal statement of reporting goals and additional data and measures that will support the quality initiative												
153	Draft recommendations for a plan to reward health plans that achieve quality goals												
154	Project B. Wellness Programs												
155	Inventory and analyze state-based wellness programs including those offered by the Department of Health, Insurers, and employers												
156	Identify and Analyze other national wellness programs (8 weeks)												
157	Review evidence based research on wellness programs (8 weeks)												
158	Conduct stakeholder meetings on possible wellness program designs												
159	Develop a Wellness Program Plan that includes operations plan, budget, timeline, and analysis of trends or gaps in programs (8 weeks)												
160	Recommendations for opportunities for coordination/collaboration/integration with existing programs outside the Exchange												
161	Identify steps the Exchange can take to assist users find wellness programs they could participate in (8 weeks)												
162	Section 7: Payment Reform												
163	Develop Baseline Qualitative and Quantitative Information on Payment Methodologies and Relative Payment Levels												
164	Conduct interviews with stakeholders to develop a qualitative catalog of existing payment methodologies employed by public and private payers in Vermont												
165	Compile a baseline dataset of current payment practices and reimbursement rates, standardized to a common benchmark												
166	Perform a baseline analysis of the existing dispersion in payment levels and methodologies across payers												
167	Develop Catalog of Existing Models of Rate Setting and Assess Applicability to Vermont												
168	Catalog of existing rate-setting models and provide detailed information related to their reimbursement methodologies, impact on cost and utilization, and contribution to the enhancement of quality and value												
169	Simulate results of transitioning current market to new rate setting method												

ID	Task Name	2012											
		Dec	1st Quarter			2nd Quarter			3rd Quarter			4th Quarter	
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct		
170	Simulate the impact of various rate-setting methodologies and assess the anticipated impact on a range of stakeholders												
171	Analyze impact of changed payment methodology on overall administrative costs												
172	Assess the intersection of provider payments with coverage expansion initiatives and other important provider cost drivers												
173	Provide Options and/or Recommendations on how to transition towards all payer rate setting												
174	Provide recommendations and options related to the implementation and structure of rate setting												
175	Section B: Universal Exchange												
176	Modeling Work												
177	Update modeling efforts conducted to date to reflect latest available data												
178	Model the impact of combining risk pools on premiums, and the resulting feedback effects on insurance enrollment												
179	Reforming Insurance Markets												
180	Summarize literature on past approaches by both the private and public sector to improve quality and control costs through insurance market structures												
181	Identify which strategies might make the most sense for Vermont												
182	Assess the perceptions of groups offering, and consumers presently receiving coverage through payers and programs inside and outside the small-group and												
183	Model the impacts of combining risk pools on impacted stakeholders												
184	Determine the necessary law changes and intergovernmental actions required to bring the maximum number of existing coverage programs into the Exchange and the timing of such changes												
185	Transitioning the Exchange to Single-Payer												
186	Conduct extensive interviews and workgroups with staff in DVHA, BISHCA, DoR and other relevant agencies in state government on vision and planning												
187	Develop options for transitioning to a single-payer system under the ACA by 2017												
188	Develop a "roadmap" to single-payer, the key steps required year-by-year to reach the goal of developing the necessary programmatic elements for a comprehensive waiver proposal for single-payer												
189	Staffing, Sustainability and Business Operations for a Universal Exchange												
190	Model projected staffing, operating costs, budget, and revenue sources												

ID	Task Name	2012											
		1st Quarter			2nd Quarter			3rd Quarter			4th Quarter		
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct		
191	Develop a high-level plan of operations for the exchange through the first full year of operating a single-payer system												
192	Develop operating budget for first full year of single-payer status in the exchange												

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