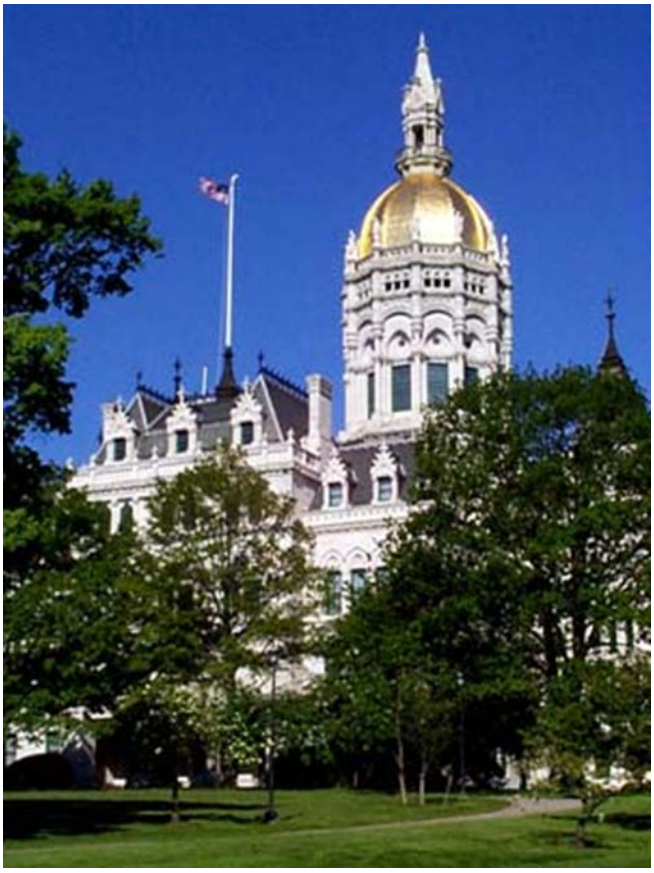
STATE OF CONNECTICUT



AUDITORS' REPORT
CONNECTICUT HEALTH INSURANCE EXCHANGE
FOR THE FISCAL YEARS ENDED JUNE 30, 2014 AND 2015

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN ❖ ROBERT J. KANE

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STATE OF CONNECTICUT

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May 7, 2019

AUDITORS' REPORT
CONNECTICUT HEALTH INSURANCE EXCHANGE
FOR THE FISCAL YEARS ENDED JUNE 30, 2014 AND 2015

We have audited certain operations of the Connecticut Health Insurance Exchange (Exchange) in fulfillment of our duties under Sections 1-122 and 2-90 of the Connecticut General Statutes. The scope of our audit included, but was not necessarily limited to, the years ended June 30, 2014 and 2015.

The objectives of our audit were to:

1. Evaluate the internal controls of the Exchange over significant management and financial functions;

2. Evaluate the Exchange's compliance with policies and procedures internal to the Exchange or promulgated by other state agencies, as well as certain legal provisions, including but not limited to whether the Connecticut Health Insurance Exchange has complied with its regulations concerning affirmative action, personnel practices, the purchase of goods and services, the use of surplus funds, and the distribution of loans, grants and other financial assistance, as applicable; and

3. Evaluate the economy and efficiency of certain management practices and operations, including certain financial transactions.

Our methodology included reviewing written policies and procedures, financial records, minutes of meetings, and other pertinent documents; interviewing various personnel of the Exchange, and testing selected transactions. We obtained an understanding of internal controls that we deemed significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of contracts, grant agreements, or other legal provisions could occur. Based on that risk assessment, we designed and performed

procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provided such a basis.

The accompanying Résumé of Operations is presented for informational purposes. This information was obtained from the management of the Exchange and was not subjected to the procedures applied in our audit of the Exchange. For the areas audited, we identified:

1. Deficiencies in internal controls;

2. Apparent noncompliance with legal provisions; and

3. Need for improvement in management practices and procedures that we deemed to be reportable.

The State Auditors' Findings and Recommendations in the accompanying report presents any findings arising from our audit of the Connecticut Health Insurance Exchange.

COMMENTS

FOREWORD

The Connecticut Health Insurance Exchange, which does business as Access Health CT (AHCT), operates under the provisions of Title 38a, Chapter 706c, of the General Statutes. The Exchange is a public instrumentality and political subdivision of the state, created to develop and implement a state-based health insurance marketplace in accordance with the federal Patient Protection and Affordable Care Act. Pursuant to Chapter 12 of the General Statutes, the Exchange is classified as a quasi-public agency.

The goal of the Exchange is to reduce the number of individuals in Connecticut without health insurance and to assist individuals and small employers in the procurement of health insurance by offering easily comparable and understandable information about health insurance options. The Exchange does this by operating an online marketplace where individuals, families, and small employers can compare and purchase health insurance from a choice of qualified health plans. The Exchange's website also operates as a portal for low income adults and families to apply for coverage under Medicaid and the Children's Health Insurance Program. The Exchange had its first open enrollment on October 1, 2013, for the benefit year beginning January 1, 2014.

Board of Directors and Administrative Officials

Pursuant to Section 38a-1081 of the General Statutes, the Exchange operates under a 14-member board of directors. The board of directors consists of 11 voting members and 3 nonvoting members. Members of the board of directors as of June 30, 2015, were as follows:

Appointed Members:
Nancy Wyman, Lieutenant Governor, Chair
Maura Carley
Paul Philpott
Grant A. Ritter
Robert E. Scalettar
Robert F. Tessier
Cecilia J. Woods
1 vacancy

Ex Officio, Voting Members:
Roderick L. Bremby, Commissioner, Department of Social Services
Vicki Veltri, State Healthcare Advocate, Office of the Healthcare Advocate, Vice-Chair
Benjamin Barnes, Secretary, Office of Policy and Management

Ex Officio, Non-Voting Members:
Katharine Wade, Commissioner, Connecticut Insurance Department
Dr. Jewel Mullen, Commissioner, Department of Public Health
Miriam Delphin-Rittmon, Ph.D., Commissioner, Department of Mental Health and Addiction Services

Mary C. Fox served on the board during the audited period as an appointed member. In addition, Anne Melissa Dowling, former Deputy Commissioner of the Connecticut Insurance Department, and Patricia Rehmer, former Commissioner of the Department of Mental Health and Addiction Services, served as ex-officio, non-voting members.

The chief executive officer is appointed by the board of directors. Kevin Counihan served as the chief executive officer of the Exchange until September 5, 2014. James Wadleigh assumed Mr. Counihan's responsibilities after his departure and was appointed by the board on February 19, 2015. Mr. Wadleigh served as the chief executive officer until April 2018. In September 2018, the board named James Michel as the Exchange's new chief executive officer.

Significant Legislation

The following notable legislative changes affecting the Exchange took effect during the audited period:

- Public Act 13-247, effective June 19, 2013:

  Section 137 reduces the number of voting members on the board of directors from 12 to 11 and provides that 6, rather than 7 members, constitutes a quorum.

  Section 139 allows the Exchange to impose interest and penalties on health carriers that make delinquent payments for assessments or fees.

  Section 144 transfers responsibilities for the all-payer claims database from the Office of Health Reform and Innovation to the Exchange. The all-payer claims database is a database that receives and stores data relating to medical insurance claims, dental insurance claims, pharmacy claims, and other insurance claim information from enrollment and eligibility files. The Exchange shall oversee the planning, implementation, and administration of the database program, ensure that data received from reporting entities is securely collected, compiled, and stored in accordance with state and federal law, and conduct audits of data submitted by reporting entities to verify its accuracy. The Exchange shall seek funding from the federal government, other public sources, and private sources to cover costs associated with the planning, implementation, and administration of the database program.

Other Examinations

Independent public accountants audited the Exchange's financial statements for the years under review. The audits provided opinions that the financial statements present fairly, in all material respects, the financial position of the Connecticut Health Insurance Exchange in accordance with accounting principles generally accepted in the United States of America. The independent public accountants also audited the Exchange's compliance with the types of requirements described in the Office of Management and Budget Circular A-133 Compliance Supplement that could have a direct and material effect on each of the major federal programs handled by the Exchange. The audits provided opinions that the Exchange complied, in all material respects, with the compliance requirements that could have a direct and material effect on each of its major federal programs.

RÉSUMÉ OF OPERATIONS

Statement of Revenues, Expenses, and Changes in Net Position

Based on the Exchange's audited financial statements, a summary of revenues, expenses, and changes in net position for the audited period and the preceding fiscal year follows:

	Fiscal Year Ended June 30,		
	2015	**2014**	**2013**
Operating Revenues:			
Government Grants and Contracts	$ 41,921,051	$ 73,303,817	$ 45,463,090
Grants	-	205,000	-
Marketplace Assessment	26,862,411	12,465,573	-
Interest Income	42,923	17,879	513
Total Revenues	68,826,385	85,992,269	45,463,603
Operating Expenses:			
Wages	7,856,531	6,985,039	2,734,791
Fringe Benefits	2,053,491	1,546,881	626,199
Consultants	40,271,647	50,438,598	16,838,212
Equipment	248,022	1,231,834	217,628
Supplies	36,293	38,849	21,882
Travel	239,640	202,096	99,891
Administration	597,622	1,270,282	249,885
Maintenance	1,471,757	1,502,855	875,491
Depreciation and Amortization	12,067,967	9,469,050	1,509,001
Total Operating Expenses	64,842,970	72,685,484	23,172,980
Change in Net Position	3,983,415	13,306,785	22,290,623
Net Position, Beginning of Year	37,194,319	23,887,534	1,596,911
Net Position, End of Year	$ 41,177,734	$ 37,194,319	$ 23,887,534

The main sources of revenue for the Exchange is government grants and contracts and marketplace assessments. The initial development of the state health insurance exchange was funded by federal grants. These grants covered all development, start-up, and operating expenses during the Exchange's first years of operation. Revenue from grant awards peaked during the fiscal year ended June 30, 2014, when the majority of development and implementation activities occurred. Beginning in January 2014, marketplace assessments were charged to all health and

dental carriers capable of offering a qualified health plan through the Exchange in order to generate the funding necessary to support Exchange operations. The amount of marketplace assessments collected increased in 2015 because the Exchange was able to collect a full year of assessments compared to a partial year in 2014.

Total operating expenses increased by $49,512,504 during the fiscal year ended June 30, 2014. The increase in operating expenses was due mostly to increases in expenses for wages and fringe benefits, consultants, and depreciation and amortization. Wage and fringe benefit increases were due to the increase of staffing levels from 43 to 68, plus required seasonal staffing for the first open enrollment. The increase in consulting expenses was related to costs associated with the development and implementation of the Individual and Small Business Health Options (SHOP) marketplaces, as well as costs for marketing and operating a call center. The depreciation and amortization expense is related to the capitalization of the integrated eligibility system, which was developed by the Exchange to determine program eligibility and facilitate enrollment.

Total operating expenses decreased by $7,842,514 during the fiscal year ended June 30, 2015, primarily due to reductions in consultant expenses. This amount was offset by an increase in wages and fringe benefits, and depreciation and amortization expenses. As of June 30, 2015, the Exchange had 73 permanent employees, 5 more than the previous year. In addition, depreciation and amortization expenses increased due to an increase in the amount the Exchange had invested in capital assets.

Consulting expenses decreased by $10,166,951 due to a decrease in the amount of services needed and an increased reimbursement rate from the Department of Social Services (DSS). The Exchange's integrated eligibility system determines eligibility and facilitates enrollment for both the Exchange and DSS programs. Expenses associated with the system are shared between the agencies. DSS reimburses the Exchange for its portion of costs that were paid by the Exchange. During the fiscal years ended June 30, 2014 and 2015, the Exchange was reimbursed $21.6 and $16.5 million, respectively, from DSS for operating costs.

Statement of Net Position

Based on the Exchange's audited financial statements, a summary of assets, liabilities, and net position for the audited period and the preceding fiscal year follows:

	Fiscal Year Ended June 30,		
	2015	**2014**	**2013**
Assets			
Current Assets			
Cash and Cash Equivalents	$ 22,144,345	$ 39,782,505	$ 4,994,339
Accounts and Grants Receivable	34,227,705	3,325,310	7,342,366
Prepaid Expenses	185,410	154,822	1,003,958
Total Current Assets	56,557,460	43,262,637	13,340,663

Noncurrent Assets			
Security Deposit	8,653	8,653	-
Software Development in Progress	179,735	-	16,869,697
Equipment and Software, Net	15,571,488	25,177,072	7,017,837
Total Noncurrent Assets	15,759,876	25,185,725	23,887,534
Total Assets	72,317,336	68,448,362	37,228,197
Liabilities and Net Position			
Current Liabilities			
Accounts Payable	$ 1,973,945	$ 214,732	$ 112,509
Accrued Liabilities	29,165,657	30,303,613	9,773,138
Refundable Advances	-	735,698	30,811
Total Current Liabilities	31,139,602	31,254,043	9,916,458
Long-Term Liabilities			
Accounts Payable – Long-term	-	-	3,424,205
Total Liabilities	31,139,602	31,254,043	13,340,663
Net Position			
Net Position Invested in Capital Assets	15,751,223	25,177,072	23,887,534
Net Position	25,426,511	12,017,247	-
Total Net Position	41,177,734	37,194,319	23,887,534
Total Liabilities and Net Position	$ 72,317,336	$ 68,448,362	$ 37,228,197

Cash and Cash Equivalents primarily consists of funds received by DSS for the reimbursement of development costs as well as marketplace assessments received.

Accounts receivable as of June 30, 2015 included $26.3 million from DSS, $6.1 million from government grants, and $1.7 million from carriers for marketplace assessments. The amount due from DSS reflects DSS' portion of accrued expenses. DSS is not actually billed for its portion of the costs until the expenses have been paid by the Exchange.

As of June 30, 2015, the Exchange had $39 million invested in software and equipment. This amount primarily consists of the capitalization of software development costs associated with the Exchange's integrated eligibility system. The amount reported for equipment and software increased during the fiscal year ended June 30, 2014 because that is when the majority of costs for the integrated eligibility system were capitalized. The amount reported for the fiscal year ended June 30, 2015 decreased due to depreciation and amortization. Total capitalized expenses reported were reduced by $5.8 million during the fiscal year ended June 30, 2014 and $6.4 million during the fiscal year ended June 30, 2015 due to costs that were reimbursed by DSS.

Accrued Liabilities represents unpaid work and contractual holdbacks. The amount of accrued liabilities increased during the fiscal year ended June 30, 2014 as the result of the significant increase in operating expenses that the Exchange experienced.

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

The following reportable matters resulted from our review of the records of the Connecticut Health Insurance Exchange:

Lack of Approval for Severance Payments

Criteria: Section 38-1082(a) of the General Statutes provides that the board of directors of the Exchange adopt written procedures for hiring, dismissing, promoting, and compensating employees of the Exchange. In addition, board approval is required for any non-budgeted expenditure in excess of $5,000.

The Exchange adopted a policy, effective July 1, 2016, which allowed for severance payments and medical and dental benefits for employees who were involuntarily terminated.

Condition: Between the fiscal years ended June 30, 2014 and June 30, 2018, 16 employees were involuntarily terminated and paid severance payments totaling $678,954. In addition, these employees continued to receive medical and dental insurance benefits for as long as 1 to 6 months after termination. Severance payments, which were not included in the adopted budget, were not approved by the board of directors. Furthermore, the payments made to 4 employees, totaling $207,363, were made prior to the implementation of the Exchange severance policy.

Effect: The Exchange was not in compliance with Section 38-1082(a) of the General Statutes. The total amount of the severance payments and ancillary benefits may not have been a prudent use of the Exchange's resources. In addition, since these payments were not included in the adopted budget, less funds may have been available for program operations.

Cause: The Exchange allowed the Chief Executive Officer to make decisions regarding severance packages without the approval of the board of directors.

Recommendation: The board of directors should approve non-budgeted severance payments in excess of $5,000 in accordance with Section 38-1082(a) of the General Statutes. (See Recommendation 1.)

Agency Response: "The board of directors approves all non-budgeted expenditures in excess of $5,000 in accordance with CGS § 38a-1082(a) through the quarterly reforecast votes. Prior to the beginning of each fiscal year, the board approves the AHCT annual operating budget. The operating budget includes total amounts for each budget category, but the board does not approve each contractual expenditure or individual salaries and benefits for

employees. During the fiscal year, the staff presents a quarterly reforecast for the operating budget showing any revisions to the expense or income categories. This reforecast is presented to the finance committee and then to the full board for approval. All severance payments and any payments for benefits were included in board approved reforecasts.

AHCT believes that the ability to offer severance packages to some departing employees is a necessary employment tool due to the nature of AHCT's operations and statutory restrictions on future employment for departing employees. AHCT employs individuals with industry experience to support its operations, and may require flexibility to support restructuring efforts periodically as it responds to a changing landscape. AHCT employees are subject to the Connecticut Code of Ethics provisions regarding restrictions on future employment opportunities, even though they are not employees of the State of Connecticut. Further, AHCT employees are also subject to additional restrictions on future employment opportunities pursuant to CGS § 38a-1081(e)(1)(C)(2). The elimination of positions and possible severance payments that may flow from a restructuring, result in a reduction in overall operating expenses, making funds available for other operations in successive budget years."

Auditors' Concluding Comments:

While the net effect of severance payments may have been included in the annual operating budget and quarterly reforecasts as a salary expense, the budgeting for salary expense suggests that the Exchange will be receiving a direct benefit for the amount being paid. Employees receiving severance payments do not provide a direct benefit to the Exchange, and severance payments categorized as a salary expense are not appropriate. In addition, our review of board of director meeting minutes did not reveal any discussion of severance payments. As a result, we were unable to determine that the board of directors was aware that severance payments were included in the budget and that they approved of the payments.

Lack of Competitive Procurement

Criteria:

Section 38a-1082(a)(4) of the General Statutes provides that the board of directors of the Exchange shall adopt written procedures for contracting for financial, legal, bond underwriting, and other professional services, including a requirement that the Exchange solicit proposals at least once every three years for each such service that it uses.

Condition:

We reviewed contracts awarded to 5 vendors to determine whether the contracts were awarded based on a competitive process. Our review disclosed that more than $8 million of contacts awarded to 1 vendor were not the result of a competitive process. Further review of the Exchange's contract log as of January 1, 2015, disclosed an additional $37 million of

contracts that are listed as being sole source, and do not appear to be the result of a competitive process.

Effect: The Exchange is not in compliance with Section 38a-1082(a)(4) of the General Statutes. In addition, since the contracts were not the result of a competitive process, the Exchange may not be receiving the most cost-efficient services.

Cause: The Exchange considered the vendor a sole source provider due to the amount of time it would have taken to go through a formal competitive process.

Recommendation: The Connecticut Health Insurance Exchange should solicit proposals at least once every three years for all professional services, as required under Section 38a-1082(a)(4) of the General Statutes. (See Recommendation 2.)

Agency Response: "The Exchange does solicit proposals for a variety of professional services as required by Section 38a-1082(a)(4). The Legislature created the Connecticut Health Insurance Exchange as a quasi-public agency of the State of Connecticut for a number of reasons. The Exchange needed to be able to contract for the required goods and services in order to have its system up and running in time for the October 1, 2013 deadline imposed by the federal government for state-based marketplaces pursuant to the Affordable Care Act (ACA). The Exchange successfully met this challenge through a variety of business decisions, hard work, and contracting with experienced vendors. Therefore, timing did become a factor in vendor selection and some vendors were selected through a variety of competitive procurement processes to meet the business and regulatory needs of the Exchange."

Auditors' Concluding Comments: We were unable to determine whether the Exchange did in fact solicit proposals for the referenced exceptions, as no documentation was provided to support a competitive process.

Weakness Over Information Security

Background: The Connecticut Health Insurance Exchange maintains information systems to operate an online marketplace where individuals and small employers can compare and purchase health insurance plans. These information systems process and store personally identifiable information (PII) and federal tax information (FTI).

The Exchange has a Memorandum of Understanding with the Department of Administrative Services Bureau of Enterprise Systems & Technology (DAS BEST) to oversee some of its information security functions.

Criteria: The Centers for Medicare and Medicaid Services Minimum Acceptable Risk Standards for Exchanges (MARS-E) provides security information to protect and ensure the confidentiality, integrity, and availability of PII and FTI. MARS-E includes guidance from the National Institute of Standards and Technology (NIST), which provides minimum requirements for federal information systems.

Condition: In 2016, the Exchange contracted with a third-party vendor to conduct a comprehensive risk assessment of its information systems and associated physical infrastructures to determine the effectiveness of its information security controls. The third-party risk assessment noted that the information security controls of the Exchange did not always comply with federal requirements established by MARS-E, NIST, or other relevant regulatory sources. While many deficiencies were due to the Exchange not adequately documenting its established control processes, some deficiencies indicated weaknesses in the Exchange's information security controls.

Effect: The Exchange's information security controls are not in compliance with federal requirements. In addition, control weaknesses could result in unauthorized access to and disclosure of PII and FTI, as well as disruption of critical marketplace operations.

Cause: The Exchange has not adequately documented all of its control processes. In addition, some of the control weaknesses noted are items that DAS BEST would be responsible for correcting.

Recommendation: The Connecticut Health Insurance Exchange should work with DAS BEST to ensure that its information security controls meet relevant federal requirements, such as those of the Centers for Medicare and Medicaid Services Minimum Acceptable Risk Standards for Exchanges and the National Institute of Standards and Technology. (See Recommendation 3.)

Agency Response: "Information security controls are of the upmost importance to the Exchange given the sensitive nature of the data held in its Integrated Eligibility System (IES), including personally identifiable information and federal tax information. The Exchange's IES is hosted by the State Department of Administrative Services, Bureau of Information Technology (DAS BEST). Recent IT security audits have identified some issues with documentation, and some items controlled by DAS BEST. The Exchange created a cross agency team to address these items, including personnel from the Exchange, the Department of Social Services (DSS) and DAS BEST. This team has been engaging in daily and weekly meetings monitoring the progress being made on these open items. The Exchange has submitted copies of its current project plan to the State Auditors to show the progress being made, and the items that have been completed in response to various IT Security audits.

In addition, contractual amendments and Memorandum of Understanding (MOU) have been executed to enforce compliance with IRS regulations regarding the handling of FTI, including an amendment to the contract between the State of Connecticut and Deloitte Consulting, and an MOU between DAS BEST and the five FTI agencies in the State of Connecticut, including the Exchange."

Outdated Memorandum of Agreement with the Department of Social Services

Background: The Access Health Connecticut state-based marketplace application is an integrated eligibility system that determines eligibility and facilitates enrollment for both AHCT and Department of Social Services programs. Operating and capital expenses associated with the system are shared between the agencies. DSS reimburses the Exchange for its portion of costs. During the fiscal years ended June 30, 2014 and 2015, the Exchange received $22.3 and $28 million, respectively, from DSS in reimbursements.

Criteria: Good business practices include having a written memorandum of agreement when 2 parties share resources such as a computer system. The memorandum of agreement should include both parties' responsibilities and the methodology used to allocate costs between the parties.

Condition: The memorandum of agreement between the Exchange and DSS during the audited period was outdated and did not describe the methodology that was being used to allocate shared costs between the agencies. An updated memorandum of agreement was not completed until May 2018.

Effect: Without a written memorandum of agreement specifying the agreed-upon methodology to allocate shared costs, there is an increased risk that a dispute may arise, which could result in costs not being reimbursed in a timely manner. In addition, specifying how costs will be allocated between the Exchange and DSS would allow for more accurate budgeting and cash flow forecasting.

Cause: The Exchange and DSS did not execute an addendum to the memorandum of agreement in a timely manner to include the methodology that was used to allocate shared costs.

Recommendation: The Connecticut Health Insurance Exchange should ensure that it has an up-to-date memorandum of agreement with the Department of Social Services specifying the methodology to allocate shared costs. (See Recommendation 4.)

Agency Response: "The Exchange and the Department of Social Services (DSS) executed an addendum to its memorandum of agreement (MOA) on May 14, 2018. This addendum 4 included detailed information regarding the current and future

cost allocation methodology, and also historical methodology that the parties had agreed to and implemented during the past few years. The Exchange and DSS had also entered into an earlier addendum 1 in 2013 detailing earlier cost allocation methodologies between the agencies."

Auditors' Concluding Comments: During the audited period, we found that cost allocation methodologies included in addendum 1 of the memorandum of agreement between the Exchange and DSS were outdated. The Exchange should ensure that the memorandum of agreement is updated in a timely manner to include any changes to the terms of the agreement.

Inadequate Documentation – Criminal Background Checks and Training

Background: The Navigator and In-Person Assister (NIPA) program was created to provide educational and enrollment assistance to uninsured Connecticut residents. During the fiscal year ended June 30, 2014, the Exchange made payments to 6 Navigator organizations totaling $390,000 and 134 In-Person Assister organizations totaling $1,760,000. Since NIPA personnel have access to personally identifiable information (such as client name, date of birth, social security number, and income), the Exchange required all personnel to undergo a criminal background check and complete a training program.

Criteria: Sound internal control policies require that adequate documentation be kept to support the activities of the Exchange.

Condition: Our review disclosed that documentation was not on hand to support the completion of criminal background checks and training for all NIPA personnel listed in the Exchange's agreements with the NIPA organizations.

Effect: There is reduced assurance that PII was protected.

Cause: The Exchange did not maintain a list of all personnel who completed the training program. In addition, since the Exchange was not able to provide us with a comprehensive list of NIPA personnel who received final clearance to participate in the program, we were unable to verify whether any personnel who did not undergo a criminal background check participated in the program.

Recommendation: The Connecticut Health Insurance Exchange should maintain sufficient records to document that personnel with access to personally identifiable information have undergone a criminal background check and completed required training. (See Recommendation 5.)

Agency Response: "The Exchange maintains documentation that shows that all certified personnel in the NIPA program passed the criminal background check required by the Exchange, and the training program. Documentation has been provided to State Auditors in response to inquiries regarding criminal background check procedure and certain in-person assisters."

Auditors' Concluding Comments: Documentation to support that criminal background checks and training was completed for all NIPA personnel was not provided. Training documents were not received for 77% of the NIPA personnel reviewed and criminal background checks were not received for 9% of the NIPA personnel reviewed. Since the Exchange was not able to provide us with a comprehensive list of NIPA personnel who received final clearance to participate in the program, we were unable to verify whether personnel who did not undergo a criminal background check participated in the program.

Excessive Custodial Credit Risk

Criteria: Section 38a-1083(c)(9) of the General Statutes provides that the Connecticut Health Insurance Exchange is authorized and empowered to invest any funds not needed for immediate use or disbursement in obligations issued or guaranteed by the United States of America or the state, and in obligations that are legal investments for savings banks in the state.

Sound business practices include minimizing custodial credit risk, which is defined as the risk that, in the event of a bank failure, the depositor will be unable to recover deposits. Deposits are exposed to custodial credit risk if they are uninsured. This occurs when the amount deposited at a single financial institution exceeds the federally insured limit.

Condition: Our review of the Exchange's bank balances as of June 30, 2014 and June 30, 2015, disclosed $6,376,028 and $7,694,223, respectively, in uninsured funds.

Effect: Uninsured bank balances increase the risk that the Exchange will not be able to recover its deposits in the event of a bank failure

Cause: The Exchange does not have a policy restricting the amount of cash that can be deposited into any one bank.

Recommendation: The Connecticut Health Insurance Exchange should reduce custodial credit risk by decreasing the amount of uninsured deposits. (See Recommendation 6.)

Agency Response: "The Exchange maintains separate accounts for its operating and reserve funds: operating funds are in an account with a commercial bank, and the remaining reserve funds are in an account with the State of Connecticut Treasurer's Short-Term Investment Fund (STIF). The STIF is an investment pool of high-quality, short-term money market instruments for state and local governments. The STIF provides a safe, liquid, and effective investment vehicle for the operating cash of the State Treasury, state agencies and authorities, municipalities, and other political subdivisions of the state, pursuant to CGS §§ 3-27a and 3-27b. The STIF is required to maintain a designated surplus reserve to provide an added layer of security. The Exchange has implemented a Zero Balance Account utilizing a Treasury Repurchase Investment Account that has eliminated the overnight custodial credit risk for its commercial bank operating account previously identified. In addition, the Exchange is more actively managing the balances held in STIF and its commercial bank operating account with the goal of ensuring that funds are available to meet all disbursements."

Weaknesses over Purchasing

Criteria: Section 38a-1082(a)(3) of the General Statutes provides that the Exchange board of directors shall adopt written procedures for acquiring real and personal property, as well as personal services.

Written procedures of the Exchange require a purchase order for all purchases to obligate the commitments. Proper internal controls require that commitment documents be properly approved prior to the ordering of goods or services.

In addition, the Exchange's written procedures provide that a contract is not deemed awarded until it is fully executed.

Condition: We reviewed 9 expenditures totaling $13,537,606 that were paid during the fiscal years ended June 30, 2014 and 2015, and noted that 4 purchase orders were approved after the receipt of goods or services and 1 purchase order was not properly approved. In addition, we noted that services for another expenditure totaling $500,000 were provided prior to the contract being fully executed.

Effect: Incurring an obligation without a valid purchase order increases the risk that unauthorized purchases will occur and funding will not be available at the time payment should be made. In addition, not having a fully executed contract prior to the commencement of services increases the risk of disputes over the scope of services to be provided and the associated costs.

Cause: Established purchasing procedures were not adequately executed.

Recommendation: The Connecticut Health Insurance Exchange should adhere to established purchasing procedures by ensuring that funds are properly committed prior to purchasing goods and services. In addition, contracts should be fully executed prior to the commencement of services. (See Recommendation 7.)

Agency Response: "The Exchange has refined its purchasing process to ensure that it is adhering to established purchasing procedures. The Exchange has adopted written procedures for acquiring real and personal property and personal services. The Exchange has created a Procurement Services group, comprised of members of the legal and finance departments that meets on a weekly basis to manage all procurement requests and ensure that all personnel comply with the procurement and purchasing procedures."

RECOMMENDATIONS

Our prior audit of the fiscal years ended June 30, 2012 and 2013 contained 3 recommendations. Of those recommendations, 2 have been implemented or resolved and 1 has been restated to reflect current conditions. The status of prior recommendations is presented below.

Status of Prior Audit Recommendations

- **The Connecticut Health Insurance Exchange should develop a management control system which holds the organization accountable for responding in a timely manner to reported deficiencies in the security of the Exchange, in order to provide assurance that the PII in its possession is secure.** The current audit disclosed that the information security controls of the Exchange did not always comply with federal requirements. Therefore, the recommendation is being restated to reflect current conditions. (See Recommendation 3.)

- **The Connecticut Health Insurance Exchange should take the necessary steps to ensure that meeting minutes and related materials are released within the timeframe required by state statute.** The current audit did not disclose any meeting minutes or related materials that were not released within the timeframe required by state statute. Therefore, the recommendation is not being repeated.

- **The Connecticut Health Insurance Exchange should respond with appropriate action based upon the opinion of the office of the Attorney General on the legal sufficiency of the "faithful performance" rider.** Public Act 16-129, effective October 1, 2016, modified Section 38a-1081(c)(8) of the General Statutes to allow the Connecticut Health Insurance Exchange to obtain insurance covering their board members, executive officer, and employees, instead of executing a bond for them. Therefore, the recommendation is not being repeated.

Current Audit Recommendations:

1. **The board of directors should approve non-budgeted severance payments in excess of $5,000 in accordance with Section 38-1082(a) of the General Statutes.**

   Comment:

   Severance payments totaling $678,954 were not approved by the board of directors.

2. **The Connecticut Health Insurance Exchange should solicit proposals at least once every three years for all professional services, as required under Section 38a-1082(a)(4) of the General Statutes.**

   Comment:

   Our review disclosed that over $8 million of contracts awarded to 1 vendor were not the result of a competitive process. Our further review of the Exchange's contract log as of January 1, 2015, disclosed an additional $37 million of contracts that were listed as being sole source and did not appear to be the result of a competitive process.

3. **The Connecticut Health Insurance Exchange should work with DAS BEST to ensure that its information security controls meet relevant federal requirements, such as those of the Centers for Medicare and Medicaid Services Minimum Acceptable Risk Standards for Exchanges and the National Institute of Standards and Technology.**

   Comment:

   A risk assessment performed by a third-party vendor determined that the information security controls of the Exchange did not always comply with federal requirements.

4. **The Connecticut Health Insurance Exchange should ensure that it has an up-to-date memorandum of agreement with the Department of Social Services specifying the methodology to allocate shared costs.**

   Comment:

   The memorandum of agreement between the Exchange and the Department of Social Services during the audited period was outdated and did not describe the methodology used to allocate shared costs between the agencies.

5. **The Connecticut Health Insurance Exchange should maintain sufficient records to document that personnel with access to personally identifiable information have undergone a criminal background check and completed required training.**

   Comment:

   There was no documentation on hand to corroborate that criminal background checks and training were completed for all Navigator and In-Person Assister program personnel.

6. **The Connecticut Health Insurance Exchange should reduce custodial credit risk by decreasing the amount of uninsured deposits.**

   Comment:

   Our review of the Exchange's bank balances as of June 30, 2014 and June 30, 2015, disclosed $6,376,028 and $7,694,223, respectively, in uninsured funds.

7. **The Connecticut Health Insurance Exchange should adhere to established purchasing procedures by ensuring that funds are properly committed prior to purchasing goods and services. In addition, contracts should be fully executed prior to the commencement of services.**

   Comment:

   Our review of 9 expenditures identified 4 purchase orders that were approved after the receipt of goods or services and another purchase order was not properly approved. We also noted that services were provided prior to the contract being fully executed for 1 expenditure.

ACKNOWLEDGEMENT

The Auditors of Public Accounts would like to recognize the auditors who contributed to this report:

Catherine Dunne
Charles Edenburn
Logan Johnson
Amy Williams

CONCLUSION

We wish to express our appreciation for the cooperation and courtesies extended to our representatives by the personnel of the Connecticut Health Insurance Exchange during the course of our examination.

State Auditor John C. Geragosian recused himself from reviewing and signing the audit report in order to avoid the possible appearance of a conflict of interest.

Catherine L. Dunne
Principal Auditor

Approved:

Robert J. Kane
State Auditor