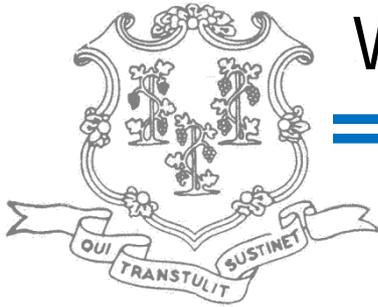


# Connecticut Health Insurance Exchange

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Board of Directors Meeting

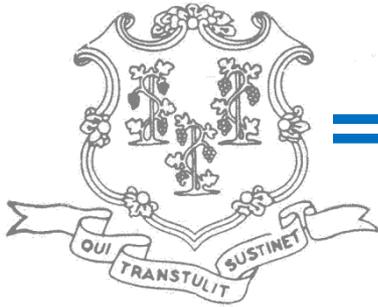
*September 27, 2012*



# Welcome and Introductions

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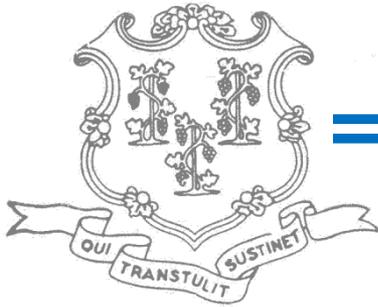
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# Public Comment

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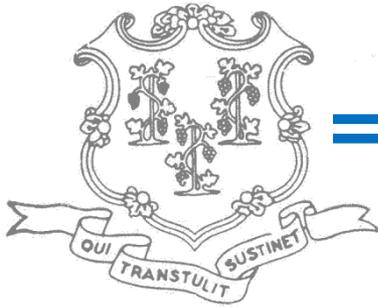
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# Review and Approval of Minutes

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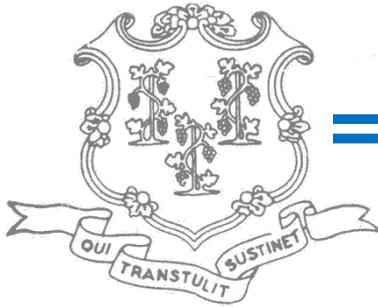
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# Annual Election of Vice Chair

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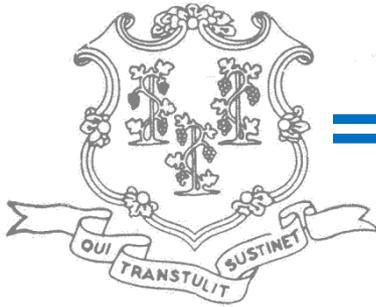
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# CEO Report

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# Policies and Procedures

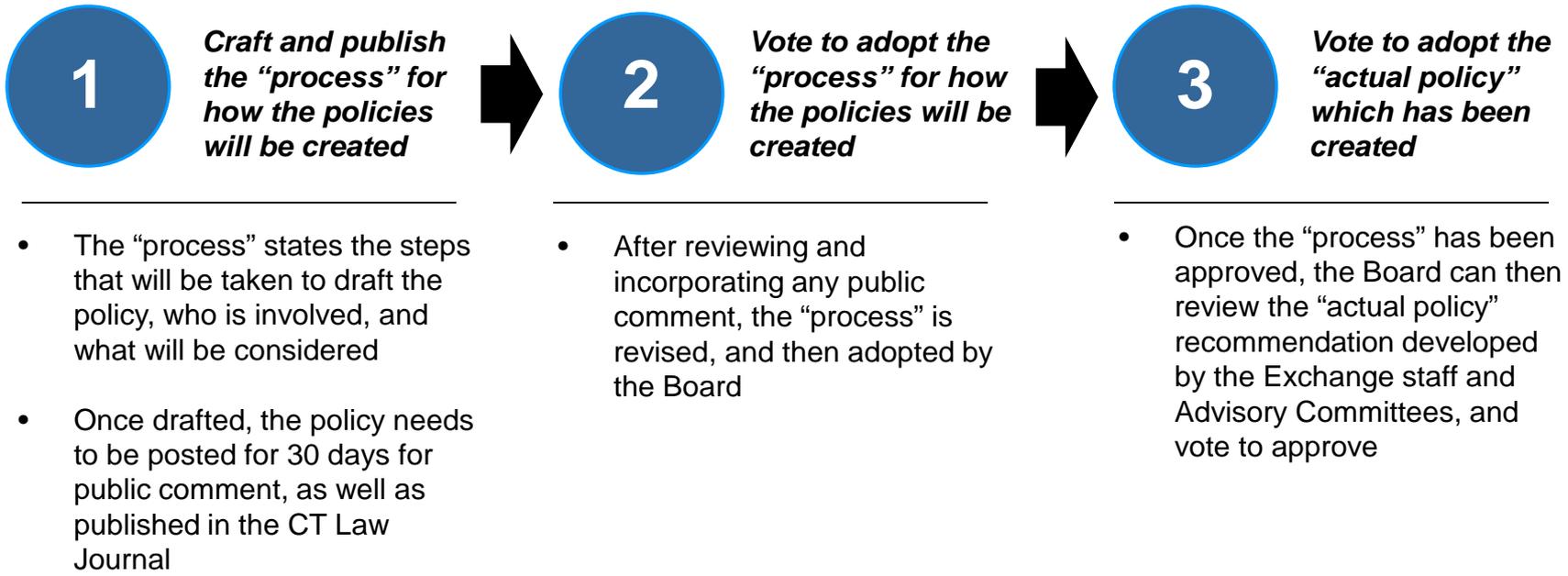
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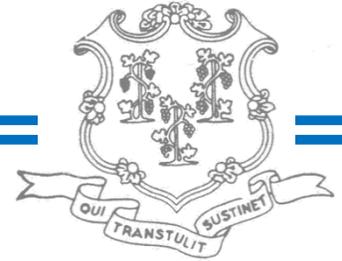
# Steps in the Process



- As the Exchange looks to establish and adopt policies in key areas, there is a 3-step process which needs to be undertaken in accordance with CT State law



# Existing Policies and Procedures



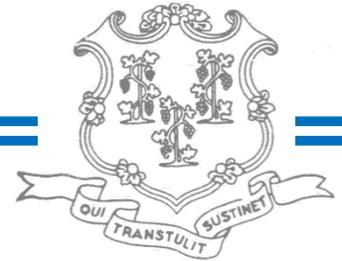
## Financial

- Annual Budget, adopted
- Audits, adopted
- Reports, adopted
- Procurement: Personal Services, adopted
- Procurement: Real and Personal Property, adopted

## Human Resources

- EEO-Affirmative Action, adopted
- Compensation and Benefits, adopted
- Hiring and Promotion, Discipline & Termination, adopted

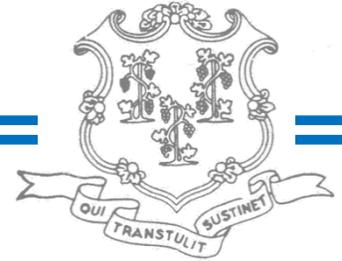
# **Policies and Procedures for Publication**



Procedures proposed for Board review at the September 27, 2012 Board meeting with subsequent publication in the *CLJ* and public comment:

- **Investment Policy**, in support of CGS 38a-1083(9) including the Form required by CGS 3-13j (disclosure of third party investment fees); affects public, required under CGS 1-121;
- **Establishing the Navigator Program/Award Grants Procedure** as required by CGS 38-1082(7) and CGS 1-121 in support of CGS 38a- 1083(15); 38a-1084(19) and in accordance with Section 1311 of ACA and CGS 38a-1087;
- **Establishing the SHOP Program Procedure** as required by CGS 38a-1084 (13) and CGS 1-121 and CFR 155.700;
- **Certification, Recertification and Decertification of Qualified Health Plans Procedure** as required by CGS 38a-1082(6);

# Common Characteristics

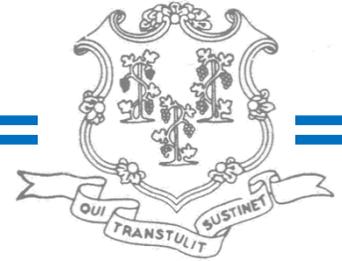


## Advisory Committee Structure and Reports

- From 10-15 members appointed by Board
- Members drawn from Exchange Board
- Members drawn from stakeholders, insurance brokers and producers, small business owners, providers and consumer advocates
- Co-chaired by board member and by stakeholder
- Exchange staff evaluates options and recommendations and presents to Advisory Committee for comment
- Board member co-Chair reports to Exchange Board

# Common Characteristics

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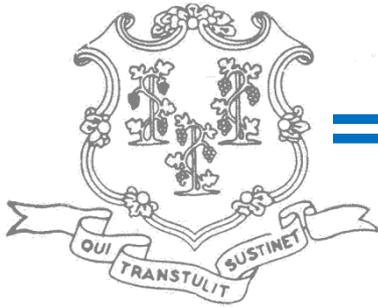


## Meetings

- Open to public and noticed on HIX website
- Transcript or minutes kept and published on HIX website
- Quorum for business is majority of membership
- Vote passes if majority of quorum approves

## Public Participation

- Public initially invited to participate as committee members
- Public offered opportunity to comment at meeting
- But not allowed to participate directly in discussions or deliberations unless invited by Committee Chair
- Public can address written comments to Exchange



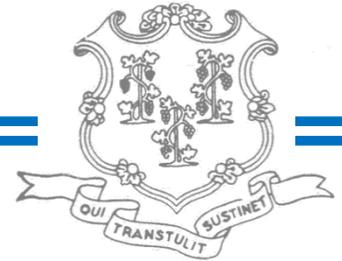
# Investment Policy

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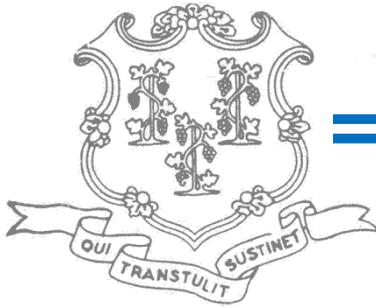
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# Connecticut Health Insurance Exchange – Investment Policy

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- Addresses the Exchange employees' 401K plan, as well as investment funds of the Exchange
- Employs the “prudent investor” rule, a guideline that requires a fiduciary to invest public funds as if they were their own
- Identifies prospective investment objectives for Exchange funds when such funds become available
- Contains 3rd party fee disclosure requirements for any contracted investment services



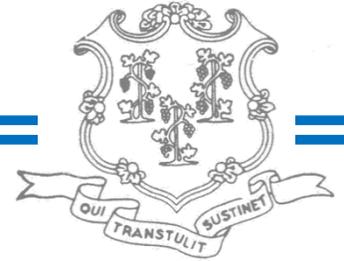
# Policy for Establishing Navigator Grant Program

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# Policy for Establishing Navigator Grant Program

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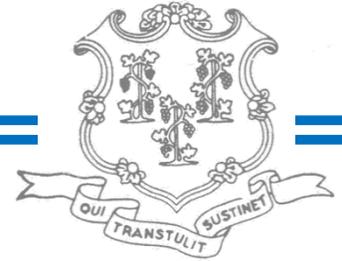


- Designate Brokers, Agents and Navigators Advisory Committee
  - Tasked with developing recommendations
  
- Exchange staff presents issues, options, and recommendations to Committee
  
- Consumer Experience and Outreach Committee
  - Tasked with review and recommendations to Committee on Navigators
  
- Exchange Board evaluates recommendations

# Policy for Establishing Navigator Grant Program

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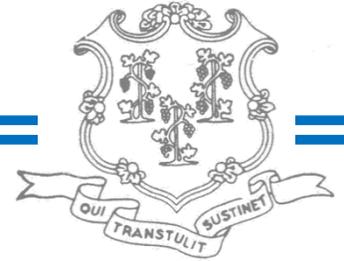


## Navigator Grant Program required to follow:

- Provisions of the ACA including §1311
- Provisions of Connecticut General Statutes §38a-1087, the Exchange Act
- HHS Regulations 45 CFR Sections 155 and 156 (Navigator Program)
- Guidance Bulletins from U.S. Department of Health and Human Services

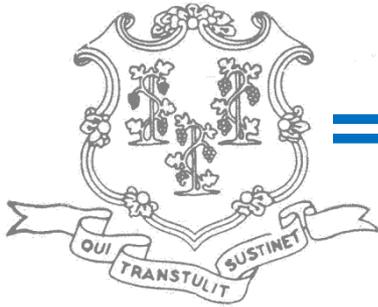
# Policy for Establishing Navigator Grant Program

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## Must Consider:

- Performance and accountability standards applicable to navigators
- Certification and training requirements; and
- Maximum grant amounts for Navigators

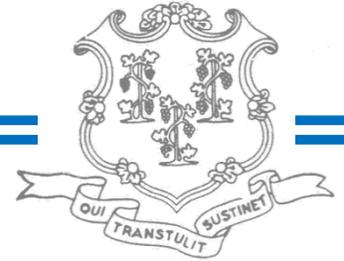


# Small Employer Health Options Program (SHOP) Policy

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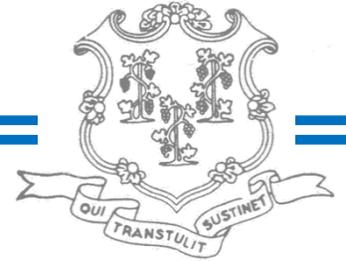
# Policy for Small Employer Health Options Programs (SHOP)



- Designate Small Employer Health Options Program (SHOP) Advisory Committee
  - Tasked with developing recommendations
  
- Exchange staff presents issues, options, and recommendations to Committee
  
- Exchange Board evaluates recommendations

# Policy for Small Employer Health Options Programs (SHOP)

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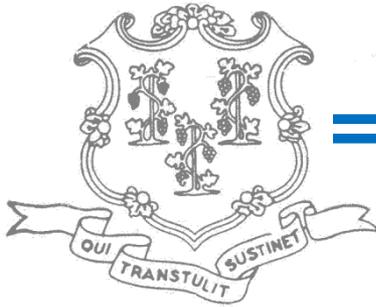
## Must Consider:

- Plan options available to the SHOP
- Attractiveness of plans offered
- Administrative ease
- Whether to develop internally or to outsource

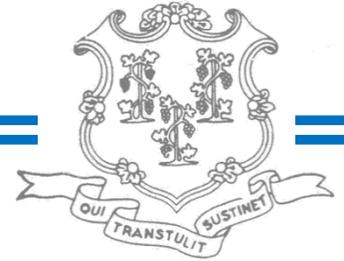
# Process for Certification, Recertification, and Decertification of Qualified Health Plans

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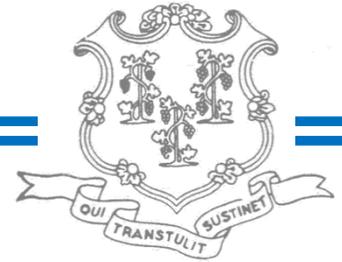
# Policy for Establishing Requirements for Certification, Recertification and Decertification of Qualified Health Plans



## Definition of Qualified Health Plan (QHP):

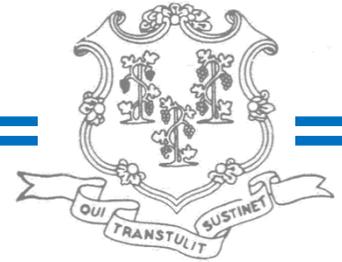
- A QHP is an insurance plan that is certified by the Exchange to provide essential health benefits with established limits and cost-sharing elements such as deductible, co-payments, and out-of-pocket maximums.
- Once a health plan becomes certified, it will receive a seal of approval from the Exchange.

# Policy for Establishing Requirements for Certification, Recertification and Decertification of Qualified Health Plans



- Exchange staff presents issues and options to the Health Plan Benefits and Qualifications (HPBQ) Advisory Committee, which is tasked with developing recommendations to the Board
- The Consumer Experience and Outreach Committee consults with the HPBQ Advisory Committee to review decisions and provide guidance on the recommendations
- The Exchange Board evaluates recommendations for resolution

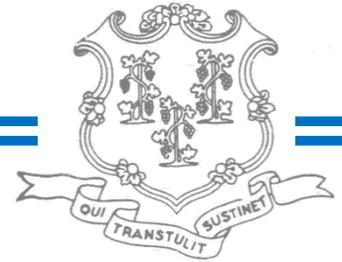
# Policy for Establishing Requirements for Certification, Recertification and Decertification of Qualified Health Plans



## The Exchange and HPBQ required to follow:

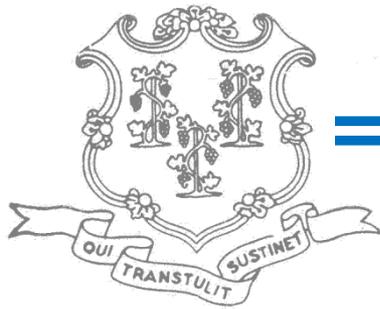
- Provisions of the ACA including §1302 and §1311
- Provisions of Connecticut General Statutes §38a-1080, et seq, Exchange Act including §38a-1085 (Qualified Health Plans) and §38a-1086 (certification of health benefit plans)
- HHS Regulations 45 CFR Sections 155 and 156 regarding certification and recertification standards and the decertification process for QHPs
- Bulletins from U.S. Department of Health and Human Services

# Policy for Establishing Requirements for Certification, Recertification and Decertification of Qualified Health Plans



## Must Consider:

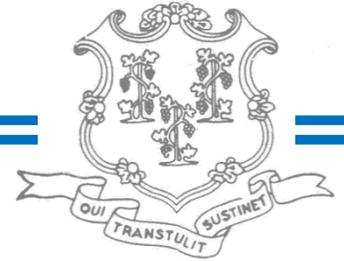
- Minimum standards for marketing practices;
- Network adequacy;
- Essential community providers in underserved areas;
- Accreditation;
- Quality improvement / Quality measures for health plan performance;
- Uniform enrollment forms and descriptions of coverage;
- A process for appeal of a decertification of a QHP; and
- A process for providing notice of a QHP decertification to all affected parties.



Vote

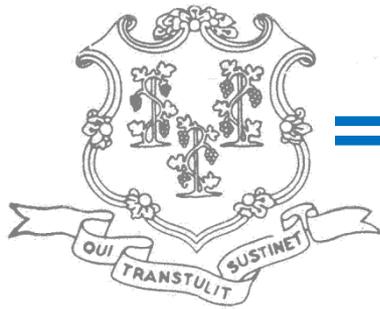
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# **Policies and Procedures for Adoption**



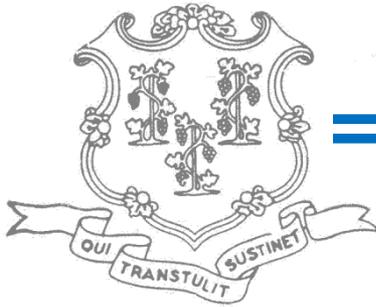
The procedures the Exchange is scheduled to adopt today:

- **Revised Ethics Policy** (based on changes required by PA 12-1)
- **Essential Health Benefits Benchmark Plan Process**



Vote

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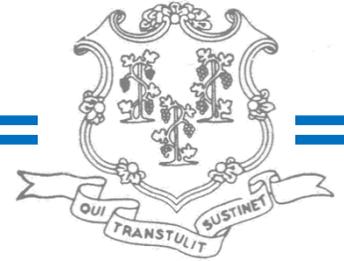
# Essential Health Benefits Benchmark Plan

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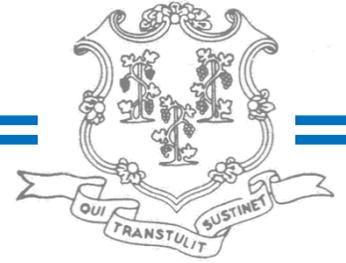
# Presentation Objectives

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- Overview of Essential Health Benefits (EHB)
- EHB Selection Process
- The Advisory Committees' EHB Recommendation
- Vote

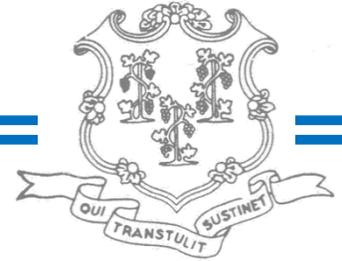
# Overview: §1302(b) EHB Requirements



The ACA stipulates that an EHB plan must include coverage in these 10 categories of services:

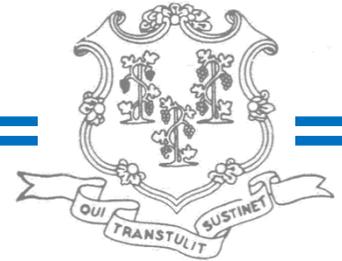
- A. Ambulatory patient services
- B. Emergency services
- C. Hospitalization
- D. Maternity and newborn care
- E. Mental health and substance abuse disorder services, including behavioral health treatment
- F. Prescription drugs
- G. Rehabilitative and habilitative services and devices
- H. Laboratory services
- I. Preventative and wellness services and chronic disease management
- J. Pediatric services, including oral and vision care

# Benchmark Selection Process



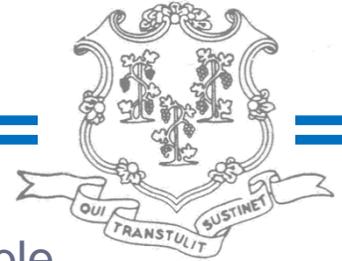
- The ACA has not provided direction or specified what benefits or services must be included in the 10 categories of care
- Each state was instructed to base the EHB on a typical employer health plan with the largest enrollment
- HHS identified 10 potential benchmark options by enrollment for each state
  - The three largest small group plans
  - The three largest state employee health benefit plans
  - The three largest FEHBP plan options
  - The largest commercial HMO in the state

# Benchmark Selection Process

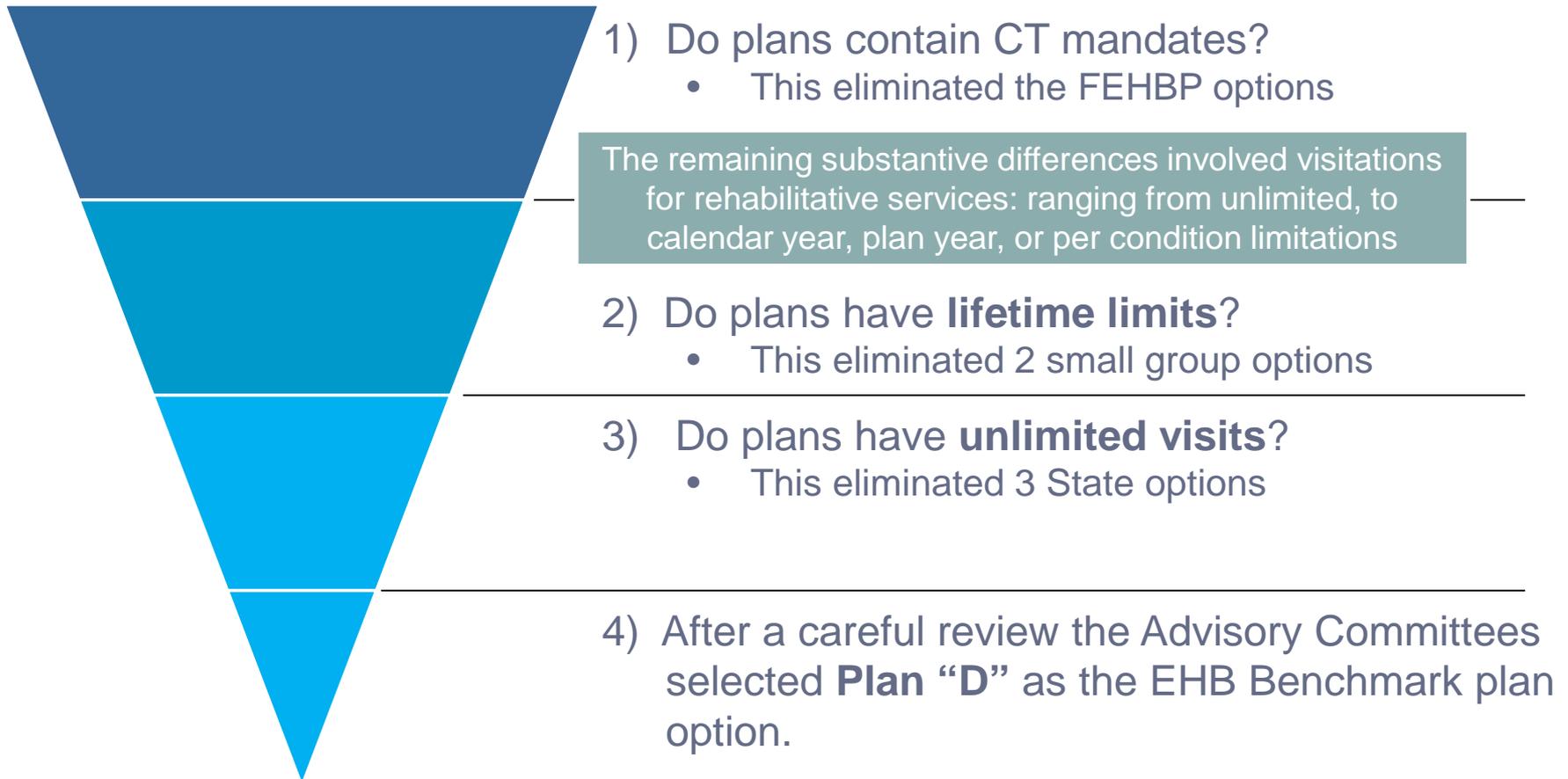


- The selected Benchmark plan option will set the minimum benefit standards for the individual & small group market for 2014-2015
- A state's EHB package would include:
  - The benefits offered in the Benchmark plan, and;
  - Any supplemental benefits required to ensure coverage in all ten statutory categories of benefits.
- The benchmark plan option selected will be the plan design standard for a QHP inside the Exchange and plans offered in the individual and small group markets (outside of the Exchange)

# Benchmark Evaluation Process

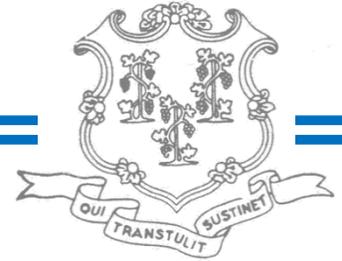


An evaluation of key differences between the benchmark plans was conducted and resulted in eliminating the options which were not feasible.

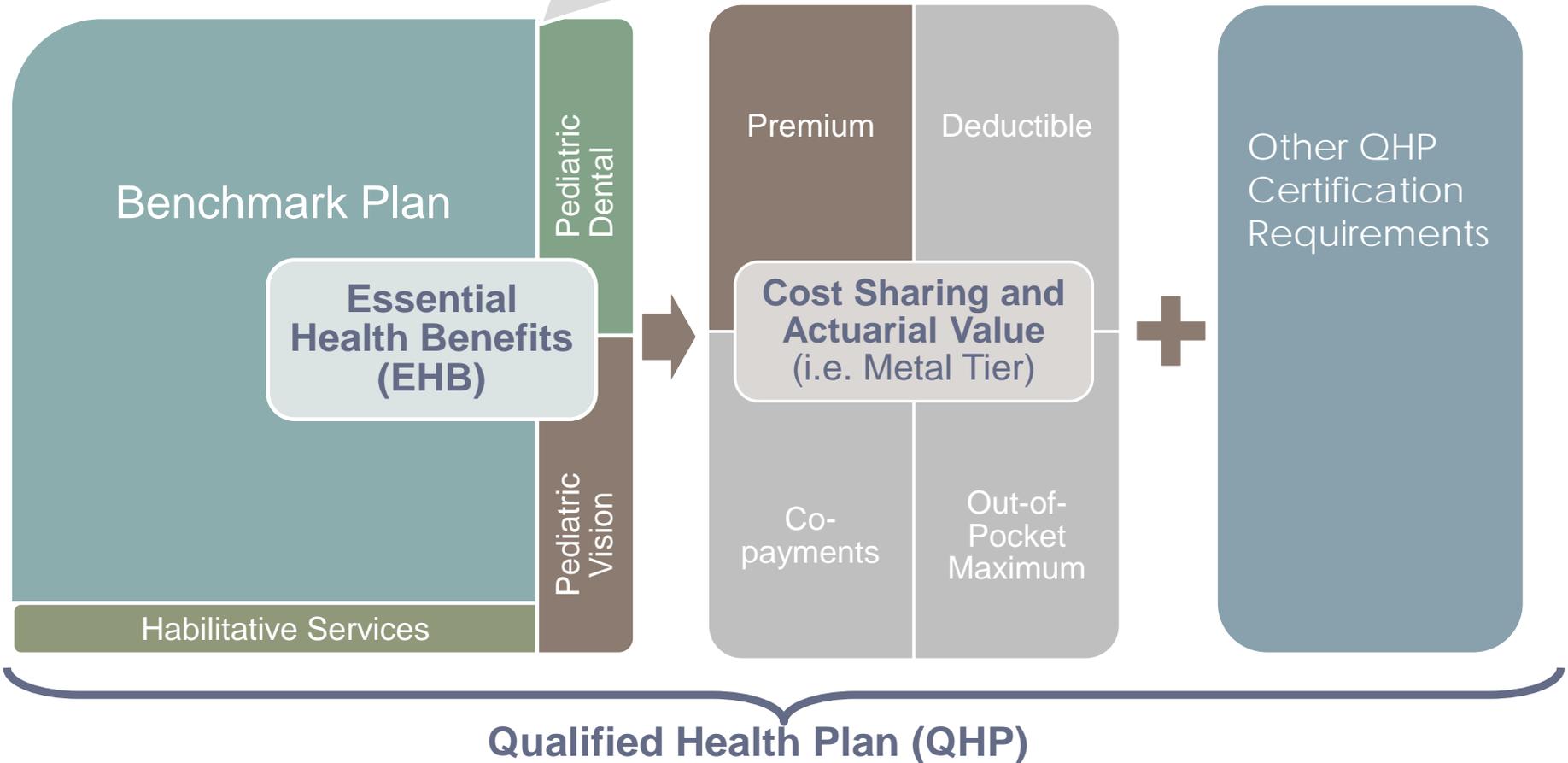


# Essential Health Benefits (EHB):

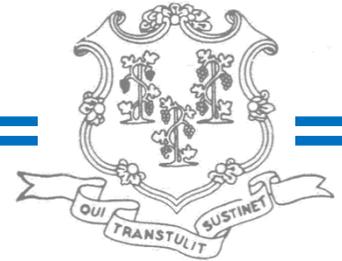
## From Benchmark → EHB → QHP



Board Vote of 9/27 on AC's Recommendation for EHB



# Supplementing the Benchmark

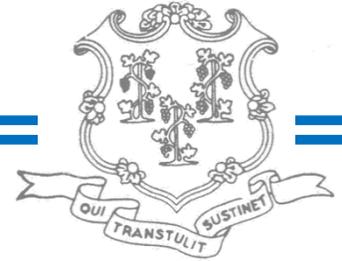


## PRESCRIPTION DRUG UPDATE:

- The recommendation made at the last Board meeting for the prescription drug benefit was Plan C. Federal guidance changed as of July 20<sup>th</sup>
- The guidance is required and permits the use of riders in lieu of supplementing benefits from another benchmark plan option
- Therefore, the prescription drug rider offered through benchmark Plan D will become the prescription benefit
- The minimum plan requirement did not change (e.g. if a benchmark plan offers a drug in a certain category or class all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary)
- The change from Plan C to Plan d is not material as the RX rider available through Plan D includes a minimum of one drug in each category or class

# ***Essential Health Benefits (EHB):***

## **Supplementing: Habilitative, Pediatric Services – Oral & Vision**

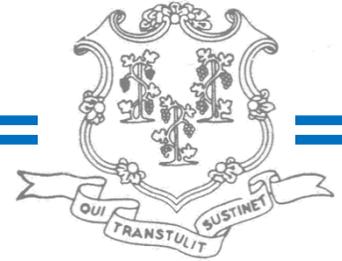


Plan D does not provide coverage for the following services and therefore must be supplemented:

- Habilitative
- Pediatric dental services
- Pediatric vision services

# ***Essential Health Benefits (EHB):***

## **Supplementing: Habilitative, Pediatric Services – Oral & Vision**



### **Pediatric Dental**

The Advisory Committees selected the CHIP (HUSKY B) program as the pediatric dental option.

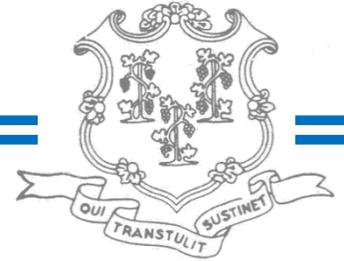
- Covered Services include preventive and basic dental services (cleanings, fillings, root canals, crowns and orthodontia when medically necessary)

### **Pediatric Vision**

The Advisory Committees selected the federal employee vision plan (FEDVIP) as the pediatric vision plan.

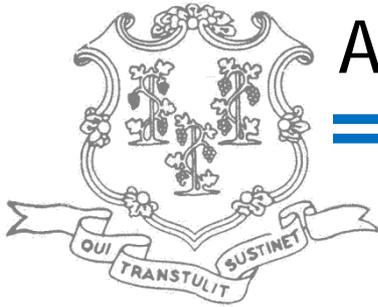
- Coverage includes routine eye exam and refraction, corrective lenses and contact lenses.

# **Recommendation for State's EHB**



## **EHB Recommendation:**

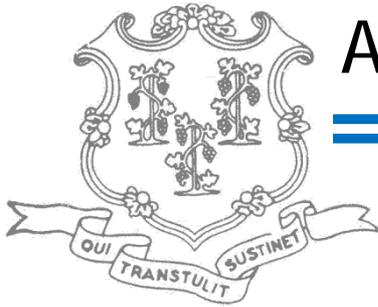
The Exchange staff agrees with its Advisory Committees and advises the Board to approve Plan “D” as the State of Connecticut’s Benchmark plan, supplemented by the Husky B pediatric dental plan and the FEDVIP pediatric vision plan.



# Advisory Committees Update

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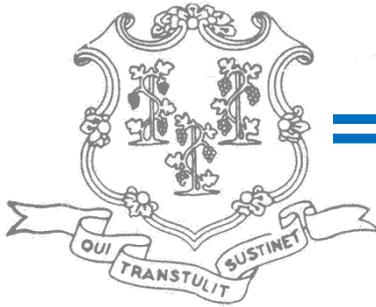
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# Audit Committee Membership

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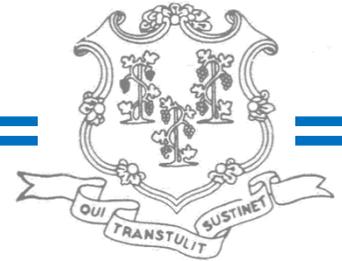


# FY 2013 Operating Budget

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# FY 2013 Operating Budget – Fiscal Year 2013 Budget (July 1, 2012 to June 30, 2013)

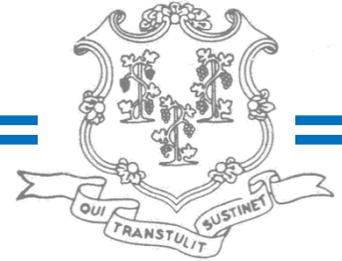


## Executive Summary

- HIX FY 2013 Operating Budget totals \$69.5 Million
- Source of funding is the remainder of funds from the Level One Establishment Grant, the Level One Establishment Supplement Grant, as well as proportional amounts from the Level Two Establishment Grant, which extends for more than 28 months to December 31, 2014.
- Provides for appropriate use of resources to accomplish fiscal objectives including:
  - HIX Staff ramp up
  - Establishing an independent HIX office
  - Advertising Campaign and Web Design & Development
  - First year of multi-year creation of all payer claims database
  - Design, Development and Implementation (DDI) expenditures for HIX platform and System Integrator

# FY 2013 Operating Budget

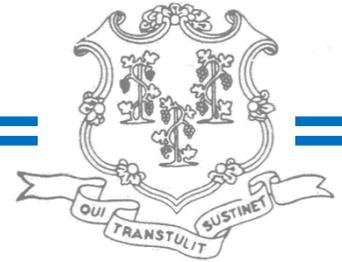
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## Agenda

- Overview
- Approach
- FY 2013 Budget
- Questions & Answers
- Appendix I – Reconciliation of Grant Funding
- Appendix II – Level Two Awarded vs. Budgeted
- Appendix III – FY 2012

# FY 2013 Operating Budget



## Overview

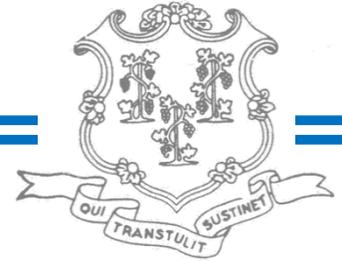
HIX FY 2013 Operating Budget totals \$69.5 Million

Source of funding is the remainder of funds from the Level One Establishment Grant, the Level One Establishment Supplement Grant, as well as proportional amounts from the Level Two Establishment Grant, which extends for more than 28 months to December 31, 2014

Provides for appropriate use of resources to accomplish fiscal objectives including:

- HIX Staff ramp up from 11 FTE's to 37 FTE's at June 30, 2013
- Establishing and relocating to independent HIX office: \$436,041
- Phases of Advertising Campaign and Web Design & Development: \$3,258,750
- Progress in developing the all payer claims database together with the office of Health Reform and Innovation: \$2,261,360 (of the total funds of \$6,554,667)
- Design, Development and Implementation (DDI) costs & Hardware and software capital expenditures for HIX platform and System Integrator: \$48,262,651

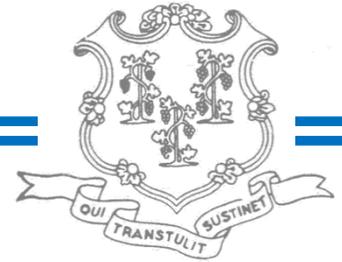
# FY 2013 Operating Budget



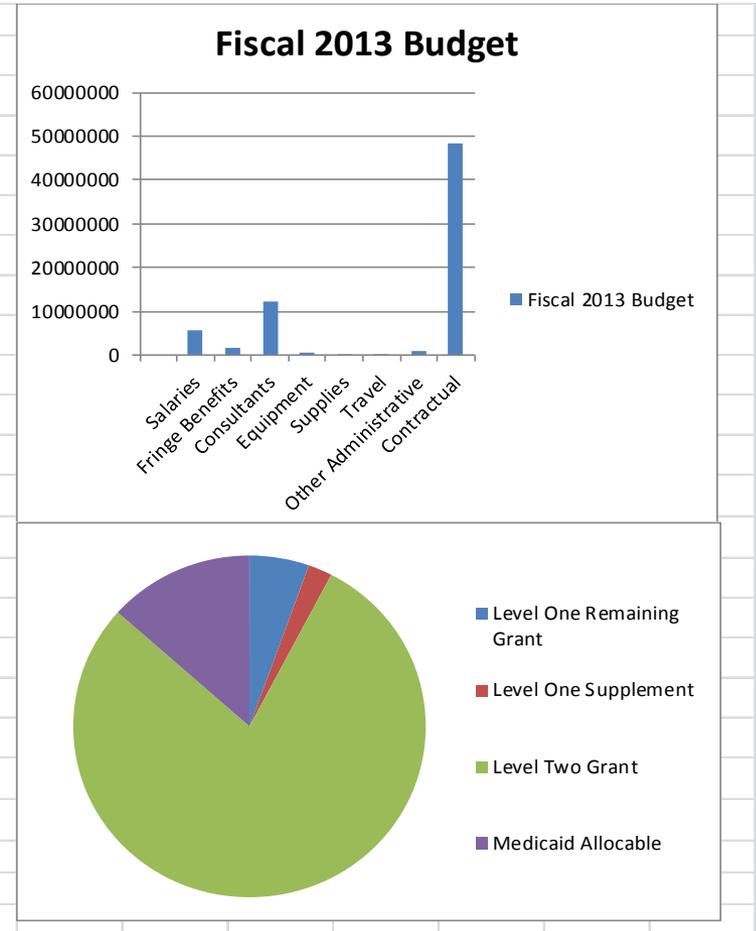
## Budget Approach

- Apportions establishment grant funding for activities anticipated to be completed in fiscal period.
- Necessarily includes prudent estimates for items not yet finalized.
- Maintains conservatism underlying the budget assumptions used for the establishment grants.
- Budget will be achieved by closely monitoring expenditures.

# FY 2013 Operating Budget



Expense Category	Fiscal 2013 Budget
Salaries	\$ 5,774,354
Fringe Benefits	1,710,097
Consultants	12,159,066
Equipment	576,090
Supplies	7,496
Travel	102,651
Other Administrative	888,397
Contractual	48,262,651
<b>Total</b>	<b>\$ 69,480,802</b>
<b>Source of Funds</b>	
Level One Remaining Grant	\$ 3,804,413
Level One Supplement	1,521,500
Level Two Grant	54,845,277
Medicaid Allocable	9,309,612
	<b>\$ 69,480,802</b>



# FY 2013 Budget – Salaries & Fringe Benefits

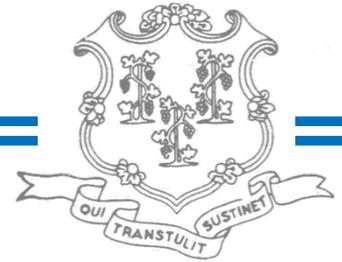


- Salaries / Fringe Benefits – Salary and Fringe Benefits cost totals \$7,484,451, including \$1,710,097, a 30% benefit load.

<b>\$ 7,484,451</b>
26 FTE Increase
Total FTE's 37

Program Area	FTE's FY 12	FTE's Growth FY 13	FTE's FY 13
Accounting	0	3	3
Administrative	1	2	3
Budget	0	1	1
Finance	1	3	4
Grievances & Appeals	0	0	0
IT	0	4	4
Legal	0	2	2
Marketing	1	2	3
Operations	1	2	3
Outreach	0	1	1
Plan Management	1	2	3
Policy	1	1	2
Reporting And Analysis	0	1	1
Senior Executives	5	2	7
SHOP	0	0	0
	<b>11</b>	<b>26</b>	<b>37</b>

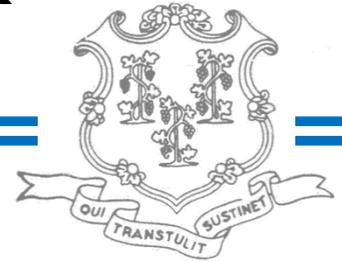
# FY 2013 Budget – Consultants



- Consultants** – Consulting totals \$12,159,066. In addition to the All-Payer Claims Database (APCD) and Advertising & Web Design, Integrated Eligibility Program Management Services and Navigator Program Design are included, in addition to KPMG services.

Non-IT Consultants	Amount
Marketing & Advertising	\$3,258,750
Legal Support	137,466
Auditing Services	191,473
APCD	2,261,360
Reports & Briefings	525,000
SHOP Procurement Strategy	234,375
Program Management	2,137,500
Outreach & Education	300,000
Exchange & Evaluation Plan	202,500
Consulting & Professional Services	2,416,896
Other	493,746

# FY 2013 Budget – Equipment, Supplies, Travel & Other Administrative



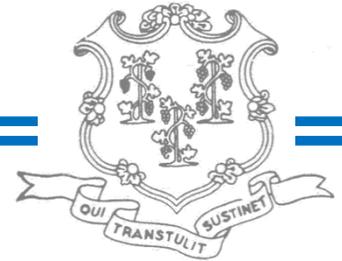
**Equipment** – cost includes capital expenditures for non-DDI hardware and software, and communication costs, as well as costs to retrofit new office space

**Travel** – provides for out of state trips taken by Exchange Personnel for conferences hosted by CCIO, other Federal Agencies, Professional Development, and Consultation with other states

**Other Administrative** – includes facilities costs, including moving and insurance, and various ancillary business and staff expenses

Major Category	Amount
Equipment	\$576,090
Supplies	7,496
Travel	102,651
Other Administrative	888,397

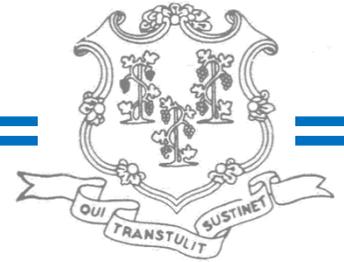
# FY 2013 Budget – Contractual



**Contractual** – contractual costs total \$48,262,651 for IT system design, development and implementation (DDI) and related activities.

Major Category	Amount
Consultants & Contracted Staff	\$ 6,424,078
Hardware and Software	13,077,749
Design, Development, and Implementation	28,578,714
Other	182,110

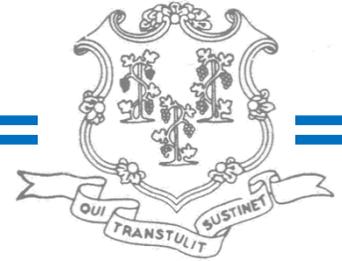
# FY 2013 Budget



## Questions & Answers

# FY 2013 Budget – Appendix I

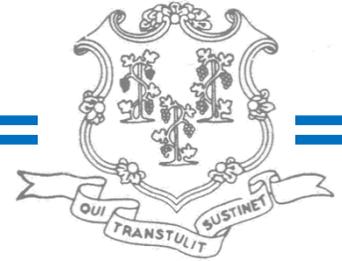
## Reconciliation of Grant Funding to FY 2013 Budget



Expense Category	Level One Grant	Level One Supplement Grant	Level Two Grant	FY 2013 Budget
Salaries	\$ 1,249,963	\$ 805,000	\$ 3,719,391	\$ 5,774,354
Fringe	352,779	241,500	1,115,818	1,710,097
Consultants	2,040,831	455,000	9,663,235	12,159,066
Equipment	26,987	-	549,103	576,090
Supplies	1,076	-	6,420	7,496
Travel	14,949	20,000	67,702	102,651
Other Administrative	117,828	-	770,569	888,397
Contractual		-	48,262,651	48,262,651
<b>Total Direct Cost</b>	<b>3,804,413</b>	<b>1,521,500</b>	<b>64,154,889</b>	<b>69,480,802</b>
<b>Medicaid Allocable</b>			<b>(9,309,612)</b>	<b>(9,309,612)</b>
<b>Level One Supplement Overlap</b>		<b>(1,096,125)</b>		<b>(1,096,125)</b>
<b>Total Funding</b>	<b><u>\$ 3,804,413</u></b>	<b><u>\$ 425,375</u></b>	<b><u>\$ 54,845,277</u></b>	<b><u>\$ 59,075,065</u></b>

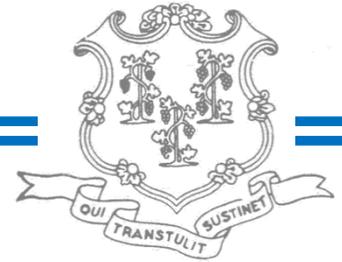
# FY 2013 Budget – Appendix II

## Level Two Establishment Grant Awarded vs. Budgeted



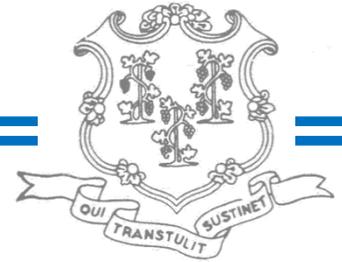
Level Two Establishment Grant Category	Grant Amount Awarded	Grant Amount Budgeted for Fiscal 2013	% of Grant Budgeted for Fiscal 2013
Salaries & Fringe	\$ 14,075,650	\$ 4,835,209	34.35%
Consultants	20,879,667	9,663,235	46.28%
Equipment	651,557	549,103	84.28%
Supplies	18,930	6,420	33.91%
Travel	132,937	67,702	50.93%
Other	2,326,453	770,569	33.12%
Contractual Costs	93,353,328	48,262,651	51.70%
<b>Total Direct Costs</b>	<b>131,438,522</b>	<b>64,154,889</b>	<b>48.81%</b>
Less: Level One Supplement Overlap	(1,461,500)	(1,096,125)	75.00%
Less: Medicaid Allocable	(22,618,346)	(9,309,612)	41.16%
<b>Total Costs</b>	<b>\$ 107,358,676</b>	<b>\$ 53,749,152</b>	<b>50.07%</b>

# FY 2013 Budget – Appendix III – Illustration of Fiscal 2012 Compared to “Hypothetical” 2012 Budget



	Fiscal 2012	2012 Hypothetical Budget	Variance Budget vs. Actuals
Salaries	\$ 219,205	\$ 4,955,115	\$ 4,735,910
Fringe Benefit	76,721	1,473,688	1,396,967
Consultants	2,847,074	10,335,206	7,488,132
Equipment	55,681	489,677	433,996
Supplies	4,076	6,372	2,296
Travel	17,221	87,253	70,032
Other Administrative	92,791	688,118	595,327
Contractual	-	26,622,194	26,622,194
<b>Total Contractual</b>	-	<b>26,622,194</b>	<b>26,622,194</b>
<b>Total Direct</b>	<b>3,312,769</b>	<b>44,657,622</b>	<b>41,344,853</b>
Indirect	47,296	-	(47,296)
<b>Total Direct and Indirect</b>	<b>\$ 3,360,065</b>	<b>\$ 44,657,622</b>	<b>\$ 41,297,557</b>

**Notes: Hypothetical Budget represents proration of Level One Grant Ignoring extention**

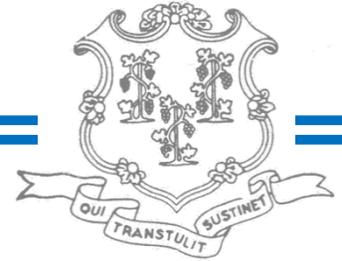


# Information Technology Update

## Agenda

- System Integrator Update
- System Overview
- Program Management Office

# System Integrator Update



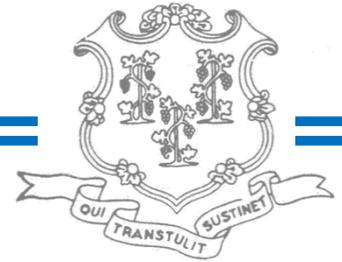
- Executed Procurement Strategy to Engage System Integrator

- 1) Received Statement of Work (SOW) - August 17
- 2) Collaboratively Refined Statement of Work and Pricing- August 17 to September 7
  - a) Department of Social Services
  - b) Department of Administrative Services
  - c) Bureau of Enterprise Systems and Technology (BEST)
- 3) Reviewed and Finalized SOW - September 7 to date
  - a) Integrated Eligibility PMO Steering Committee
- 4) Briefed CMS and CCIIO
  - a) Addressed Federal requirements

- Next Steps

- 1) Contract Award and Notification
- 2) Begin On-Boarding of System Integrator: October 1, 2012

# System Overview



- Design, Develop and Implement (DDI)

- 1) Health Insurance Exchange (HIX) Functionality

- Multi-channel Consumer engagement (e.g., web, phone, paper)

- Comparison Shopping

- Enrollment Processing

- Premium and Tax Credit Processing

- Plan Management

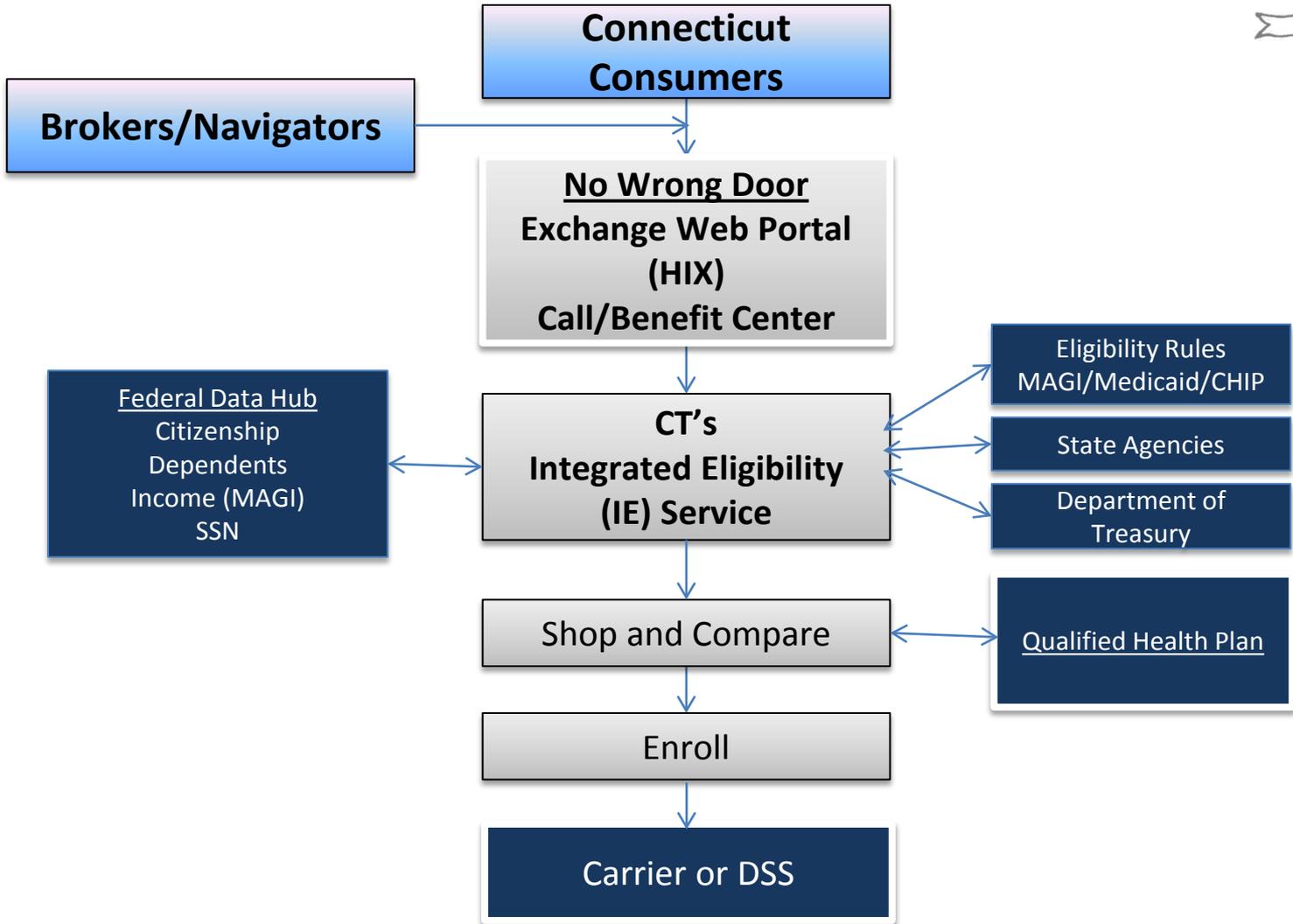
- Consumer Support

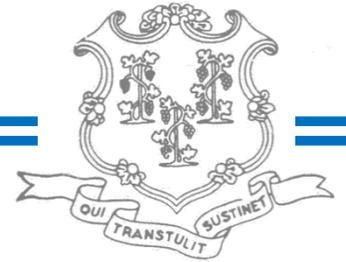
- 2) Integrated Eligibility (IE) Service

- Determines MAGI/CHIP eligibility

- Determines subsidies for which consumers are eligible

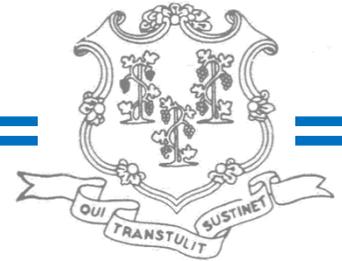
# High-Level HIX/IE Business Flow





# Program Management Office (PMO)

# Program Management Office (PMO)



*"A Program Management Office is responsible for the centralized coordinated management of a program to achieve the program's strategic objectives and benefits."  
- Project Management Institute*

## What is a Program Management Office (PMO)?

- *Centralized capability* - A Program Management Office provides a centralized capability to support multiple projects that are working towards a common Program goal.
- *Broader than IT* - PMOs are a better practice function widely used across all industries around the world where there is a significant level of complexity.
- *Implementation / tactical focus* - PMOs focus on implementing decisions made by an overseeing governance committee and board - they do not make strategic decisions.
- *People and processes* - The scale and scope of a PMO will depend entirely on the needs to the Program that is supporting. Typically a PMO comprises of dedicated staff to develop and apply a set of frameworks, templates and processes to support the communication, monitoring and the control of projects.

## Why are PMOs used?

- *Increase chance of success* - when effectively applied PMOs reduce the risk, and increase the likelihood for successful completion of a Program or set of related Projects. This is achieved through improved communication sharing, management of interdependencies and risks to each of the program constraints (cost, scope, time and quality).

## Integrated Eligibility PMO

- The IEPMO was established to help support the successful completion of the HIX and IES projects. It is intended as a temporary function that will scale up and down as the combined project requires.

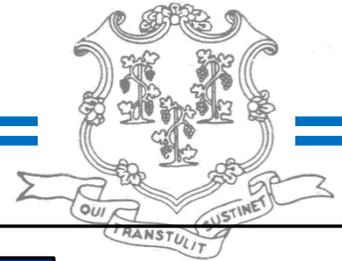
## Core functions of the PMO

- *Integrate monitoring and reporting* - Weekly management status reporting, and monthly upwards reporting to the Steering Committee and the CTHIX Board.
- *Manage the consolidated program schedule and cross-project dependencies* - critical where there is a high level of complexity, and separate discrete projects, and multiple contractors.
- *Apply better practice Project Management practices* - Including but not limited to risk management, change management, document management.

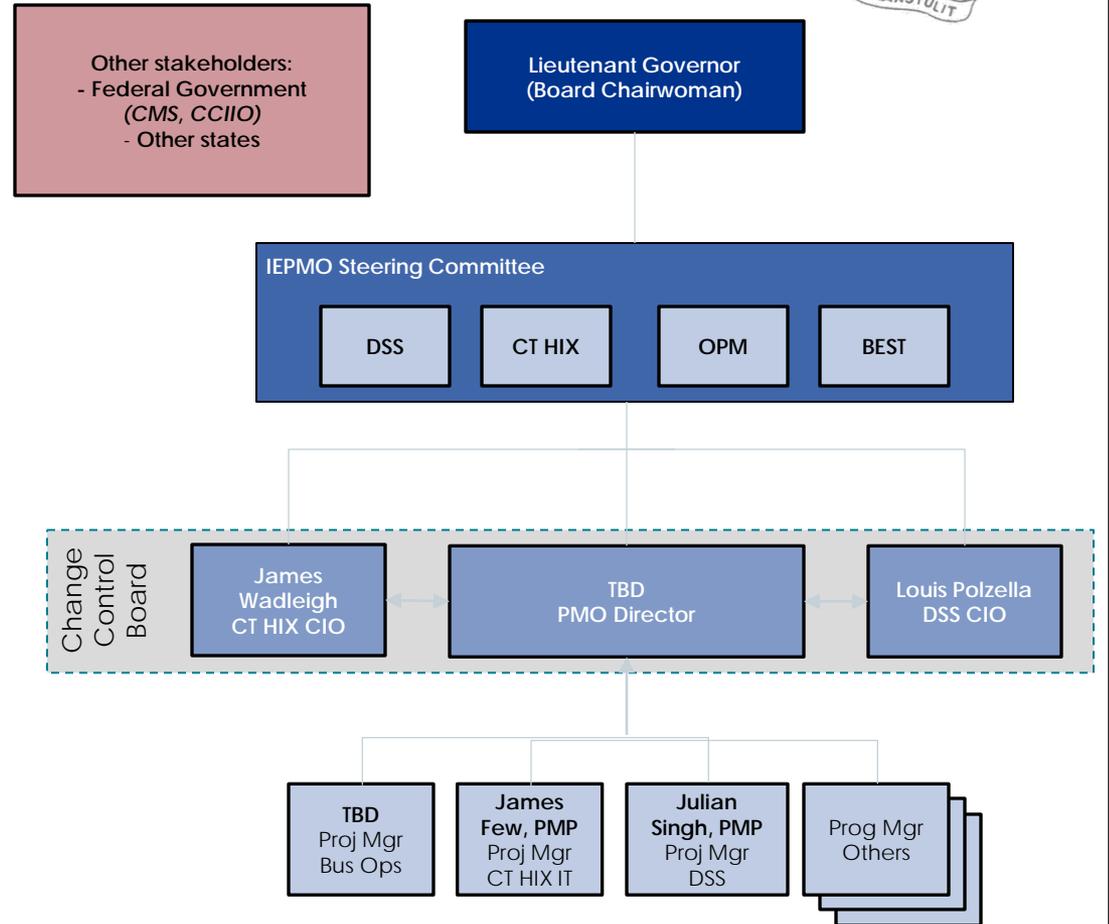
## Specific value of the CTHIX / IE PMO

- *Effective Monitoring* - A central point of monitoring and reporting is critical when there are many projects, vendors and stakeholders.
- *Flexible and Scalable* - The PMO can be scaled up or down as required to support management when needed.
- *Reduced short term resourcing and training risks* - Effective utilization of skilled resources as they become available at short notice
- *Knowledge transfer to new team members* - The PMO will immerse new staff and seek to embed better Program / Project Management practices. This will place HIX in a more sustainable position in the longer term.

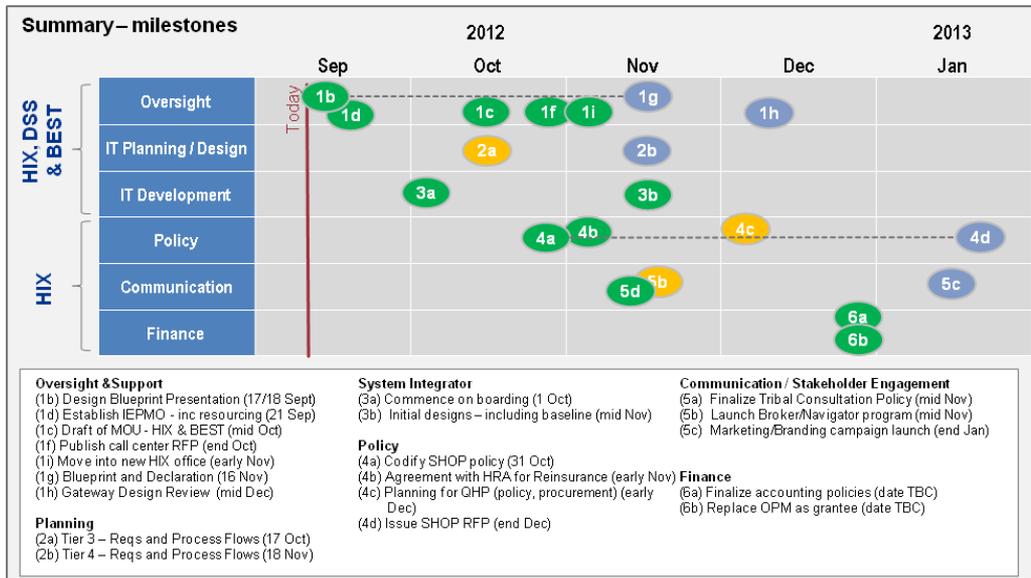
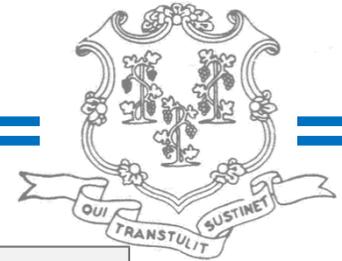
# PMO- Program Governance



- High level oversight and funding – for CT HIX/IE related work from the Federal Government. Key reporting lines include the CMS/CCIIO Establishment Reviews, and the required submission of Declaration Letter and Blueprints
- Strategic oversight and guidance – provided by the IEPMO SC. The Steering Committee is Sponsored by the Lieutenant Governor of Connecticut
- Coordination of program schedules, risks and interdependencies – performed by the PMO Director, in close contact with the CT HIX CIO and the DSS CIO
- Change Control Requests (CCRs) – will be considered and processed by a Change Control Board that consists of the PMO Director, the CT HIX CIO, and the DSS Engagement Director and meets every two weeks. Significant CCRs (large financial / scope impacts) will be escalated to the Steering Committee or the Board (where required)
- The PMO will support the Program Director – in coordinating project interdependencies. It consists of the individual project Managers from each of the key projects



# PMO- Dashboard Example



### Overall Summary

**Recent activities / accomplishments**

- (1b) Preparation for Design Blueprint presentation
- (1d) Continue establishment of the IEPMO and vetting IEPMO Director
- (1c) Develop understanding of requirements for MOU
- (1f) Negotiating lease for potential office
- (1i) RFPs received for potential office relocation
- (1g) Preparation for Blueprint and Declaration
- (1h) Started preparation for CMS Design Review
- (2a) Updated Approx 20% of Tier 3 Process Flows
- (3a) Progression of contract discussions with potential SI
- (4a) Continued development of SHOP Policy to submit to Board
- (4b) Planning for GHP
- (4c) Preparation for marketing campaign launch
- (5a) Development of Tribal Consultation Policy
- (5b) Preparation for Broker / Navigator Program
- (6a) Updating of accounting policies

**Key planned activities for current week**

- Continue all activities over from last week

**Required decisions / follow up actions (from last meeting):**

- No new follow up action that fall outside progression towards the listed milestones

### Project risk/issue summary

	Schedule Risks	Resource Risks	Deliverables Concurrence	Deliverable Quality Risks	Issues
Oversight					
IT Planning / Design		(2a)			
IT Development					
Policy	(3c)				
Communication					
Finance		(4b)			

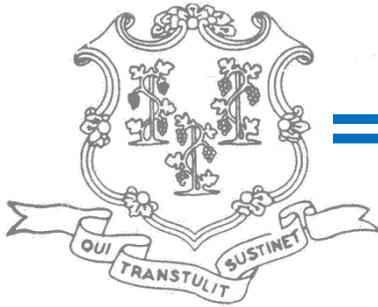
**Risk and issues – notes**  
 (2a) – Potential limited availability of state resources with EMS knowledge to review requirements and business process flows.  
 (3c) – HHS has not released an Actuarial Value calculator nor indicated when this will be available. This is needed by exchange and health insurers to develop plans.  
 (4b) – Uncertainty around who will pay for Navigator Program.

### Overall Program Status

Schedule Risks	Overall
Resource Risks	
Quality Risks	
Deliverable Quality Risks	
Issues	

**Legend**

Not started	Started and on track	Minor risk / issue	Major risk / issue
●	●	●	●

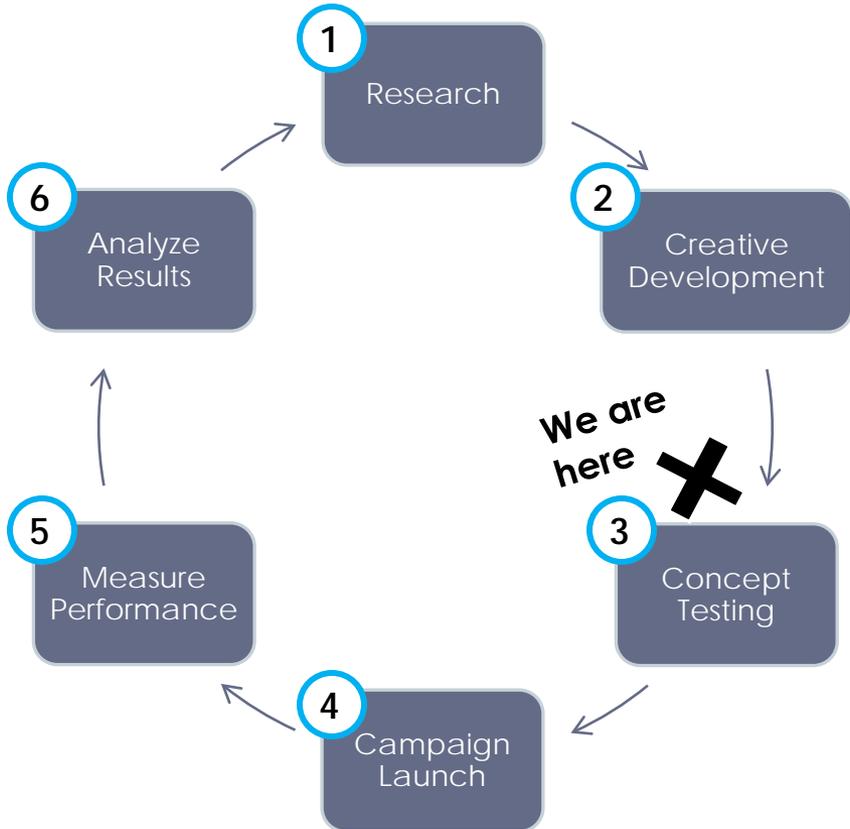


# Marketing and Communications Update

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# Established Process



With market exploration and research now complete, our full attention is now on the creation and testing of key elements of the Exchange brand.

- Brand platform
- Messaging hierarchy
- Name
- Logo

The next phase of work will focus on translating creative assets into a detailed, tactical marketing outreach plan for various segments.

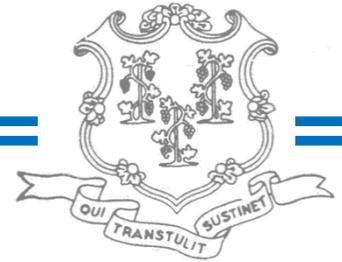
# Research Conclusions



- With the completion of our consumer and marketplace research, several final deliverables are now posted on our web site, and are being utilized in the current creative process:
  - Full Consumer Research Findings
  - Full Small Group Research Findings
  - Updated Thomson Reuters Data



# Brand and Messaging Platform



- Leveraging the key takeaway's from the consumer and small business research, a “Brand Platform” is commonly developed to act as a guide when designing other key creative elements.
  - The brand platform needs to capture the essence of what the organization's communications and engagement platforms need to do in order to connect with consumers, and appropriately meet their needs and expectations.
- Building on this brand platform, a series of supporting “messages” is then built which reinforce the core platform by providing additional details on what the brand stands for.
- This serves as the primary guide moving forward for designing ad copy, scripts, collateral, training, and other key organizational assets.

# Brand and Messaging Platform



- 1) Nearly one in ten Connecticut residents are uninsured, while countless others are underinsured or struggle to maintain the coverage they have. This not only endangers their physical health and household stability, but also takes an emotional toll as they deal with fear and uncertainty.
- 2) The CT Health Insurance Exchange now offers all Connecticut residents a unique opportunity to get high quality, name brand health coverage. Available plans will provide consumers with coverage that helps not only when they are sick, but also to help keep them well.
- 3) Exchange customers will receive friendly, expert, and culturally relevant help to guide and support them in the shopping and enrollment process whether they choose to engage with the Exchange in person, via phone, or online.
- 4) All of this will be provided with oversight from the State of Connecticut to ensure fairness.
- 5) The CT Health Insurance Exchange is helping to improve the health and peace of mind of Connecticut residents by increasing access to the healthcare system and improving quality for all.

**A**

**We are....**  
**Quality Centric**

- Offer robust name-brand health care plans
- Offer choice of plans.
- Grant access to wide range of providers (hospitals/docs, etc.)
- Deliver excellent user experience, regardless of point of entry.
- Have oversight from State of Connecticut.

**B**

**We are....**  
**Health Focused**

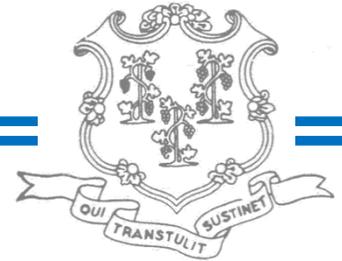
- Provides better access to care when people need treatment, but also encourage preventive care, wellness, and coordinated care.
- Eliminate disparities.
- Deliver better health outcomes.

**C**

**We are....**  
**Egalitarian**

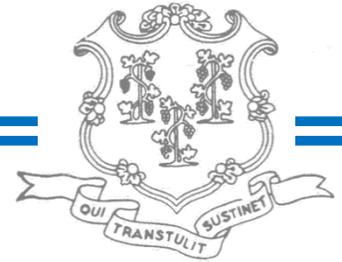
- Administer a program that treats all parties equally and with respect.
- Remove barriers to access and service across populations and delivery systems.
- Are transparent in what we do.

# Name Development



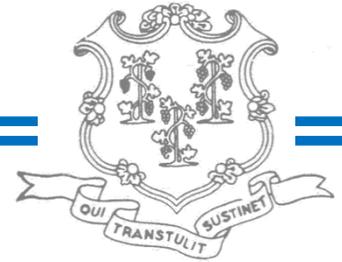
- Lastly, with the brand essence and messaging pillars established, an appropriate name is necessary to engage individuals, and quickly communicate the core value proposition in a memorable way.
- A comprehensive naming evaluation is now underway, with recent research providing some guidance on potential options
- Several other states are currently undergoing the same process, with CMS themselves recently issuing a statement saying that “Health Insurance Exchange” may not be the most consumer friendly option.
- Some states have already chosen new names, such as Washington (Washington Health Link) and Nevada (Silver State Health Exchange)

# Name Development



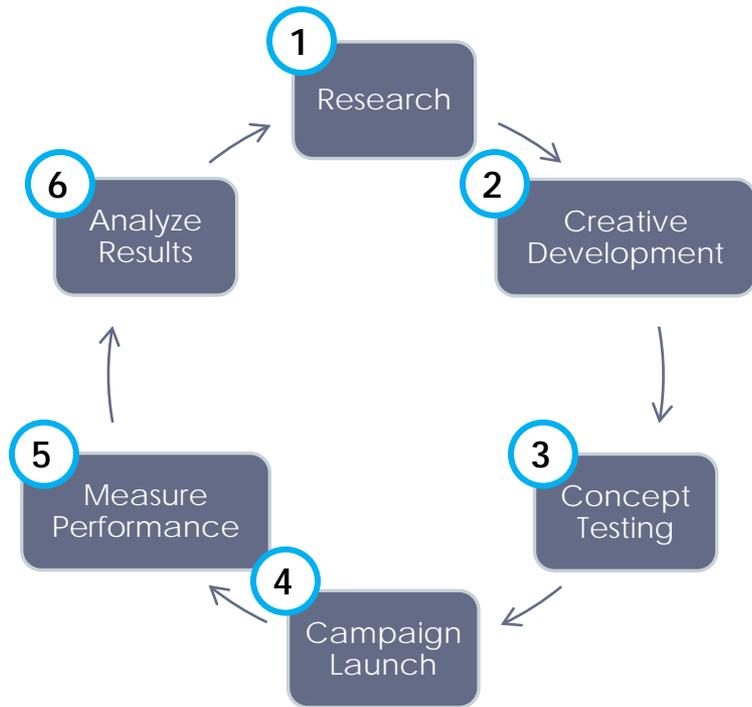
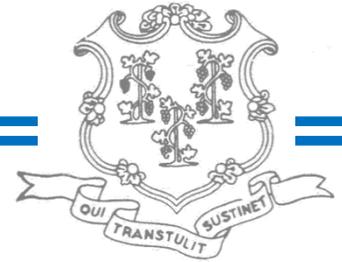
- In general, when beginning the process of selecting a new brand name (in any industry), there 4 guiding principles which should be adhered to:
  1. A brand name must be memorable, relatable, relevant and easy to understand. They should avoid sophisticated plays or words or have challenging pronunciations or spellings
  2. Selected names must work across multiple cultural backgrounds, without unexpected connotations. The classic example of this was the naming of the Chevy Nova, which when seen by Spanish speakers easily looks like “No va” which means “no go”.
  3. Avoid words that confuse (e.g. Exchange) or alienate (industry jargon).
  4. Ensure the name is based on an understanding of the target consumer, and conveys the intended image, tone and value proposition.

# Name Development



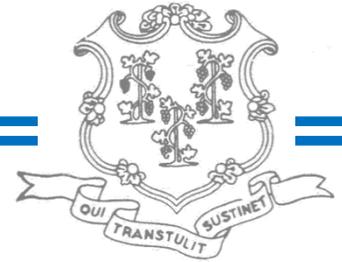
- Against this backdrop of general guiding principles, there is a sequential process containing 6 steps which we are working through to develop and test naming concepts for the Exchange.
  1. Analyze market research findings from stakeholders, and targeted consumers.
  2. Conduct a series of brainstorming sessions
  3. Refine recommendations.
  4. Test 4-6 name recommendations among target audience
    - CT Health Connection
    - CT Health Pass
    - CT Health Bridge
    - CT Health Link
    - CT Health Port
    - CT Healthy Choices
  5. Review results (clear winner, multiple contenders, back to the drawing board)
  6. Full vetting of the name from a usage, trade mark and legal perspective

# Next Steps



1. Finalize naming exploration
2. Test brand, messaging, and naming elements
  - “Activate” segmentation with same quantitative research
3. “Media” plan development
4. RFP for full year 2012 marketing services provided

# Call, Click or Chat!



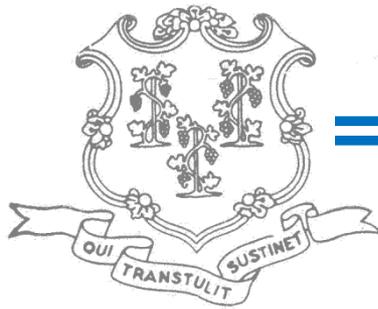
**860-418-6420**  
to talk directly



**[www.ct.gov/hix](http://www.ct.gov/hix)**  
to sign up for updates.



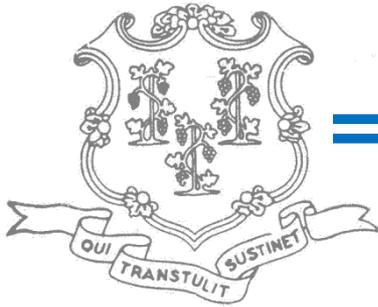
**@ExchangeCT**



# Strategy Subcommittee

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# Executive Session

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