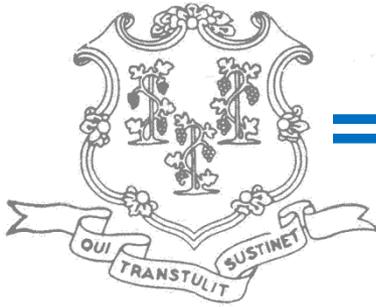


Connecticut Health Insurance Exchange

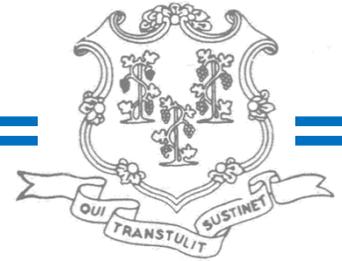
Board of Directors Meeting

July 26, 2012



Ethics and Bylaws Update

Added Restrictions

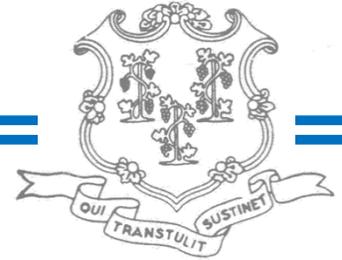


PA 12-1 Added Restrictions on Exchange Employees- No employee can be:

A consultant to, a member of board of directors of, affiliated with or otherwise representative of any:

- Insurer
- Insurance Producer or Broker
- Health Care Provider
- Health Care Facility
- Health or Medical Clinic

Added Restrictions

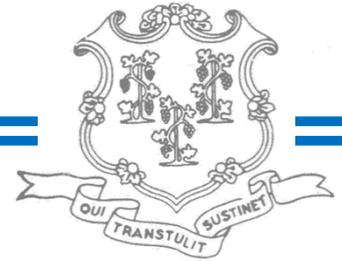


PA 12-1 Added Restrictions on Exchange Employees- No employee can be:

A consultant to a trade association of any:

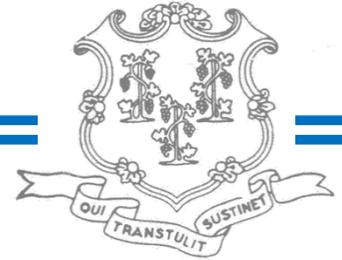
- Insurer
- Insurance Producer or Broker
- Health Care Provider
- Health Care Facility
- Health or Medical Clinic

Producer Licensing and Timing



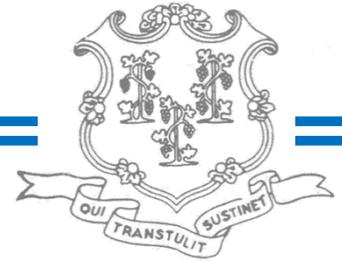
- Extends time to get licensed as an insurance producer from 12 months to 18 months after date of hire
- Applies to Exchange employees who will be assisting individuals or small employers in selecting health insurance plans

Compliance Officer Designation



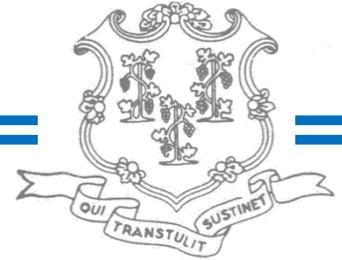
- Identifies the Exchange's General Counsel as the Compliance Officer

Bylaw Revisions



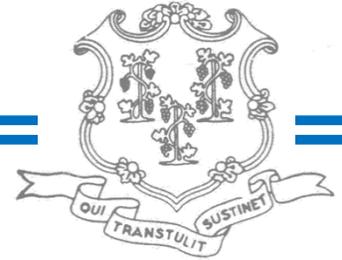
- Healthcare Advocate is now an ex-officio voting board member
- Increased voting board members from 11 to 12
- Decreased ex-officio non-voting board members from 3 to 2
- Increased ex-officio voting board members from 3 to 4
- Extended term of House Majority Leader appointed board member from 1 year to 2 years

Bylaw Revisions (Cont.)



- Increased Board quorum from 6 to 7 voting members
- Ethics restrictions applied to all board members

Bylaw Revisions (Cont.)



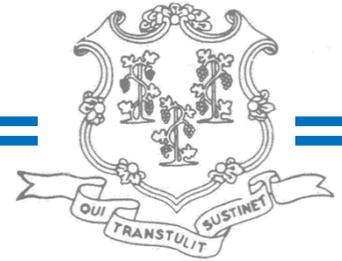
PA 12-1 Added Restrictions on Exchange Board- No Board member can be:

A consultant to, a member of board of directors of, affiliated with or otherwise representative of any:

- Insurer
- Insurance Producer or Broker
- Health Care Provider
- Health Care Facility
- Health or Medical Clinic

**Restriction previously applied only to appointed board members

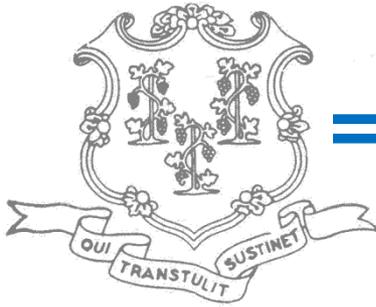
Bylaw Revisions (Cont.)



PA 12-1 Added Restrictions on Exchange Board- No Board member can be:

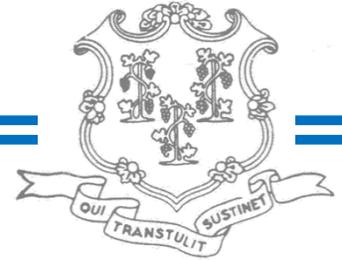
A consultant to a trade association of any:

- Insurer
- Insurance Producer or Broker
- Health Care Provider
- Health Care Facility
- Health or Medical Clinic



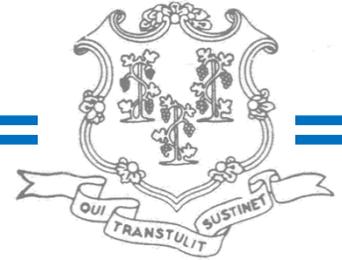
Process for Defining Essential Health Benefits

Process for Defining EHB



- Designate Health Plan Benefits and Qualifications Advisory Committee
 - Tasked with developing recommendations
- Designate Consumer Experience and Outreach Committee
 - Tasked with review and recommendation to Health Plan Benefits and Qualifications Committee
- Connecticut Health Insurance Exchange Board evaluates recommendations

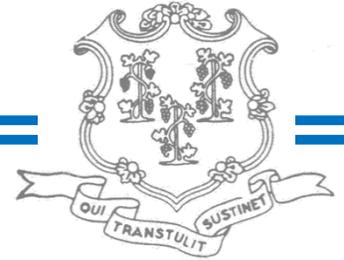
Process for Defining EHB (Cont.)



Advisory Committee Structure and Reports

- From 10-15 members appointed by Board
- Members drawn from Exchange Board
- Members drawn from stakeholders (consumer advocates, health care providers, insurance providers, small business)
- Co-chaired by board member and by stakeholder
- A Stakeholder is member of both Consumer Experience and Health Plan Benefits Committees
- Consumer Experience and Outreach Committee reviews and makes recommendations to the Health Plan Benefits & Qualifications Committee
- Department of Insurance (CID) provides subject matter expert
- Exchange staff provides planning support
- Board member co-Chair reports to Exchange Board

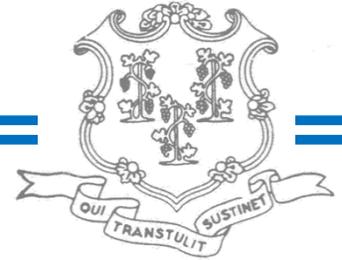
Process for Defining EHB (Cont.)



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

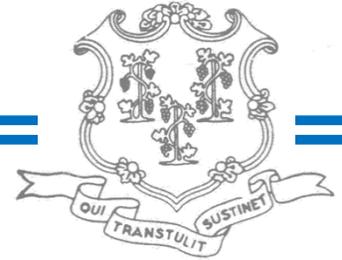
Process for Defining EHB (Cont.)



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
- Public can address written comments to Exchange

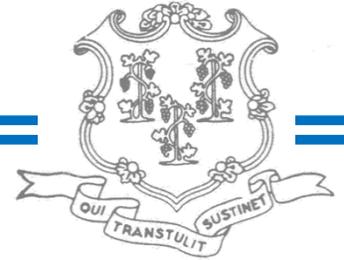
Process for Defining EHB (Cont.)



Recommendations on Benchmark Plan

- Must include 10 statutory categories of Essential Health Benefits under §1302 of Affordable Care Act

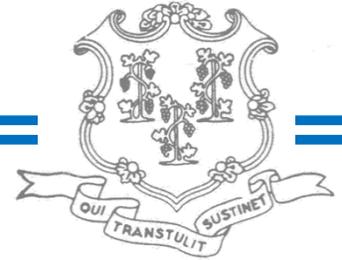
Process for Defining EHB (Cont.)



Must Balance:

- Affordability
- Diverse needs of Connecticut residents and business

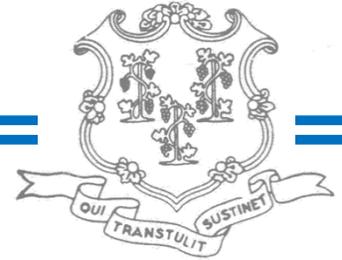
Process for Defining EHB (Cont.)



Must Consider Impact Of:

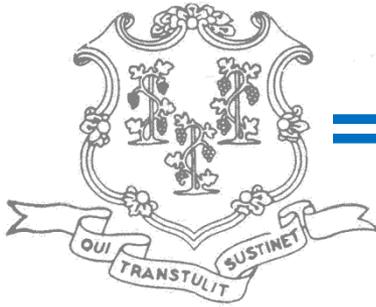
- State mandated coverage (C.G.S., Chapter 700c)
- The health needs of diverse segments of population and be non-discriminatory
- Diversity of provider network including the network for the underserved.

Process for Defining EHB (Cont.)



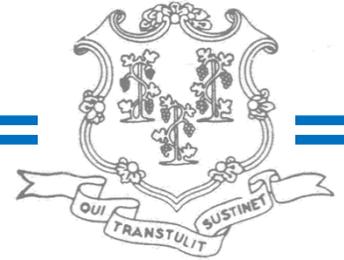
Essential health benefits benchmark plan followed guidelines of:

- CCIIO's Essential Health Benefits Bulletin issued 12/16/2011
- HHS's FAQ on Essential Health Benefits
- Provisions of the ACA including §1302 (10 statutory categories)
- Provisions of PA 11-53



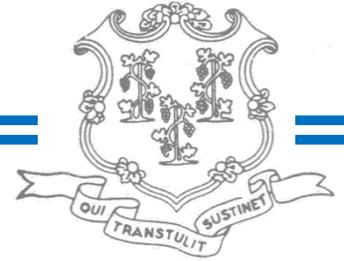
Essential Health Benefit Update

Presentation Objectives



1. Overview of Essential Health Benefits (EHB)
 - Required EHB elements
 - IOM Recommendations
 - HHS Guidance
2. Summarize the Advisory Committee's EHB Selection Approach
3. Summarize the Advisory Committee's EHB Recommendations

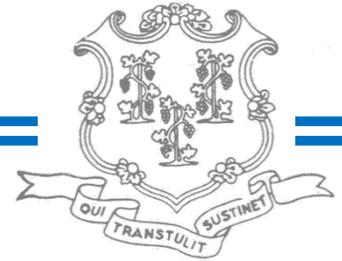
Overview



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

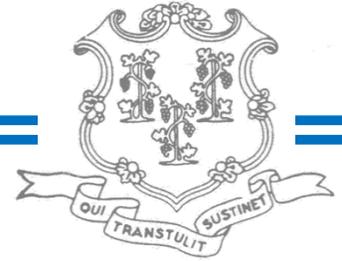
- 1) Ambulatory patient services
- 2) Emergency services
- 3) Hospitalization
- 4) Maternity and newborn care
- 5) Prescription drugs
- 6) Rehabilitative & habilitative services & devices
- 7) Laboratory Service
- 8) Preventative and wellness services and chronic disease management
- 9) Pediatric services, including oral and vision care
- 10) Mental Health and Substance Abuse disorder services, including behavioral health treatment

Institute of Medicine Recommendations



- IOM considered how policy domains (ethics, economics, population-based health) could guide formulation of EHB benefits
- IOM determined cost and affordability are key considerations in determining EHB
- “Typical employer plan” should be a small employer health plan
- EHB should be evidence-based, and value based. Any added services should be offset by medical management savings or elimination of outdated services

Benchmark Approach



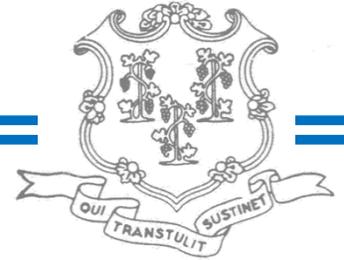
- In December 2011, HHS released a bulletin describing guidance defining the EHB
- HHS recommended that the EHB be defined by a benchmark plan approach
- Four benchmark plan types were selected for 2014 & 2015*:
 - 1) The largest plan by enrollment in any of the 3 largest small group insurance products in the state's small group market
 - 2) The largest 3 state benefit plans by enrollment
 - 3) The largest 3 FEHBP plan options by enrollment
 - 4) The largest insured commercial HMO in state

Benchmark plan:
a reference plan reflecting the scope of benefits offered by a typical employer plan.

For all the options evaluated, only plan benefits were considered, not carrier or plan names (as these are irrelevant)

* Enrollment data from the first quarter of 2012 was used to identify potential benchmarks for selection for the coverage year 2014

Benchmark Approach



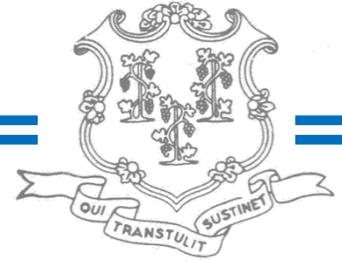
Carrier Flexibility:

- Once a state has chosen a benchmark plan, all individual and small group health plans will be required to offer benefits that are “substantially equal” to the benchmark plan
- Carriers will have some flexibility to adjust the specific services that are included, as well as adjust any visit limits on services, so long as the coverage has the same actuarial value as the benchmark plan

Updating Benchmark Plans:

- HHS intends to propose a process to evaluate the benchmark approach that will include appropriate medical practices, insurance market practices, and difficulties with access for reasons of coverage or cost

Benchmark Evaluation Process

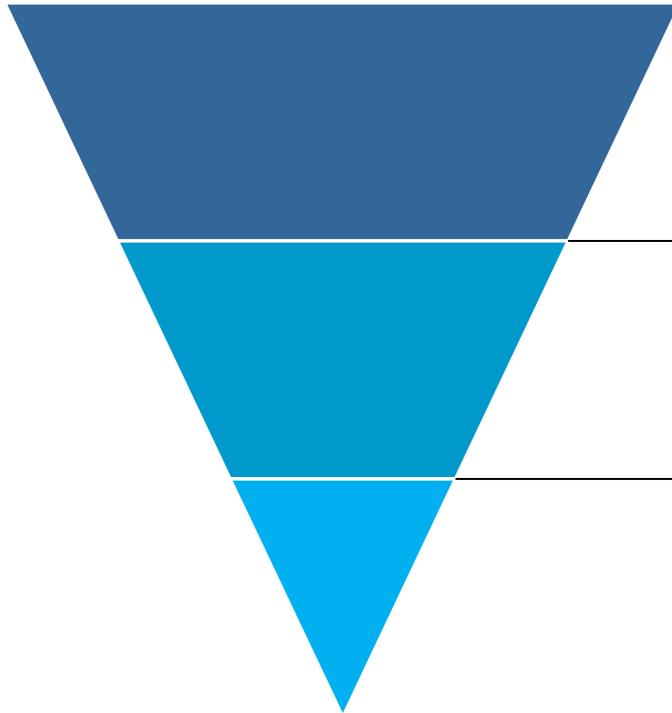
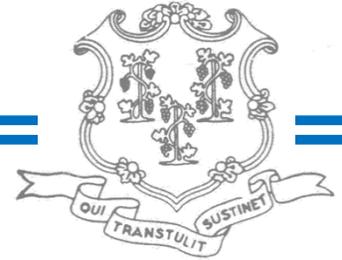


- Benchmark plan options were compiled, and compared side by side across the 10 required categories of benefits

Example Only:

Services	Small Group Plans			Largest Non-Medicaid HMO	State Employee Plans	Federal Employee Plans	
	"Plan A"	"Plan B"	"Plan C"	"Plan D"	"Plan E"	"Plan F"	"Plan G"
Ambulatory Patient Services							
Primary Care Visit to Treat an Injury or Illness	Y	Y	Y	Y	Y	Y	Y
Specialist Visit	Y	Y	Y	Y	Y	Y	Y
Other Practitioner Office Visit (Nurse, Physician Assistant)	Y	Y	Y	Y	Y	Y	Y
Outpatient Surgery Physician/Surgical Services	Y	Y	Y	Y	Y	Y	Y
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Y	Y	Y	Y	Y	Y	Y
Emergency Services							
Emergency Room Services	Y	Y	Y	Y	Y	Y	Y
Emergency Transportation/Ambulance	Y	Y	Y	Y	Y	Y	Y
Urgent Care Centers or Facilities	Y	Y	Y	Y	Y	Y	Y
Hospitalization							
Inpatient Hospital Services	Y	Y	Y	Y	Y	Y	Y
Inpatient Physician and Surgical Services	Y	Y	Y	Y	Y	Y	Y
Pharmacotherapy	Y	Y* inpatient Rx only	Y* inpatient Rx only	Y* inpatient Rx only	Y* inpatient Rx only	Y	Y
Maternity and Newborn Care							
Prenatal and Postnatal Care	Y	Y	Y	Y	Y	Y	Y
Delivery and All Inpatient Services for Maternity Care	Y	Y	Y	Y	Y	Y	Y
Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment							

Benchmark Evaluation Process

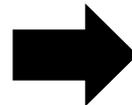


- 1) Do plans contain CT mandates?
 - This eliminated the Federal options

- 2) Do plans have lifetime limits?
 - This eliminated 2 small group options

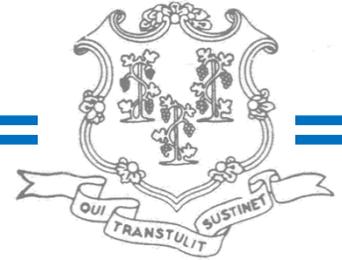
- 3) Do plans have unlimited visit limits?
 - This eliminated 3 State options

4 plans remained. An evaluation of key differences between plans was then conducted



The main difference was visit limitations, ranging from calendar year, plan year, or per condition

Selection Process Determination



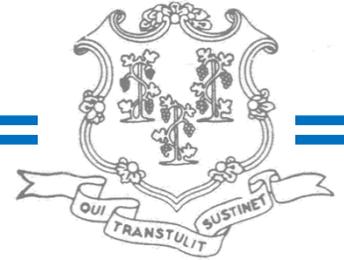
- After a careful review of all the options and elimination factors, the Advisory Committees, selected Plan “D” for the medical portion of the EHB.
- As stated earlier, the selection of Plan “D” only relates to its benefits, and has no relation to the carrier or product name.

Variation in Durational Limits Across Remaining Benchmark Plans (excludes FEHBP plans)

Services	Small Group Products			Largest HMO	State Employee
	Plan A	Plan B	Plan C	Plan D	Plan E
Skilled Nursing Services	30 days/condition up to 90 days/year	30 days/year	30 days/year	90 days/year	unlimited
Inpatient Rehabilitation Services (PT/OT/ST)	60 days/condition (lifetime limit)	not specified	60 days/condition (lifetime limit)	90 days/year (combined with SNF)	unlimited
Outpatient Rehabilitation Services (PT/OT/ST)	30 visits/year	20 visits/year	60 visits/condition (lifetime limit)	40 visits/year	unlimited
Chiropractic Visits	20 visits	20 visits	20 visits	20 visits	unlimited
Home Health Care Visits	100 visits	80 visits	80 visits	100 visits	200 visits

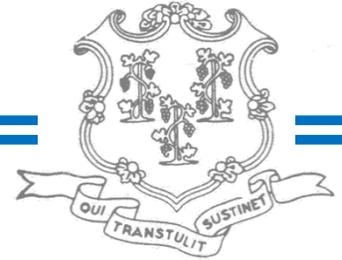
Source: Exchange analysis of benchmark plan documents. See Exhibit 5 and Exhibit 6 for more detailed analysis.

Supplementing the Benchmark



- The CT benchmark option selected does not provide services for the following categories:
 - a) Prescription drugs
 - b) Habilitative services
 - c) Pediatric dental services
 - d) Pediatric vision services

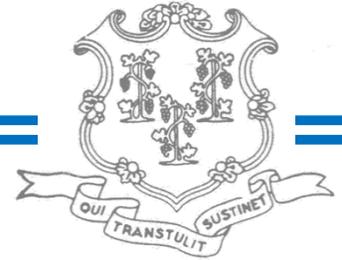
Prescription Drug Coverage



- The EHB chosen as the Medical benchmark does not include prescription coverage. Additionally, Rx coverage cannot be included as an optional “rider”.
- CCIO guidance allows states to supplement prescription coverage from another benchmark option.
- Only 2 of the existing benchmark plans contains Rx coverage as part of their Medical offering.
- When deciding between these two, CCIO guidance stipulates that:
 - 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.**

After a careful review of all the options and elimination factors, the Advisory Committees selected Plan “C” for the Rx portion of the EHB.

Habilitative Services

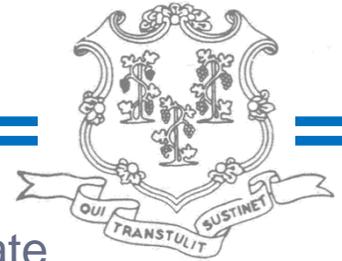


- CCIO acknowledges there is no generally accepted definition of habilitative services.
- There is no recommendation required of the Advisory Committees as the carriers will determine how to provide the coverage.
- Carriers will have two options:
 1. Carriers may offer habilitative at parity with rehabilitative services (PT, OT, ST)
 2. Carriers determine services to be covered and report the coverage to the Department of Health & Human Services.

Proposed definition for habilitative services:

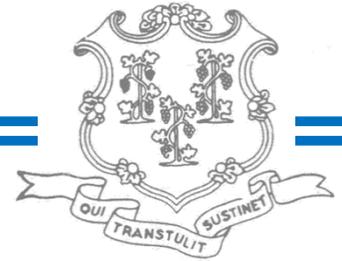
Learning a fundamental physical or cognitive skill for the first time

Pediatric Services – Oral & Vision



- Coverage for dental and vision services are often provided separate from the medical portion of the health plan
- **Dental:** Guidance indicates that states may supplement the EHB package with dental services from the largest Federal (FEDVIP) plan by enrollment or the states CHIP (HUSKY B) program
 - Services include preventive and basic dental services (cleanings, fillings, root canals, crowns and orthodontia when medically necessary)
- These 2 options provide coverage for the same services
- The Advisory Committees selected the CHIP (HUSKY B) program
- **Vision:** The only option available for pediatric vision services was the largest federal vision plan by enrollment. Coverage includes routine eye exam and refraction, corrective lenses and contact lenses

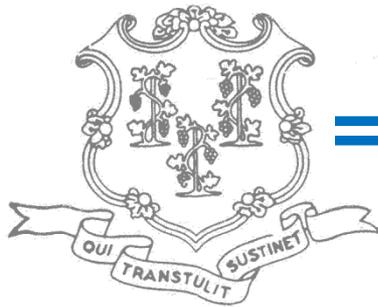
Next Steps



- Board votes to approve proposed EHB procedure
 - Pending vote, EHB procedure will be posted for 30 days for public comment
-

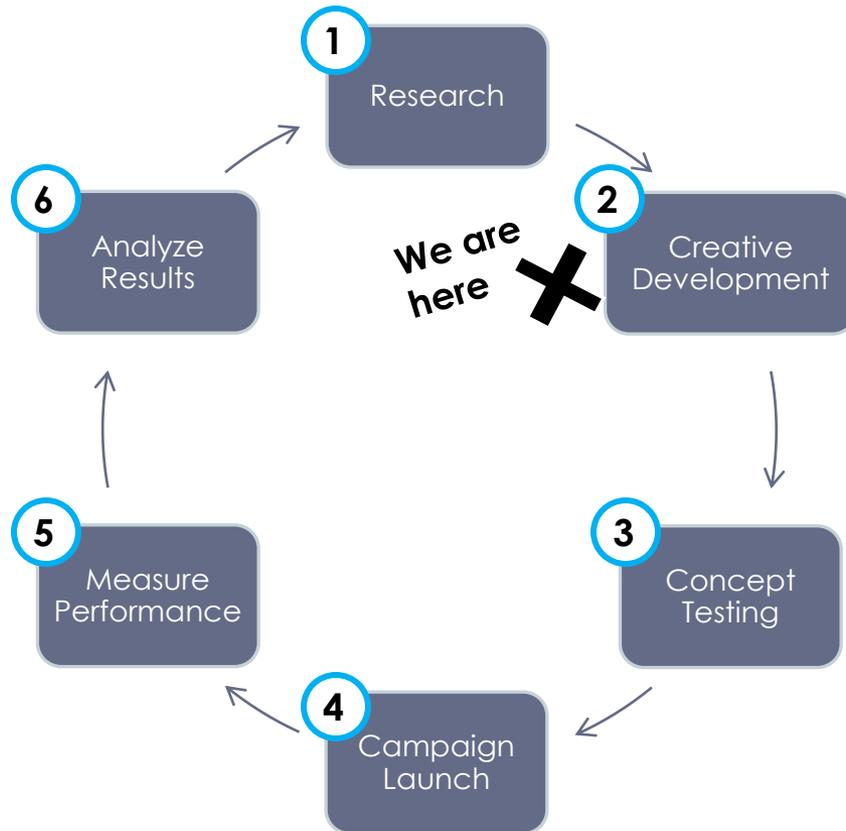
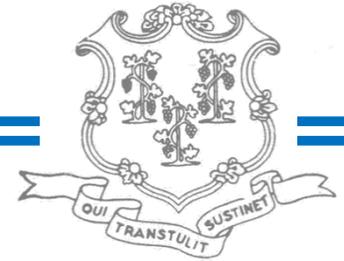


- Board votes to adopt the proposed EHB procedure
- Board votes on accepting the EHB Benchmark Health Plan option and Supplements



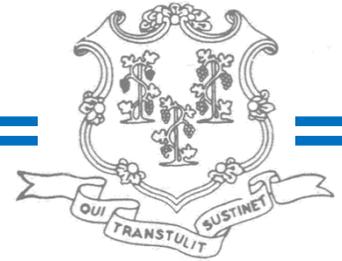
Marketing and Communications Update

Established Process



- There are 6 major steps in the cycle of a complete marketing and communications campaign
- Research is wrapping in July, with several deliverables coming out of this important stage
- Focus will now shift to utilizing this information to begin the creative development process

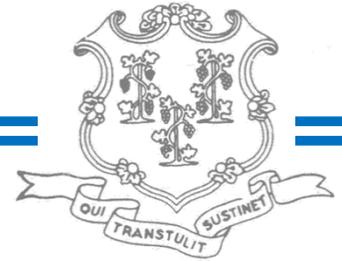
Data Analysis Overview



- Thomson Reuters was contracted to develop a more detailed profile of CT residents engaging with the Exchange and State programs beginning in 2013 and beyond
- Data was extracted and analyzed from several sources, including:
 - U.S. Census
 - America Community Survey
 - Insurance Coverage Estimates (ICE) tool
- Final deliverable consisted of 2 large Excel databases, with pivot tables embedded to facilitate analysis across 40+ variables



Data Analysis Overview



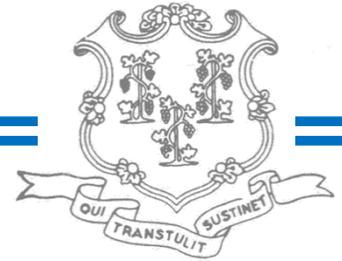
- The first of these Excel documents contained estimates of the number of CT residents in 7 major categories of insurance coverage

- Medicaid
- Medicare
- Dual Eligible
- Employer Sponsored Insurance
- Exchange (Non-Group)
- Non-Exchange (Non-Group)
- Uninsured

- For each category, a comprehensive breakdown of the estimates are available at additional sub-levels of detail:

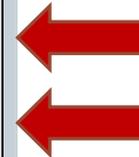
- County
- Zip code
- Age
- Gender

Data Analysis Approach

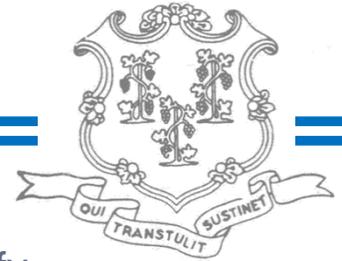


- Current year estimates place the number of uninsured at 344,582 statewide (or roughly 10% of the CT population).
- For the purpose of initial investigation, this group was analyzed first
- Given Medicaid program expansion, an additional analysis of this population (currently 15% of residents) was performed as well.

Insurance Coverage (2012)	(#)	(%)
Private - Employer Sponsored	2,014,645	56.1%
Medicaid	537,827	15.0%
Medicare	422,610	11.8%
Uninsured	344,582	9.6%
Private - Direct Purchase	175,595	4.9%
Medicare - Dual Eligible	93,628	2.6%
Private - Exchange	-	0.0%
Grand Total	3,588,886	100.0%



Data Analysis Key Findings

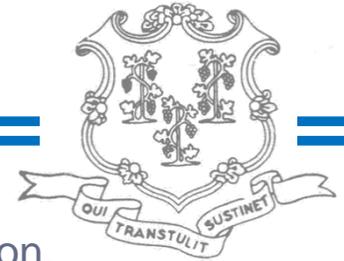


- A comprehensive geographic review of the data was performed to identify key areas of focus for future activities.
- **Major finding:** The uninsured population across the state (and within counties) is heavily concentrated in a small number of zip codes.

County	Column (A)		Column (B)
	(#) Uninsured Residents	(%) of Total Uninsured in State	(%) of Counties Uninsured Population in Top 20 Zips
New Haven	110,179	32.0%	82.9%
Hartford	100,289	29.1%	81.5%
Fairfield	69,526	20.2%	82.1%
New London	20,622	6.0%	95.7%
Windham	15,083	4.4%	99.4%
Litchfield	10,893	3.2%	90.9%
Tolland	9,140	2.7%	100.0%
Middlesex	8,849	2.6%	99.7%
Total	344,581		38.0%

e.g. 5 City of Hartford zip codes alone comprise 33% of the counties uninsured, and 10% of uninsured state wide

Data Analysis Key Findings

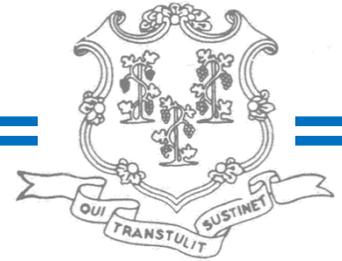


- When conducting a similar analysis of the current Medicaid population, this same trend holds true.
- Major finding:** The zip codes with the heaviest concentration of uninsured are nearly identical to those with the largest Medicaid populations.

County	Column (A)		Column (B)
	(#) Uninsured Residents	(%) of Total Uninsured in State	(%) of Counties Uninsured Population in Top 20 Zips
New Haven	110,179	32.0%	82.9%
Hartfordd	100,289	29.1%	81.5%
Fairfield	69,526	20.2%	82.1%
New London	20,622	6.0%	95.7%
Windham	15,083	4.4%	99.4%
Litchfield	10,893	3.2%	90.9%
Tolland	9,140	2.7%	100.0%
Middlesex	8,849	2.6%	99.7%
Total	344,581		38.0%

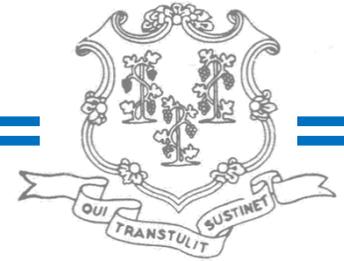
County	Column (A)		Column (B)
	(#) Medicaid Residents	(%) of Total Medicaid in State	(%) of Counties Medicaid Population in Top 20 Zips
New Haven	156,881	29.2%	83.0%
Hartfordd	152,141	28.3%	82.5%
Fairfield	115,937	21.6%	82.2%
New London	40,772	7.6%	95.7%
Litchfield	22,580	4.2%	90.9%
Windham	18,740	3.5%	99.4%
Middlesex	17,203	3.2%	99.7%
Tolland	13,572	2.5%	100.0%
Total	537,826		38.0%

Data Analysis Approach



- The second data set that was developed by Thomson Reuters profiles the demographic characteristics of currently uninsured populations who will be eligible for either Medicaid enrollment, or enrollment via the Exchange, as the result of new eligibility requirements.
 1. Children in the state who will be Medicaid or SCHIP eligible
 2. Adults(18+) in the state who will be Medicaid eligible
 3. Children in the state who will be in eligible for subsidized purchase via the Exchange
 4. Adults (18+) in the state who will be eligible for subsidized purchase via the Exchange

Data Analysis Key Findings



- When looking at the adult population who will be impacted via Medicaid expansion or through subsidized QHP purchase, some theme's emerge:

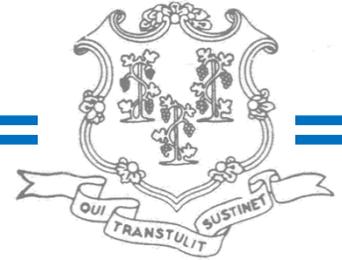
	Uninsured Adults in Connecticut Currently Medicaid Eligible		Uninsured Adults in Connecticut Currently Exchange Eligible	
	(#)	(%)	(#)	(%)
Total	66,465	--	205,401	--
US Citizen	46,673	70.2%	145,641	70.9%
US Born	38,783	58.4%	122,580	59.7%
Disabled	8,670	13.0%	13,125	6.4%
Ambulatory Difficulty	3,223	4.8%	5,944	2.9%
Self Care Difficulty	1,056	1.6%	2,032	1.0%
RACE: White	34,397	51.8%	135,677	66.1%
RACE: Black	15,204	22.9%	28,007	13.6%
RACE: Asian	4,387	6.6%	11,139	5.4%
RACE: Native American	1,498	2.3%	1,777	0.9%
ETHNICITY: Hispanic	22,481	33.8%	66,323	32.3%
Difficulty Speaking English	11,503	17.3%	35,296	17.2%

Exchange eligible adults 1/2 as likely to be disabled

Exchange eligible population 2/3rds White, with consistent levels of Hispanic representation

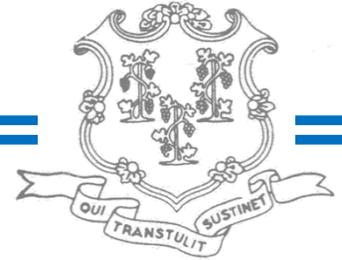
Both populations have consistent proportions of individuals with difficulty speaking English

Data Analysis Next Steps



- Current view of data provides geographic overview and demographic overview... but separately.
- Will be working with CERC on providing a combined view of the information to aid in more targeted development of:
 - Outreach and education efforts
 - Marketing plans
 - Communication materials
 - Navigator efforts
- In addition to current tables, an additional set of summary documents will be prepared profiling these findings, in addition to the development of “heat maps” to visually illustrate various concentration levels

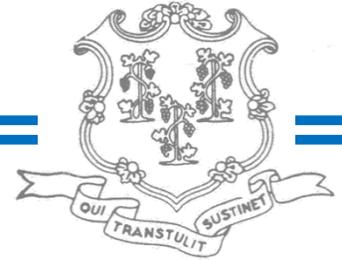
Consumer Outreach Update



M I N T Z & H O K E

- Market Exploration
- Strategic Development
- Bridging Communications

Market Exploration



- Mintz & Hoke is bringing closure to a comprehensive exploration of internal and external factors impacting the Exchange.
- This entailed conducting research in several diverse areas.

January

July



Report/Policy Review



Media Monitoring



Social Listening

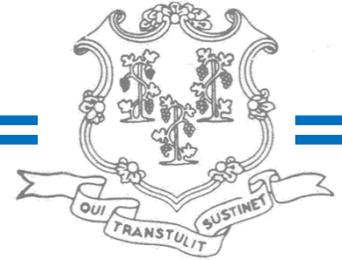


Stakeholder Research



Consumer Research

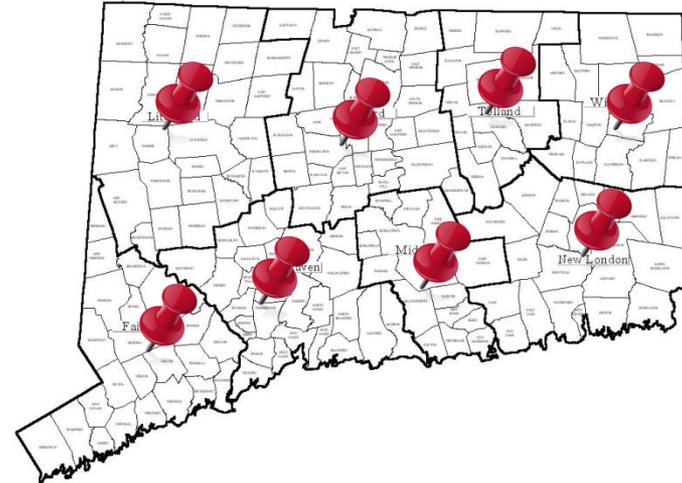
Consumer Research



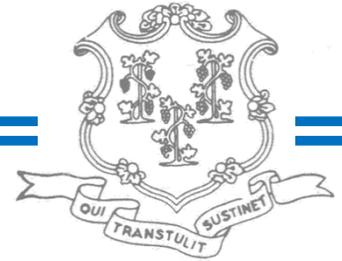
- Series of focus groups and interviews conducted in May, June and July.
- Engaged with diverse set of consumers of different insured status, demographics and cultural backgrounds

• A total of 149 individuals to date.

- Consumer research to be completed July 31, having spoken to 160 consumers and 24 small employers.



Consumer Research

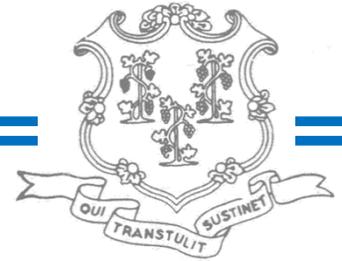


County	% of CT's Uninsured	Total
Fairfield	35%	46
Hartford	17%	50
Litchfield	2%	2
Middlesex	2%	3
New Haven	28%	31
New London	10%	7
Tolland	4%	1
Windham	4%	9
Total	100	149

FPL Level	% Eligible for Credit	Total
Less than 139%	0%	9
139 - 250%	44%	97
250 - 400%	56%	40
More than 400%	0%	3
Total	100	149

Insured Status	Total
Uninsured	134
Medicaid	7
Employer Plan	8
Total	149

Consumer Research

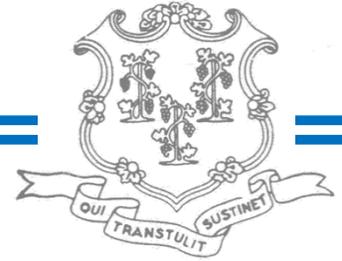


Gender	% of Uninsured	Total
Female	43%	72
Male	57%	77
Total	100	149

Age Group	% of Uninsured	Total
25-34	34%	62
35-44	27%	35
45-54	25%	30
55-64	15%	21
Total	100	149

Ethnicity	% of Uninsured	Total
African-American	12%	35
Caucasian	55%	64
Hispanic	25%	45
Other	8%	3
Total	100	149

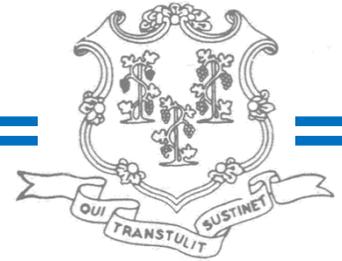
Consumer Research



Focus Groups

Date	County	Focus	Total
5/24	New London	FQHC Consumer Board	7
6/6	New Haven	2 sessions: Individuals & Families	18
6/7	Fairfield	2 sessions: Male & Female	17
6/12	Hartford	2 sessions: 25-44 & 45-64	15
7/6	Hartford	All female	7
7/9	Hartford	Single men	5
7/9	Hartford	Mixed group	8
7/10	New Haven	Hispanic dominant	7
7/12	Fairfield	Single men	6
		Total	90

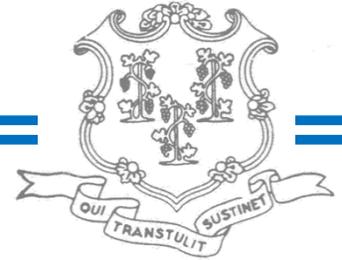
Consumer Research



Interviews

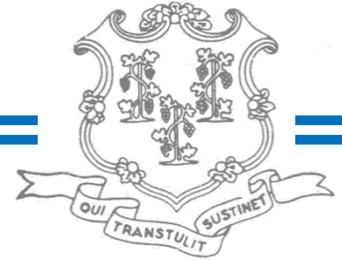
Date	City	Location/Referral Organization	Total
4/30	Enfield	Enfield Square	8
5/21	Bristol	Bristol Hospital	1
5/21- 5/25	Hartford	Capital Community College; Hartford Public Library; St. Francis Care; Burr Elementary School; Corner Store	7
5/30	Milford	Connecticut Post Mall	8
6/7	Bridgeport	The Salvation Army	4
6/7	Bridgeport	Optimus Health Care	8
6/8	New Haven	Newhallville Community Resource Center	6
6/12	Danbury	Danbury Public Library	4
6/19	Willimantic	Western Connecticut State University	3
7/9	Hartford/N. Haven	Advocacy for Patients with Chronic Illness	4
7/10	Willimantic	Generations Family Health Center	6
		Total	59

Consumer Research



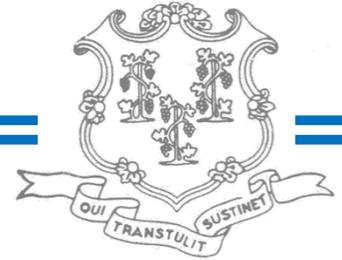
- 3 Small Employer Focus Groups: July 24 – 25
 - Less than 50 employees.
 - Average wages less than \$25,000, or \$25,000-50,000.
 - Range of employers who do/don't offer insurance now.

Consumer Research



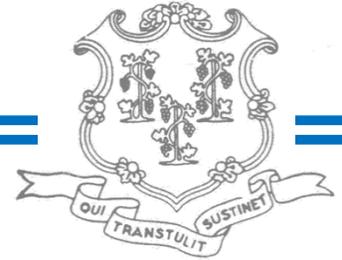
- While formal qualitative consumer research is complete, we will continue to engage as needed for additional perspective.
 - Asian-American cultural background, working with APAAC.
 - Consumers living with mental illness, facilitated by NAMI-CT.
 - Litchfield County consumers, arranging with the Community Health & Wellness Center in Torrington.
 - Middlesex county consumers, being arranged by a member of Consumer Experience & Outreach Advisory Committee.

Consumer Research



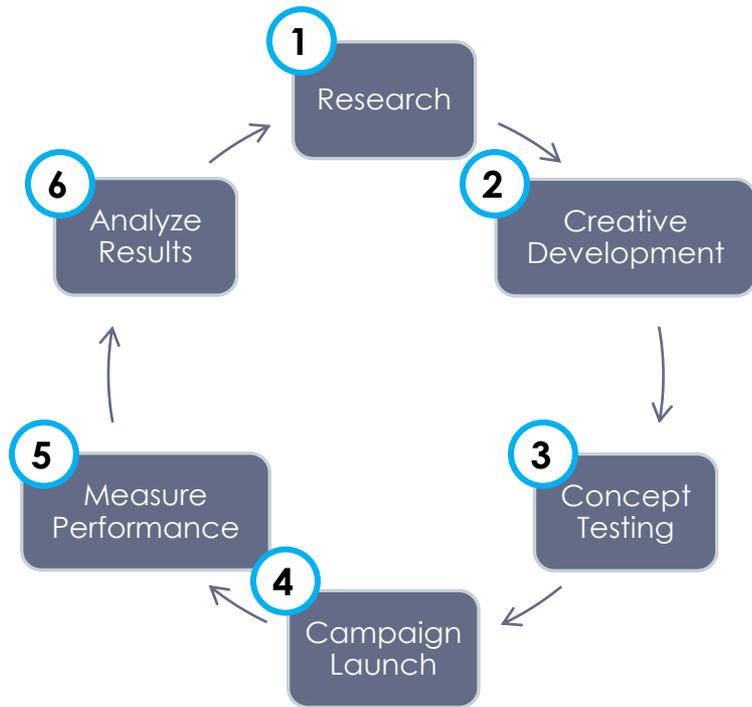
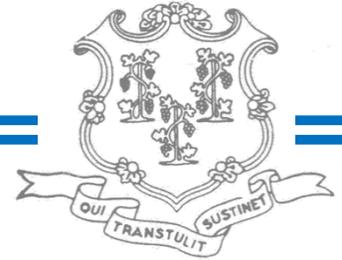
- A full report of consumer research is being analyzed and compiled and will be issued on July 27, with a full report of small employer research to be issued on August 10.
- Research is naturally yielding consumer segments with different perspectives, priorities, and appetites for health insurance.
- Findings are informing development of strategic approach for addressing these audiences.

Strategic Development



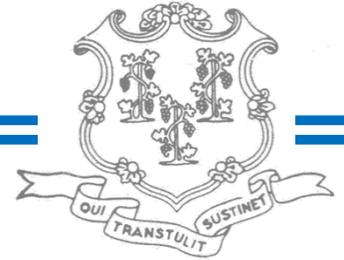
- Create overarching value proposition and message platforms tailored to audience segments.
- Develop recommendations for branding elements, including name and logo.
- Assemble initial creative concepts for general and segmented audiences.
- Recommend testing branding and creative concepts among consumers and small employers through a full-scale quantitative study.

Next Steps



1. Target audience identification and mapping.
2. Recommended value proposition based on research.
3. Name, logo, and descriptor concept recommendations.
4. Creative concepts for outreach materials.
5. Outreach communications and media approach.

Bridge Communications

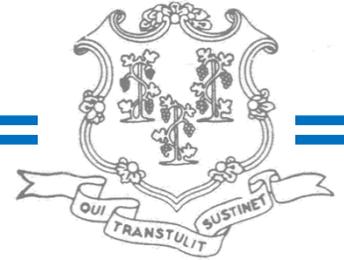


- Ongoing communications to stakeholder audience are fully underway.
- Website launched and postcard mailed June 29.
- Biweekly emailed activity updates initiated July 19.



www.ct.gov/hix
to sign up for updates.

Bridge Communications



- Launched social media engagement with via Twitter platform. We will use this to:
 - Build relationships with community leaders and media influencers
 - Establish the Exchange as a resource for information and thought-leadership.

follow us on
twitter
@ExchangeCT