**HIX**

The Health Insurance Exchange (HIX) is the name used throughout this dashboard for the computer system that runs Connecticut’s state-based marketplace, i.e., Access Health CT. The HIX is a jointly developed and shared DSS and Access Health CT system.

The HIX is responsible for eligibility determination for those types of HUSKY that use the MAGI eligibility methodology (MAGI is described below), i.e., this includes most types of HUSKY A, all of HUSKY B, and all of HUSKY D. The HIX is also responsible for eligibility and enrollment in Access Health CT’s Qualified Health Plans (QHPs).

**ImpaCT**

This DSS computer system determines eligibility for specialized types of non-MAGI HUSKY A, for HUSKY C and for the Medicare Savings Program (MSP). It is also responsible for eligibility determination and benefit issuance for the Department’s non-medical programs such as TFA and SNAP.

**MAGI**

Modified Adjusted Gross Income (MAGI) is the Medicaid and CHIP eligibility methodology, which was defined by the Affordable Care Act (ACA), and that came into effect on January 1, 2014 for certain Medicaid programs and the Children’s Health Insurance Program. The methodology counts taxable types of income and does not consider assets. Approximately 88% of the HUSKY program uses this eligibility methodology. For example, HUSKY C does not use the MAGI methodology when calculating income and must consider assets, per federal regulations.
Medical Enrollment

Notes:

- DSS medical consists of:
  - HUSKY programs (A, B, C & D)
  - HUSKY Limited Benefits
  - Medicare Savings Program (MSP)
  - State-funded programs

- The enrollment counts shown here are for HUSKY, HUSKY Limited Benefits and MSP.

- HUSKY is further subdivided:
  - HUSKY A – Medicaid for children, parents, pregnant women, etc.
  - HUSKY B – Children’s Health Insurance Program (CHIP)
  - HUSKY C – Medicaid for the aged, blind and disabled
  - HUSKY D – Medicaid for low income adults

- These are mainly CMS match-funded programs. There are a small number of refugees whose health care is funded by the Office of Refugee Resettlement (ORR).

- The enrollment includes the HUSKY Limited Benefit programs; HUSKY A includes Family Planning and Family Planning Presumptive Eligibility, and HUSKY C includes Tuberculosis health care.

- Dual eligible MSP and HUSKY C recipients are duplicated in the counts

- HUSKY B band 2 includes individuals who have yet to pay their first premium and so while otherwise-eligible are not truly enrolled.
Notes:

- These coverage types are included in the previous slide.
  - Family Planning and Presumptive Eligibility for Family Planning are HUSKY A programs.
  - Tuberculosis health care is a HUSKY C program.
### Notes:

- Shows year-over-year growth.
- 2017 data is missing as it was a period of complex system and program transitions.
- In July 2015, the parent federal poverty level (FPL) was reduced to 155%. It took a year to see the full effect as most parents received Transitional Medical Assistance (TMA).
- In December 2017, the State reduced the FPL level threshold to 138% and then effective July 1, 2018 the FPL% was reinstated. Most individuals moved to TMA coverage for that period and were then reinstated.
- 2016 data is sourced from EMS.
- HUSKY A does not include the non-MAGI individuals (~10k). These are included in 2018.
- 2018 onwards HUSKY A, B & D data is sourced primarily from the HIX.
- HUSKY C data is sourced from ImpaCT.
- HUSKY B includes individuals who have yet to pay their first premium and so while eligible are not truly enrolled.
Notes:

- Shows year-over-year growth of the Medicaid expansion population (the Adult group is included in the totals in the prior graphs).
- 2015 drop is attributable to catching up on backlogged discontinuance actions.
- 2017 data is missing (a period of complex system transition).

- 2014 - 2016 data is sourced from EMS.
- 2018 onwards the HUSKY D data is sourced from the HIX and ImpaCT (~1000 institutionalized non-disabled consumers).
Notes:

- Shows the HUSKY children, i.e., the under 19s and including newborns.
- HUSKY B is equivalent to the CMS Performance Indicator 8.h.
- MAGI and non-MAGI are mixed across HUSKY A and C.

The data is sourced from ImpaCT and HIX as appropriate for the coverage type.
Notes:

- These are DSS medical enrollments for the largest 15 towns that account for 56% of the enrollment.
- The remaining 154 towns account for 44% of the medical recipients, i.e., most of these “remaining towns” have less than 1% of the enrollees each.
Geographical Enrollment – Medical Enrollment by Largest Towns

Notes:
- The DSS medical enrollments for the largest 15 towns that account for 56% of the enrollment.
- The map shows the relative enrollment by town.
Enrollment: 3
Applications: 11
Renewals: 18
Medical Applications

Data Source: HIX & ImpaCT

Notes:
- This is a count of the subsidized applications with a filing (application) date in the month and:
  - Application status is in-process or determined (not inactive or canceled);
  - Application is not a change, renewal or in the renewal reconsideration period.
- This includes HUSKY and MSP applications
- 2019 Open Enrollment was November 1, 2018 through January 15, 2019.
- 2020 Open Enrollment is from November 1, 2019 with a planned end date of December 15, 2019.
**Data Source:**

HIX Applications by Channel [walk-in/phone/paper/online]

Notes:

- This is a count of the financial-assistance type applications, by channel, with a filing (application) date in the month and:
  - Application status is in-process or determined (not inactive or canceled);
  - Application is not a change, renewal or in the renewal reconsideration period.

- The HIX paper channel is small, but higher than expected when compared to the actual paper processing tasks performed in the HIX channel, i.e., typically process less than 5 per day.

- We attribute much of this to clients incorrectly using the W1-E paper form and mailing channel; DSS workers identify these and enter them into the HIX.

2019 Open Enrollment was November 1, 2018 through January 15, 2019.

2020 Open Enrollment is from November 1, 2019 with a **planned** end date of December 15, 2019.

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2019 Open Enrollment was November 1, 2018 through January 15, 2019.

2020 Open Enrollment is from November 1, 2019 with a **planned** end date of December 15, 2019.

2019 Open Enrollment was November 1, 2018 through January 15, 2019.

2020 Open Enrollment is from November 1, 2019 with a **planned** end date of December 15, 2019.
Direct Medicaid Applications by Channel [walk-in/phone/paper/online]

Notes:

- This is a count of the applications, by channel, with a filing (application) date in the month and:
  - Application status is in-process or determined (not inactive or canceled);
  - Application is not a change, renewal or in the renewal reconsideration period.

- The “Other/Unknown” channel consists of fax applications and “add a program” activity (the system does not capture the channel).

Y-Axis scale was selected to be consistent with the previous MAGI equivalent chart.

ImpaCT

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<tbody>
<tr>
<td>Other/Unknown</td>
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<td>324</td>
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<td>701</td>
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Year-over-Year Single Streamlined Paper Applications

Data Source: ScanOptics

Notes:

- Paper applications (AH2 & AH3) volume is low.
  - Online and call center channels are preferred.
- Typically less than 5 forms per business day.
  - Usually processed the same day as they are received.
- Paper W-1E applications that come through the DSS scanning channel and that are entered into the HIX (clients used the wrong form) are missed from these numbers.
The median processing time is zero (0) days.

Note that this report counts unique applicants and not applications, i.e., there can be multiple applicants on a single application.

There are very few applications that fall outside the 45-day standard of promptness (SOP). This is trending positively.

CT is third in the nation for Application timeliness.


MAGI Applications over 45-Day SOP
Non-MAGI Application Timeliness by Individual

Data Source: ImpaCT

Notes:
- The standard of promptness for long-term care is 90 days.
- The median processing time is typically about 30 days.

This data is sourced from the ImpaCT system. The results are primarily for HUSKY C and MSP applicants.

Y-Axis scale was selected to be consistent with the previous MAGI equivalent chart.
At renewal time the HIX system attempts to auto-renew households by electronically verifying data.

Approximately 8% of the auto-renewals will report some changes to the Department.

Each month approximately 15% of the renewals are manual and non-responsive by the middle of the month, i.e., they are sent a discontinuance notice.

There is a 90-day reconsideration window in which someone can submit a late renewal. In this case their start date will be backdated to eliminate gaps in coverage.

November 2019 was an anomaly:

- Projection was for a reduced population for technical reasons (50% moved to December).
- The unavailability of updated DOL data resulted in reliance on older IRS data and a household-level of income verification. This increased the auto-renewal rate.
There are three types of non-MAGI renewals in ImpaCT.

Currently, HUSKY C does not have an auto-renewal process.

While DSS plans to implement auto-renewals for HUSKY C, that must be done in context of fulfilling a federal requirement to implement an automated Asset Verification System (AVS). DSS is in process of determining the best solution for AVS.

The Medicare Savings Program (MSP) and the DCF children’s group do not have to consider assets and therefore have their own specialized auto-renewal processes.