

Medicaid Work Requirements: Connecticut

Operational briefing for state Medicaid leadership

295K

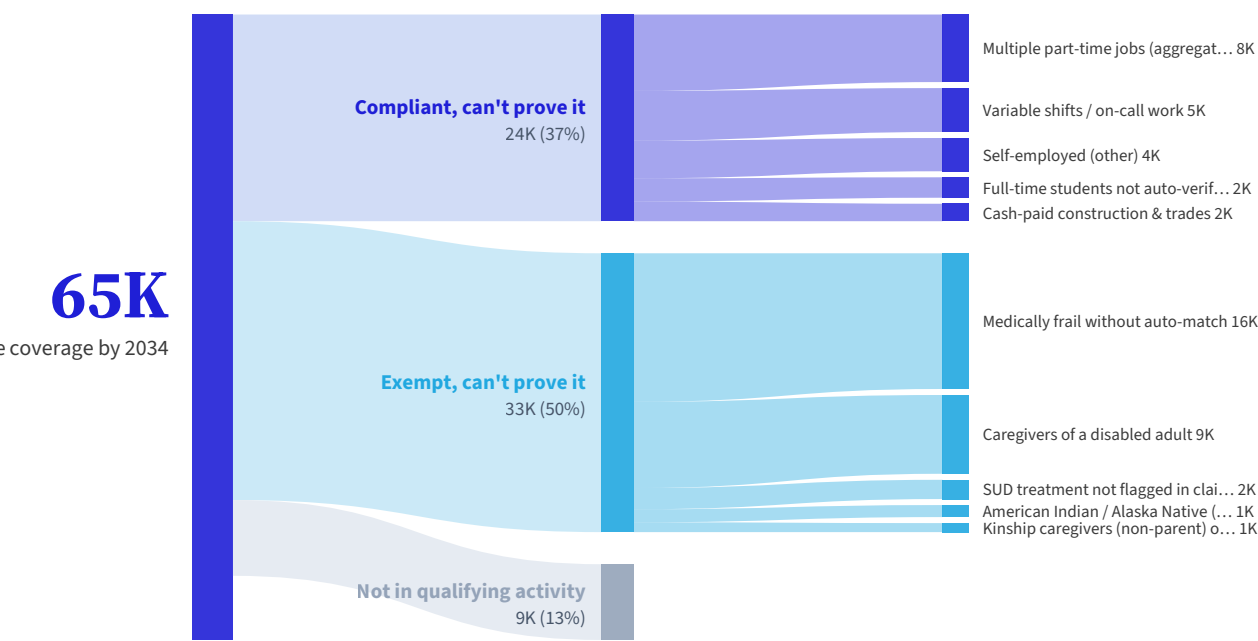
adults in Connecticut are estimated to be subject to the 80-hour-per-month work requirement starting **December 31, 2026**. About **65K** are projected to lose Medicaid coverage by 2034 — most not because they fail to work, but because they can't clear the six-month renewal paperwork.

SUBJECT TO VERIFICATION	PROJECTED LOSS BY 2034	EX PARTE CAPABILITY
295K 294,653 adults	65K 65,488 people	75 / 100 composite

Within Connecticut, the burden is not evenly spread. **3 counties (33.3% of all 9 statewide)** hold **50% of the affected enrollees**, led by **Capitol Planning Region** at 27.0% of the state's subject pool. This brief has five parts: why your losses will look the way they do, where verification will fail hardest, how capable your state already is at automatic verification, and what to do before the deadline.

Why your state's losses will look the way they do

Our bottom-up model projects **65,488** Connecticut adults will lose Medicaid by 2034 under this provision. Most are not losing it because they aren't working. They lose it because the verification system can't confirm what's already true about them. In Connecticut, the single largest at-risk group is **Medically frail without auto-match** (about 16K).

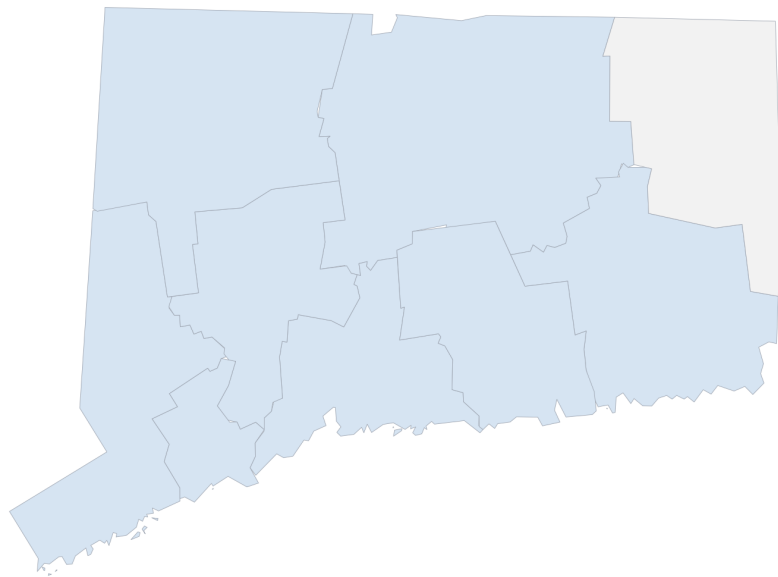


Each subgroup is sized bottom-up from ACS PUMS, SAMHSA, BJS, and the academic Section 1115 work-requirement literature; the full parameter set is in the methodology on the last page. Every county, with subject count and projected loss, is in the CSV download.

Where verification will fail hardest

Even in capable states, some share of subjects ends up on the paperwork path. The compliance-burden index marks where that path is most likely to defeat eligible enrollees. It's a composite of three predictors from prior Section 1115 implementations (Arkansas 2018, Georgia Pathways 2023–): limited-English households, low broadband access, and concentrated seasonal, gig, and hospitality employment. Counties above the national median aren't where people work less; they're where the paperwork fails more often.

Verification-burden index (centered on national median)



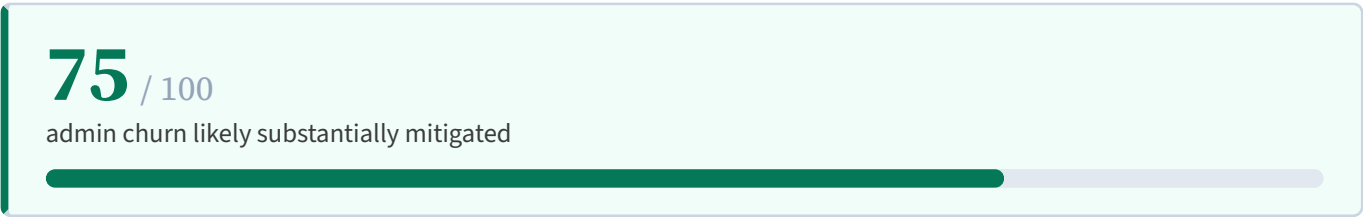
County-level estimates, CT

Highest-burden counties in Connecticut

County	Burden index	Subject enrollees
Northeastern Connecticut Planning Region	+0.1	7,852
Naugatuck Valley Planning Region	-0.2	35,759
Greater Bridgeport Planning Region	-0.3	26,425
Southeastern Connecticut Planning Region	-0.4	23,081
South Central Connecticut Planning Region	-2.2	46,279

Ex parte verification capability

Ex parte verification confirms an enrollee's hours or exemption against data the state already holds, so they never have to prove it themselves. It is the single biggest lever on the loss number above, and it has to be built before December 31, 2026. Here is how Connecticut scores today.



Observed ex parte	88 / 100	Realized auto-renewal rate, CMS unwinding data 2023–2026 (50% of composite)
Data sources	68 / 100	Work-requirement-specific feeds (35% of composite): wage 50%, frailty 30%, other 20%
Core capability	69 / 100	Vendor-tier plumbing, shown for context (not in the composite)

The 0–100 composite leads with Connecticut's observed ex parte rate: the share of Medicaid renewals it actually auto-completed during the 2023–2026 unwinding (CMS eligibility-processing data), a realized measure of whether it can clear an enrollee without making them act. That carries 50%. Data sources (the work-requirement-specific feeds income renewals didn't test: UI wage match, Medicaid claims and behavioral-health MCO, and the rest of the auto-match feeds) carry 35%, and documented prior Section 1115 work-requirement churn carries 15%. Eligibility system: **ImpaCT**.

Higher scores mean more enrollees can be verified against existing records without re-proving status. We don't publish a per-state predicted churn rate: the gap between "data source available" and "data source operationally integrated by the December 2026 deadline" is large and not yet observable. The score moves through operational work in 2026, not through anything that happens after the rule activates.

What to do before December 31, 2026

- 1 Connecticut already auto-renews at a high rate (composite 75/100); the gap is the work-requirement-specific feeds. Income-renewal ex parte is necessary but not sufficient. Confirm UI wage hours, Medicaid-claims frailty flags, and the National Student Clearinghouse feed are wired into the work-requirement decision, not just the income renewal.
- 2 Stand up UI wage match in the eligibility system if it's not already operational. UI wage data is the single most important data source — it auto-verifies the ~45% of subject enrollees who are working but would otherwise have to upload paystubs every month.
- 3 Coordinate with managed-care plans to flag medically-frail enrollees up-front. Adding the disability-determination flag at the eligibility layer (not at verification) removes the ~19% of the loss-by-2034 picture that's medically frail without a recent provider letter.
- 4 Your single largest exempt-but-at-risk group is **Medically frail without auto-match** (about 16,236). The feed that clears it: a Medicaid-claims and health-information-exchange pull for chronic conditions.
- 5 Cross-reference SNAP work-compliance rolls. Those enrollees are categorically exempt under §1902(xx)(2)(F) — the bill explicitly recognizes the overlap. Estimated to remove ~8% from the verification load nationally.
- 6 Adopting the high-unemployment hardship exception: identify qualifying counties (8%+ unemployment or 1.5× national average over 12 months) and file the CMS waiver request.
- 7 Build (or harden) a verification portal that accepts paystubs, school transcripts, training-program letters, and caregiver attestations. Nationally, about 20.0% of subject enrollees have a child under 14 in the household; caregiver self-attestation prevents most needless terminations.
- 8 Ship a Q4 2026 comms plan now. Most procedural disenrollments are people who never saw the verification letter. Postal address validation, MCO-channel outreach, and a SMS/email reminder schedule reach far more enrollees than any post-activation door-knocking campaign.
- 9 Geographic targeting (useful for staffing, but a lower priority for moving the loss number): 3 counties (33.3% of Connecticut's counties) hold 50% of the subject pool: Capitol Planning Region, Western Connecticut Planning Region, South Central Connecticut Planning Region. Concentrate field staff and county-office support there. Note that most of the enrollees a field campaign would reach in these counties have already been terminated by the verification system; staffing there speeds recovery rather than preventing the initial loss.

Peer states

Comparable expansion populations, solving the same problem.

State	Subject pool	Burden index
Maryland (MD)	310,140	-2.8
Massachusetts (MA)	321,878	-2.9
Nevada (NV)	265,520	+1.7

Every Connecticut county, with subject count, projected loss, rate, and burden index, is in the CSV:

Download CT county breakdown (CSV) →

Methodology, in brief. State counts are calibrated to CMS T-MSIS enrollment and the CBO national total; within-state detail and exemptions come from per-state ACS PUMS 2020-2024, SAMHSA, and BJS, with Section 1931 parents removed as covered outside expansion. The ex parte composite leads with the state's observed 2023-2026 renewal rate. Full methodology, sources, and limitations: gizmowarehouse.org/gizmo/medicaid-work-requirements. Corrections: joe@group17a.com. Built by 17A.