

The Impact of a Connecticut Public Option on Health Insurance Coverage and State Spending

Final Report

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About KNG Health Consulting, LLC

KNG Health Consulting, LLC, is a health economics and policy consulting company assisting clients across all sectors of the healthcare industry. The company's work focuses on two main practice areas: Healthcare Reform and Payment Innovation (HRPI), and Evaluation and Health Economics (EHE). In the HRPI practice, KNG Health's experts work with our clients to estimate the effects of a wide range of healthcare reform and payment innovation policies, ranging from modeling innovative state and federal proposals to reduce health insurance premiums to facilitating learning systems for providers on alternative payment models. In the EHE practice, KNG Health's experts conduct studies on the efficiency, effectiveness, and value of medical interventions using big and small data, applying careful research designs, and translating findings into actionable results.

KNG Health is a small, woman- and minority-owned business located in the Washington, DC metropolitan area.

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Executive Summary

The Connecticut legislature and others have considered proposals to allow different private sector employers to offer health insurance coverage through the state’s public employee health plan, the Partnership Plan 3.0. Critics of the proposal have raised concerns regarding the impact of these proposals on state tax revenues and whether premiums would be sufficient to cover expenses. In this report, we estimated the 10-year impact of offering the Partnership Plan (a public option) to employers in the state, including effects on state taxes and spending, relative to a baseline scenario where employers cannot participate in the Partnership Plan.

The analysis relied upon the KNG Health Reform Model (KNG-HRM), a microsimulation model used to estimate national and state-level impacts of healthcare reform proposals. The model assigned Connecticut residents to firms, including those who would be eligible to enroll in the Partnership Plan under certain scenarios (which varied based on firm eligibility criteria for participating in the Partnership Plan 3.0). The model estimated the expected savings (or loss) of a firm offering a Partnership Plan versus their current offer status (i.e., either offering traditional employer-sponsored insurance (ESI) coverage or not offering ESI). Each policy option was assessed assuming 25, 50, or 75 percent of eligible firms switched to or take-up the Partnership Plan. Employers were selected to take-up coverage through the Partnership Plan in the order of the “savings rate” generated from switching to the Partnership Plan 3.0 until the targeted percentage of firms was met. For each scenario, we estimated changes in coverage, healthcare spending, and tax revenue for three main employer eligibility options:

1. Private for-profit employers with fewer than 100 employees, unions, and not-for-profit firms.
2. Private for-profit employers with fewer than 50 employees, unions, and not-for-profit firms.
3. Not-for-profit firms only.

We also examined the impact on provider spending under each scenario if the state reduced reimbursement to healthcare providers to put the Partnership Plan 3.0 on secure financial footing. As of 2024, the Partnership Plan 2.0 benefit spending exceeded premiums by 3.5 percent.¹ The study examined the impact of reducing aggregate health spending such that the benefits were 88 percent of premiums, in line with the average for large insurers.² Strategies to prevent Partnership Plan 3.0’s underfunding and lower its Medical Loss Ratio (MLR) may include reducing the actuarial value through higher out-of-pocket costs and reduced benefits, utilization management tools, raising premiums, or drawing from other tax revenue.

¹ Office of the State Comptroller. (2005). *Report on the Status of the Connecticut Partnership Plan FY25*. Available at <https://osc.ct.gov/wp-content/uploads/2026/01/FY-2025-Partnership-Plan-Report-OSC.pdf>.

² <https://www.kff.org/private-insurance/medical-loss-ratio-rebates/>

Key Findings

- State revenue from premium taxes and health insurance assessments would fall between \$44.5 million and \$1.13 billion between 2026 – 2035 with the higher range values under a scenario where eligibility to the Partnership Plan 3.0 is broad and take-up is high (75%).
- Total spending would need to be reduced by 15 percent to ensure the Partnership Plan 3.0 remains on secure financial footing. One method to achieve this spending reduction would be to reduce provider reimbursements by approximately 19 percent. The spending reduction between 2026 – 2035 would range between \$89 million and \$16.2 billion, with the higher value under a scenario where eligibility for the Partnership Plan 3.0 is broadest and take-up is highest (75%).
- To replace lost revenue and ensure financial stability the state would need to collect between an additional \$134.5 million to \$17.3 billion over 2026 – 2035 with the higher range values under a scenario where eligibility to the Partnership Plan 3.0 is broadest and take-up is highest (75%).

As the legislature considers making available a Partnership Plan 3.0 for private employers, decision-makers will want to understand the coverage and fiscal impacts for the state and its citizens. This report addresses that need.

Figure 1: Additional Funding Needed to Replace Lost Tax Revenue and Sustain Partnership Plan 3.0 Without Reducing Provider Reimbursement Rates, 2026 – 2035 (Billions of Dollars)

Firm Scenario	Take-up Rate	Tax Revenue Lost	Unaccounted for Health Expenditures	Total
For-profit Firms with Fewer than 100 Employees, Not-for-profits, and Unions	25%	\$0.15	\$0.76	\$0.91
	50%	\$0.54	\$9.69	\$10.23
	75%	\$1.13	\$16.20	\$17.33
For-profit Firms with Fewer than 50 Employees, Not-for-profits, and Unions	25%	\$0.11	\$0.46	\$0.57
	50%	\$0.46	\$8.97	\$9.43
	75%	\$1.03	\$15.35	\$16.38
Not-for-profits only	25%	\$0.04	\$0.09	\$0.13
	50%	\$0.11	\$6.80	\$6.91
	75%	\$0.33	\$9.08	\$9.41

Source: KNG Health analysis using the KNG Health Reform Model

I. Introduction

The state of Connecticut provides a comprehensive and generous insurance benefit to state employees. Through the Connecticut Partnership Plan 2.0 (Partnership Plan), non-state public employees, such as employees of a municipality or other subdivision of the state, may also join this plan. The Connecticut legislature and others have proposed extending access to this state-administered insurance plan to other employers, including small for-profit businesses, not-for-profit organizations, and multi-employer groups (i.e., unions).³ Supporters of the legislation argue that such an expanded Partnership Plan, referred to here as Partnership Plan 3.0, would increase competition in the employer insurance market and reduce insurance costs.

Critics have raised several concerns related to the fiscal impact of expansion. First, private insurers in the state pay a premium tax and other taxes that likely would not be required of the Partnership Plan 3.0. The more employers that would offer the Partnership Plan 3.0, the more state tax revenue would fall. The state would have to find ways to replace this lost revenue.⁴ Second, the Partnership Plan 2.0 has a history of spending more on medical services and quality improvement activities than it collected in premiums (i.e., MLR greater than 100%).⁵ Underfunding of the insurance product is unsustainable and would require the state to raise premiums, reduce spending, or use other state funds to cover losses.

In this report, we estimated the 10-year impact of offering the Partnership Plan (a public option) to employers in the state, including effects on state taxes and spending, relative to a baseline scenario where employers cannot participate in the Partnership Plan. To complete the study, we used the KNG Health Reform Model (KNG-HRM), a microsimulation model that estimates national and state-level impacts of healthcare reform proposals. The scenarios modeled included different assumptions about the likelihood that employers would offer a Partnership Plan 3.0 if eligible.

³ For example, Connecticut Senate Bill No. 842 (SB 842), introduced during the January 2021 legislative session, would have extended the option to small businesses, not-for-profit organizations of any size, and multi-employer groups to participate and allow employees to choose this coverage. See: <https://www.cga.ct.gov/2021/TOB/S/PDF/2021SB-00842-R00-SB.PDF>.

⁴ The Congressional Budget Office discusses options for excess revenues and shortfalls for a federal public option. <https://www.cbo.gov/system/files/2021-04/57020-Public-Option.pdf>.

Insurers in the state have argued that the potential loss of business in the state may result in employment loss and insurers choosing to move their offices out of the state – all of which could have a negative impact on the state economy and related state revenues. These potential responses to a public option in Connecticut are beyond the scope of this study.

⁵ Report on the Status of the Connecticut Partnership Plan FY25. Available at <https://osc.ct.gov/wp-content/uploads/2026/01/FY-2025-Partnership-Plan-Report-OSC.pdf>. For comparison, the medical loss ratio standards for the ACA Marketplace are 80 to 85%. That is, 80 to 85 percent of premiums are spent on medical services with the rest covering administrative costs and quality improvement activities. The Partnership Plan 2.0 has often been much higher, with the exception when it fell to the 85 percent range between July 2019 and December 2020, which coincides with the COVID-19 public health emergency (PHE), during which overall healthcare utilization decreased significantly from prior years.

II. Study Approach

To complete the analysis, KNG Health used its KNG-HRM and built upon modeling done in a prior analysis of the Partnership Plan. A detailed appendix on the KNG-HRM is available online at:

<https://www.knghealth.com/kng-health-develops-health-reform-model/>. As in our prior analysis, the study sample was limited to households in Connecticut, with a focus on those household members and dependents eligible for employer-sponsored insurance. The analysis updates our prior analyses in the following ways:

- Updates the underlying population data from federal sources.
- Updates health policy landscape (e.g., Marketplace cost-sharing options).
- Adds an additional set of policy scenarios that restricts participation to not-for-profit firms.
- Examines a 10-year time horizon for coverage, spending, and revenue effects instead of a 1-year period.

We briefly describe methods specifically to the Partnership Plan 3.0 in Connecticut.

A. Overall Approach: Scenarios, Population, and Decision Model

The analysis was limited to Connecticut residents under the age of 65 who are not enrolled in government assistance programs (Medicare, Medicaid, Tricare, VA, or Indian Health Services). We also removed all employees and dependents of federal, state, and local government workers from our sample because they either already participate in the Partnership Plan 2.0 or, in the case of federal employees, have more generous coverage that the state does not intend to replace.

We modeled the policy in two parts: first, employers decide whether to offer coverage through participation in the Partnership Plan 3.0; second, individuals choose coverage from among the available offerings, including ESI, Partnership Plan 3.0, Marketplace coverage, or not obtaining insurance coverage (i.e., uninsured). With respect to individual (non-employer) market coverage levels, we estimated coverage for 2026 – 2035 using the Affordable Care Act (ACA) premium tax credit levels that are in place after the expiration of the enhanced premium tax credit.

We modeled the impact of nine scenarios relative to the baseline, each of which varied in terms of firms' eligibility for the Partnership Plan 3.0 and assumptions about the share of firms that would offer the Partnership Plan 3.0 (i.e., take-up rates) (Figure 2). In Scenarios 1 through 3, employers with fewer than 100 workers are eligible to offer coverage through the Partnership Plan 3.0; in Scenarios 4 through 6, employers with fewer than 50 workers are eligible to join. Scenarios 1 through 6 also permit unions and not-for-profit firms of any size to participate. Scenarios 7 through 9 limited firm eligibility to not-for-profits of any size. Within these three groupings of eligible employers, we modeled the impact of a low (25% of firms), medium (50%), or high (75%) take-up rate by firms.

Modeling Employer Take-Up. To assess savings from enrolling in the public option, we evaluated premiums and out-of-pocket costs if the employer maintains its current coverage relative to what would be expected in Partnership Plan 3.0 (see Figure 3).

We split the firms eligible to enroll in Partnership Plan 3.0 into those that offer traditional ESI and those that do not. We then calculated the savings for a firm and its employees from enrolling in the Partnership Plan 3.0 as the difference in costs between a scenario where the firm maintains its current coverage offer and a scenario where the firm enrolls in the Partnership Plan 3.0. So, for eligible firms that do not offer ESI, their choice set is to maintain not offering ESI (and employees are forced to rely on the non-group market for coverage) or to switch to offering the Partnership Plan 3.0. The firm decision for eligible firms that were offering traditional ESI is to keep offering their current ESI plan or to switch to offering the Partnership Plan 3.0. Next, we divided the calculated savings by the employer’s annual payroll to get the relative savings to payroll; this ratio of savings to payroll was used as our measure when selecting which employers would take-up the Partnership Plan 3.0.

Figure 2: Firm Eligibility to Enroll in Partnership Plan 3.0 and Take-Up Rates Assumed Under Each Scenario

Scenario	Eligibility				Take-Up Rates		
	< 100 Employees at For-Profit Firms	< 50 Employees at For-Profit Firms	Unions	Not-for-Profit Firms	25%	50%	75%
Baseline	-	-	-	-	-	-	-
1	✓	✓	✓	✓	✓	-	-
2	✓	✓	✓	✓	-	✓	-
3	✓	✓	✓	✓	-	-	✓
4	-	✓	✓	✓	✓	-	-
5	-	✓	✓	✓	-	✓	-
6	-	✓	✓	✓	-	-	✓
7	-	-	-	✓	✓	-	-
8	-	-	-	✓	-	✓	-
9	-	-	-	✓	-	-	✓

The employers that enroll in the public option were selected based on the savings to the employer and its employees from enrolling in the public option compared to its current offer (which includes those employers not offering employer-sponsored insurance). Specifically, we ranked employers based on the relative savings from enrolling in the public option and then assumed employers that would benefit the most from the public option would be first to enroll. We selected the employers in order of savings rate until we met the targeted percentage of firms. We grouped union members in the same industry into a single “union firm” and treated these firms as any other individual employer with respect to choosing the public option.

Figure 3. Description of Cost Components in Firm Partnership Plan 3.0 Choice Model

Cost Component	If the employer maintains current coverage status ...	If the employer enrolls in the Partnership Plan 3.0 ...
Net Premiums for workers and dependents, net of subsidy	<p>For employers offering coverage, the sum of:</p> <ul style="list-style-type: none"> • The employee’s and employer’s share of ESI premiums for those taking up ESI coverage, reduced by the enrolling family’s marginal tax rate; and • Net non-group premiums for those opting out of ESI coverage. <p>For employers not offering coverage, the sum of:</p> <ul style="list-style-type: none"> • Net non-group premiums for workers. 	Partnership Plan 3.0 net premiums, reduced by the enrolling family’s marginal tax rate, for all workers and dependents.
Out-of-Pocket Costs	Out-of-pocket health costs for workers and dependents either participating in the ESI plan, receiving coverage through non-group coverage, or who are uninsured.	Partnership Plan 3.0 out-of-pocket health costs for workers and dependents.
Financial Penalties	No penalty if employer is offering coverage. Penalty if employer does not offer coverage and is subject to the ACA employer mandate.	No penalty.
Other Costs	For employers offering coverage, the internal HR administrative burden of offering coverage. For employers not offering coverage, no HR administrative costs.	The internal HR administrative burden of offering coverage.

Individual and Household Coverage Choice. Although our initial focus is on employer decisions to enroll in the Partnership Plan 3.0, households choose their coverage based on maximizing their individual utility. When an employer chooses to enroll in the public option and drops their current coverage, worker premiums, benefits, and out-of-pocket spending can change. As a result, these workers and their families may decide to take the public option offered by the employer or drop their ESI coverage; they may also switch to non-group coverage or choose to be uninsured. Details on the KNG-HRM and its utility maximization framework are available in the technical appendix at www.knghealth.com.

B. Development of Connecticut Baseline

To develop the analytic file for this analysis, we subset the KNG-HRM baseline data to select individuals and households located in Connecticut. The KNG-HRM baseline is based on data from the U.S. Census Bureau’s American Community Survey (ACS), with significant inputs from the U.S. Agency for Healthcare Research and Quality’s Medical Expenditure Panel Survey (MEPS), the U.S. Centers for Disease Control

and Prevention’s Behavioral Risk Factor Surveillance System (BRFSS), and other sources.^{6,7,8} The primary data source for the model is the 2024 ACS. We project our baseline from 2026 (the expected first full year of Partnership Plan 3.0), through 2035 (year 10 of the policy).

Projecting Demographic Changes. We used information on demographic trends from the U.S. Census Bureau, which reports population projections by combinations of single year of age, sex, race, Hispanic status, and immigration status, to project the demographic changes in state populations between 2024 (the year for the ACS data) and 2026 – 2035 (modeled year).^{9,10} We also adjusted spending and income in future years, relying on National Health Expenditure Account projections to inflate healthcare spending and CBO’s projections of CPI-U to project income.¹¹

Grouping Workers into Firms. In our KNG-HRM, we group workers into synthetic firms. Because in some policy scenarios the Partnership Plan 3.0 would be available to unions, we modified the Connecticut baseline dataset to include information on union membership status for each employee, using imputed union status information from the 2024 Current Population Survey (CPS). This imputation is heavily dependent on the industry category where the worker is employed. Once each worker has an imputed membership status, we group union members within each industry, with one firm per industry, each of which was set as eligible to offer the public option.

Estimating Healthcare Utilization and Spending. We estimated healthcare utilization and spending for everyone in the ACS, based on an individual’s demographics and imputed health status, including general health, presence of select chronic conditions, and disabilities. We converted healthcare utilization into spending by multiplying utilization rates by prices in Connecticut. Commercial insurer prices were obtained from publicly available data from the Health Care Cost Institute (HCCI). We developed comparable Medicare prices using studies from the Congressional Budget Office (CBO) and other sources that compare commercial provider payment rates to Medicare.¹² In addition, we allowed both commercial and Medicare prices to vary geographically. For commercial prices, we used the HCCI Healthy Marketplace Index (HMI) to develop a commercial price index by geographic area and imputed an index value for geographic areas not included in the HMI. To account for geographic and provider variation in Medicare prices, we used the input price and policy adjustments under the Medicare fee schedules (e.g., wage index, indirect medical education, and geographic practice cost index).

⁶ American Community Survey. US Census Bureau. Accessed at <https://www.census.gov/programs-surveys/acs/>

⁷ Medical Expenditure Panel Survey. Agency for Healthcare Research and Quality. Accessed at <https://meps.ahrq.gov/mepsweb>.

⁸ Behavioral Risk Factor Surveillance System. US Center for Disease Control and Prevention. Accessed at <https://www.cdc.gov/brfss/index.html>.

⁹ 2023 National Population Projections Datasets. U.S. Census Bureau. Accessed at <https://www.census.gov/data/datasets/2023/demo/popproj/2023-popproj.html>.

¹⁰ University of Virginia, Weldon Cooper Center for Public Service. (2024). National and 50-State Population Projections. Retrieved from <https://coopercenter.org/national-population-projections>

¹¹ <https://www.cbo.gov/publication/60870>

¹² These will be used for pricing services for the uninsured, as described below.

We estimated expected spending based on expected utilization rates, projected price growth, and changes to expected cost-sharing on health plans. Our price and utilization estimates are approximations that may differ from those experienced by consumers on either ESI or insured through the non-group market. To account for this, we scaled spending to match external benchmarks for ESI and Marketplace premiums (see calculation of premiums discussed below). Specifically, we adjusted the ESI prices and utilization so that our ESI premiums match the average Connecticut premiums as reported in the MEPS.¹³ There is limited data available on prices paid by uninsured populations. People without health insurance coverage are often billed charges but then receive discounts through charity care programs. Following analyses of the AHA Annual Survey data for hospital services and estimates in the literature, we assumed that the uninsured pay rates comparable to Medicare for hospital services and rates comparable to commercial payers for other services.^{14,15}

C. Modeling Premiums, Tax Revenue and Spending under Partnership Plan 3.0

Premiums. To calculate what enrollee premiums would be, we made several assumptions regarding the Partnership Plan 3.0. We initially assumed that the Partnership Plan 3.0 pays provider rates comparable to commercial provider rates (see variation on this assumption discussed below). Based on the FY25 MLR faced by the Partnership Plan 2.0, reported in the Office of the State Comptroller report Office of the State Comptroller report, we initially assume that the Partnership Plan 3.0 would have an MLR of 103.5 percent. Since the Partnership Plan 2.0 does not pay premium or other taxes and assessments, we also assumed the Partnership Plan 3.0 will not either.

The premiums for the Partnership Plan 3.0 are established in one large rating area that includes only newly eligible firm employees (i.e., a separate risk pool from the Partnership Plan 2.0). Further, we assumed that when an employer switches onto the Partnership Plan 3.0, they will maintain the individual and family employer subsidy share under the Partnership Plan 3.0 as they had under the plan they were offering in the baseline. Lastly, we assumed that the Partnership Plan 3.0 has an actuarial value of 92 percent, \$0 Deductible, \$2,000 individual out-of-pocket (OOP) max and \$4,000 family OOP max.¹⁶

Tax Revenue Implications.

- *Insurance Premium Tax.* Connecticut imposes a tax rate of 1.50 percent on net direct premiums collected by admitted insurers (i.e., those authorized to operate in Connecticut), known as the insurance premium tax. The tax only applies to fully insured plans (both NOG plans and employers

¹³ https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_2/2019/tiic1.htm

¹⁴ Melnick and Fonkych. (2008). Hospital Pricing and the Uninsured: Do the Uninsured Pay Higher Prices? *Health Affairs*. Accessed at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.27.2.w116>.

¹⁵ Gruber and Rodriguez. (2007). How Much Uncompensated Care Do Doctors Provide? *Journal of Health Economics*. Accessed at <https://economics.mit.edu/files/6423>.

¹⁶ The Partnership Plan 3.0 benefit design is modeled after Partnership Plan 2.0. The model assumes in-network benefits and that individuals maintain Health Enhancement Program (HEP) compliance, resulting in the \$0 deductible. https://carecompass.ct.gov/wp-content/uploads/2025/05/Partnership2_0_brochure_2025_v2-002-1.pdf

who do not self-insure). We assume that the Partnership Plan 3.0 will not be charged insurance premium tax. For the baseline and each scenario in our model, we add up the estimated premiums charged by fully insured health plans and multiply the resulting number by the tax rate. We calculate the Insurance Premium Tax deficit under the public option by subtracting the tax revenue in each scenario from the revenue in baseline.

- *Exchange Fund Assessment.* To fund the Connecticut Exchange, the state charges an assessment on earned premiums reported by qualified health carriers on the individual and small group markets. The assessments are calculated at a rate of 1.85 percent on premiums collected during the previous calendar year. We assume that the Partnership Plan 3.0 will not be charged exchange assessments. For the baseline and each scenario in our model, we add up the estimated premiums charged by small group and individual insurers and multiply the resulting number by the exchange fund assessment rate. We calculate the Exchange Fund Assessment deficit under the public option by subtracting the tax revenue in each scenario from the revenue in baseline.
- *Connecticut Department of Insurance Assessment.* The Connecticut Department of Insurance (DOI) is funded through an assessment on all insurance (health, life, etc.). We estimated the share of Department of Insurance (DOI) fund from health insurance policies at \$27.2 million in 2025. The DOI assessment is paid by fully insured health plans, which are assessed based on premiums and amount to meet the target funds established by the state. To calculate a DOI assessment rate, we estimate total premiums collected by fully insured plans in the baseline and divided these premiums into the projected DOI fund amount (inflation adjusted to each year from 2026 - 2035). This tax rate is then applied to premiums earned by fully insured plans in each scenario to calculate DOI assessment revenues. Each scenario's tax deficit is the difference in DOI revenues between baseline and the respective scenario.
- *Health and Well-being Assessment.* The Health and Well-being Assessment applies to fully insured and self-insured health care premiums. We estimated the fund at \$12.8 million in 2024. To estimate tax revenue, we divide the total fund amount by the number of covered lives, from fully and self-insured plans, to calculate a per capita rate in the baseline. We assume the per capita rate remained constant across the scenarios and multiply the rate by the earned premiums to estimate tax revenue in each scenario. The tax deficit is calculated by subtracting the scenario-specific revenue from the total projected fund amount in each year from 2026 - 2035 (adjusted for inflation).

Provider Spending Offsets. We assume that the MLR for Partnership Plan 3.0 will remain comparable to the MLR for Partnership Plan 2.0 (FY25) at 103.5 percent. This implies that the amount spent on clinical services and quality improvement would be 3.5 percent higher in Partnership Plan 3.0 than the premiums collected, thereby creating an insurance product which is underpriced. Empirical evidence from a study on MLR rebates by the Kaiser Family Foundation suggests administrative load at 12 percent for large

group market plans, with MLR at 88 percent.¹⁷ Therefore, for the purpose of our analysis, we assume MLR of 88 percent as the target value required to eliminate underfunding of the plan.

We assume that premiums charged by the plan will remain unaffected over the short term. Instead, the channel the public option plan will use to offset the losses incurred from underpricing is through reduced provider rates. We estimate the cut in healthcare spending by multiplying spending under the Partnership Plan 3.0 with the ratio of target value of MLR to assumed initial value of MLR. In this case, the ratio is 0.85 (0.88/1.035).

III. Findings

A. Coverage

In 2026, we project the Connecticut total population under the age of 65, not employed or dependents of those employed by the government (Federal, state, or local) and not enrolled in a government assistance program (Medicare and Medicaid) to be 1.6 million (Figure 4). In the baseline scenario, we project that slightly more than 80 percent of the eligible population will receive coverage through an employer, with the remaining 20 percent split between non-group coverage and being uninsured.

Across the nine scenarios modeled, private ESI remains the leading source of coverage when the take-up rate is 25 or 50 percent and for the not-for-profit scenarios, but total enrollment in Partnership 3.0 exceeds private ESI under the 75 percent take-up rate when for-profit employers with less than 50 or 100 employees are eligible to offer Partnership Plan 3.0. For the narrowest scenario (i.e., when eligibility is limited to not-for-profit firms and firm take-up rate is set at 25 percent), we saw private ESI drop from 1.319 million to 1.308 million. Under this scenario, we also estimated that 14.2 thousand more people would be uninsured. For the most inclusive scenario with 75 percent take-up, we estimated that the Partnership Plan 3.0 enrollment (761.1 thousand) was higher than private ESI enrollment (581.4 thousand). Under this scenario we estimated a decrease of 5.3 thousand in the uninsured population similar to the baseline. In the narrowest scenarios, private ESI remained at approximately 80 percent, which was similar to baseline, but dropped to as low as 35 percent in the most inclusive scenario (Figure 5).

¹⁷ Ortaliza, J. and Cox, C. (2024). 2024 Medical Loss Ratio Rebates. Available at: <https://www.kff.org/private-insurance/medical-loss-ratio-rebates/>.

Figure 4: Projected Number (Thousands) of People by Coverage Category in 2026

Firm Scenario	Take-up Rate	ESI	Partnership Plan 3.0	Non-group	Uninsured	Total
Baseline	-	1,319.2	0.0	162.3	169.4	1,650.9
For-profit Firms with Fewer than 100 Employees, Not-for-profits, and Unions	25%	1,291.3	30.5	149.1	179.9	1,650.9
	50%	879.7	453.9	146.2	171.0	1,650.9
	75%	581.4	761.1	144.2	164.2	1,650.9
For-profit Firms with Fewer than 50 Employees, Not-for-profits, and Unions	25%	1,299.5	20.2	150.2	181.0	1,650.9
	50%	909.6	420.1	147.6	173.6	1,650.9
	75%	617.1	721.3	145.6	166.9	1,650.9
Not-for-profits only	25%	1,308.3	4.4	154.6	183.6	1,650.9
	50%	989.7	325.8	154.4	181.0	1,650.9
	75%	877.3	440.4	154.3	178.8	1,650.9

Source: KNG Health analysis using the KNG Health Reform Model

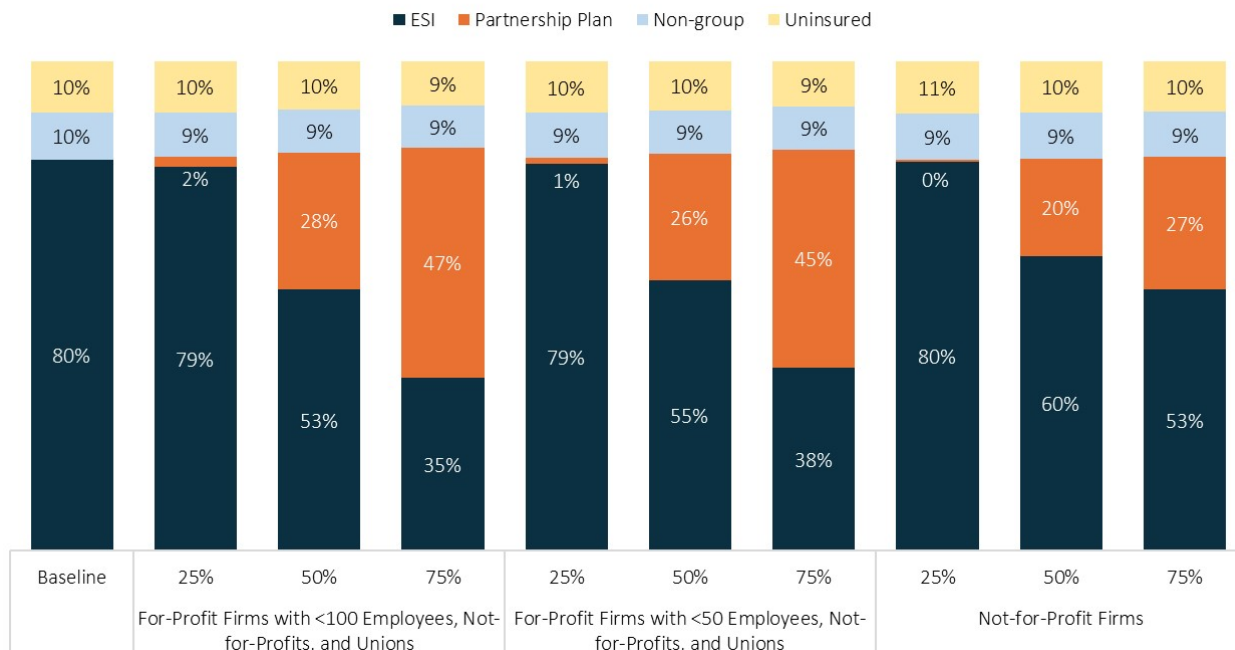
Note: The population reported here excludes Connecticut residents who are enrolled in government assistance programs (Medicare, Medicaid, Tricare, VA, or IHS) as well as all employees and dependents of Federal, state, and local government workers.

There was a large drop off in private ESI enrollment from baseline to the scenarios with eligibility that includes for-profit firms with fewer than 50 employees, and for-profit firms with fewer than 100 employees and firm take-up rate of 50 and 75 percent (reduction of about 409.5 – 439.4 thousand in the 50% take-up and 702.0 – 737.8 thousand individuals in the 75% take-up respectively). In the 25% take-up scenarios, we see small decreases in private ESI coverage (around 19.7 – 27.8 thousand). This change in ESI coverage at the 50% and 75% take-up is likely because larger organizations eligible for the Partnership Plan 3.0 were more likely to enroll at these take-up rates than at the initial 25% take-up rate. The initial eligible firms tend to be smaller, and these firms are more likely to take-up the Partnership Plan 3.0 in earlier scenarios (i.e., in the scenarios with 25% take-up). Since smaller firms choose to take-up the public option in the earlier take-up scenarios, the drop off from private ESI coverage is larger in magnitude in the higher take-up rate scenarios.

We note that there is a small rise in uninsured from baseline in scenarios with low assumed uptake of the Partnership 3.0 plan and a small reduction in uninsured at the 75% take-up scenarios. The increase in uninsured in some scenarios is a result of the model forecasting small increases in premiums for private ESI coverage. Even small increases in premiums can tip the balance from taking the offer of coverage to choosing to remain uninsured for some individuals under the model specifications. The largest rise observed is an increase of 14.2 thousand uninsured in the not-for-profits only firm eligibility scenario (25% take-up), relative to baseline. Uninsured counts are higher at low take-up rates for the Partnership

Plan 3.0 and the uninsured counts lower as take-up rises. We note that the rise seen in uninsured is sensitive to modeling assumptions in the KNG-HRM model.

Figure 5: Projected Coverage Type Percentage in each Scenario, 2026 – 2035



Source: KNG Health analysis using the KNG Health Reform Model

Note: The population reported here excludes Connecticut residents who are enrolled in government assistance programs (Medicare, Medicaid, Tricare, VA, or IHS) as well as all employees and dependents of Federal, state, and local government workers.

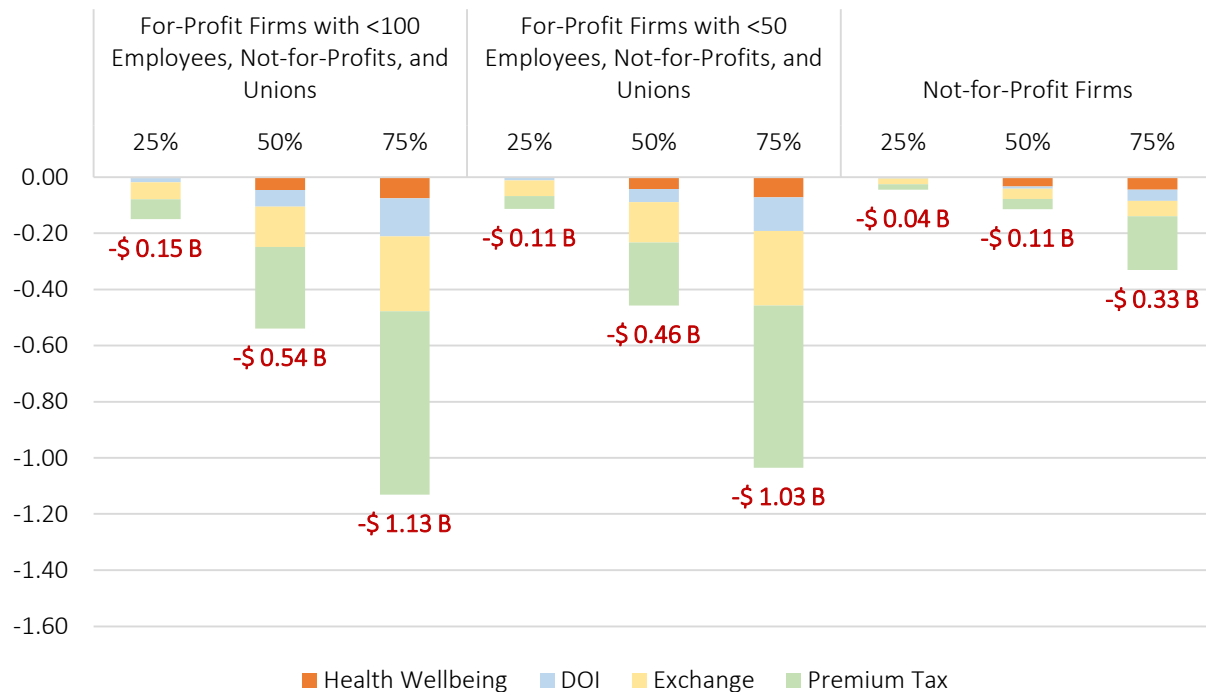
B. Tax Revenue

Private insurers in Connecticut pay taxes and assessments on healthcare premiums that likely would not be required of the Partnership Plan 3.0. As more eligible firms participate in the state-sponsored plan, the pool of firms purchasing health insurance through a private insurer would fall. This leads to a decline in the tax collection by the state. We characterize the loss in state’s tax revenue as the difference between taxes collected by the state in the baseline and taxes collected after the public option becomes available.

We calculate the aggregate health insurance related taxes and assessments in the baseline by adding externally reported tax funds estimates for: (1) Health and Wellbeing Assessment; (2) Department of Insurance Assessment; (3) Exchange Fund Assessment; and (4) Insurance Premium Tax (\$2.9 billion in total across 2026 - 2035). After implementation of the Partnership Plan 3.0, the aggregate revenue from these sources varies across different scenarios and ranges from \$2.9 billion in the scenario with 25 percent take-up and Not-for-profit firms only to \$1.8 billion in the scenario with 75 percent take-up and small firms defined as those with fewer than 100 employees (Scenario 3). The revenue across all scenarios is noticeably less than the baseline tax collection. The revenue reductions range from \$0.04

billion (Scenario 7) to \$1.13 billion (Figure 6). To offset these revenue reductions, the state may need to increase taxes and assessments on the remaining insurers or raise revenue through other mechanisms.

Figure 6: Potential Reductions in State Revenue with Partnership Plan 3.0 by Scenario, 2026 – 2035 (Billions of Dollars)



Source: KNG Health analysis using the KNG Health Reform Model

Note: The population reported here excludes Connecticut residents who are enrolled in government assistance programs (Medicare, Medicaid, Tricare, VA, or IHS) as well as all employees and dependents of Federal, state, and local government workers.

C. Provider Spending

Our model initially assumes that the Partnership Plan 3.0 will pay commercial provider rates (like private ESI insurers). As a comparison, we calculated the impact on total spending if the Partnership Plan 3.0 provider reimbursement rates were reduced to maintain an MLR of 88%. We calculated the spending impact on total spending and provider-specific spending (e.g., including hospitals and physicians).

For the scenario with 25 percent take-up and small firms defined as those with fewer than 50 employees, we estimated a decrease of \$458 million in total spending would be required to achieve an MLR of 88 percent for each year in the 10-year study window (Figure 7, Scenario 4). For the scenario with 75% take-up and small firms defined as those with fewer than 100 employees (Figure 7, Scenario 3), we estimated a decrease of \$16.2 billion in total medical spending across 2026 – 2035 to achieve a MLR of 88%.

Figure 7: Partnership Plan 3.0 Projected Spending Impacts to Achieve Financial Stability, 2026 – 2035 (Millions of Dollars)

Coverage	Current Spending (103.5% MLR)	Reduced Spending (88% MLR)	Reduction Required	Change in Spending
Scenario 4: For-profit firms with <50 employees eligible, take-up rate 25%				
Total Spending	\$3,056	\$2,598	15%	\$458
Provider Spending	\$2,436	\$1,978	19%	\$458
Scenario 3: For-profit firms with <100 employees eligible, take-up rate 75%				
Total Spending	\$108,156	\$91,959	15%	\$16,197
Provider Spending	\$85,445	\$69,248	19%	\$16,197

Source: KNG Health analysis using the KNG Health Reform Model

Note: Provider spending accounts for inpatient, outpatient, emergency room, physician services, and other spending (excluding drug spending). The population reported here excludes Connecticut residents who are enrolled in government assistance programs (Medicare, Medicaid, Tricare, VA, or IHS) as well as all employees and dependents of Federal, state, and local government workers).

For the Partnership Plan 3.0, a broad spending cut (i.e., unaccounted for health expenditures) of approximately 15 percent would be required to achieve the target MLR of 88 percent (Figure 7). To achieve this spending cut, one method would be to lower provider reimbursement rates by approximately 19 percent (Figure 7).

The total financial cost of the Partnership Plan 3.0 is the sum of the lost tax revenue plus the additional costs to maintain the plan if medical spending is not reduced. Figure 8 provides the estimated additional state revenue required under the Partnership Plan 3.0 to replace lost tax revenue and ensure financial sustainability of the plan. For the scenario with 75% take-up and small firms defined as those with fewer than 100 employees (Scenario 3), we estimated that the state would need to collect an extra \$17.3 billion across 2026 – 2035. For the scenario with 25% take-up and limited to not-for-profits only (Scenario 7), we estimated that the state would need to collect an extra \$134.5 million to the Partnership Plan 3.0 for it to be sustainable. This represents the full range of expected outcomes across the 9 modeled scenarios.

Figure 8: Additional Funding Needed to Replace Lost Tax Revenue and Sustain Partnership Plan 3.0, 2026 – 2035 (Billions of Dollars)

Firm Scenario Description	Scenario Number	Take-up Rate	Tax Revenue Lost	Unaccounted for Health Expenditures	Total
For-profit Firms with Fewer than 100 Employees, Not-for-profits, and Unions	1	25%	\$0.15	\$0.76	\$0.91
	2	50%	\$0.54	\$9.69	\$10.23
	3	75%	\$1.13	\$16.20	\$17.33
For-profit Firms with Fewer than 50 Employees, Not-for-profits, and Unions	4	25%	\$0.11	\$0.46	\$0.57
	5	50%	\$0.46	\$8.97	\$9.43
	6	75%	\$1.03	\$15.35	\$16.38
Not-for-profits only	7	25%	\$0.04	\$0.09	\$0.13
	8	50%	\$0.11	\$6.80	\$6.91
	9	75%	\$0.33	\$9.08	\$9.41

Source: KNG Health analysis using the KNG Health Reform Model

IV. Discussion

Several state legislatures have introduced or are considering establishing a public option.¹⁸ The proposals differ in important ways, such as the level of state control and the approach to provider reimbursement. In this study, we examined the potential effects of one such plan in Connecticut, whose legislature has debated a public option over the last few legislative sessions. The Partnership Plan, as last specified in SB 842 in 2021, would expand access to a state-administered insurance plan to small for-profit businesses, not-for-profit organizations, and unions. The plan would be tied to the insurance plan offered to state employees, which is a generous health insurance plan with low co-payments and out-of-pocket spending caps. The bill, however, does not specify provider reimbursement rates.

The impact of a public option on insurance coverage, health care spending, providers, and state budgets depends on several factors. An eligible entity’s decision to enroll in the public option will depend on plan premiums, benefits, deductibles, and copayments. The impact on healthcare spending will depend on, among other factors, provider reimbursement rates, while the impact on state budgets will depend on medical spending, premiums collected, and tax revenue. Critics of the Partnership Plan proposal have

¹⁸ California Health Care Foundation. State Public Options: Comparing Models from Across the Country. CHCF Issue Brief. March 2021. Accessed at <https://www.chcf.org/wp-content/uploads/2021/03/StatePublicOptionsComparingModelsAcrossCountry.pdf>

raised a few concerns, including its effects on tax revenue, if ESI moves from private insurance to a state plan. In addition, the existing public option in the state, for which eligibility is limited to municipalities and other non-state government entities (i.e., Partnership Plan 2.0), appears to be underfunded. If the new public option is also underfunded, the state would need to raise premiums, use other tax revenue, or cut provider reimbursement rates to maintain the financial health of the plan.

We examined the potential impact of expanding a public option in Connecticut to small for-profit employers, not-for-profits organizations, and unions. We modeled several scenarios that vary in terms of definition of a small employer and employer take-up rates. With respect to tax revenue, we found that the direct reduction in revenue for the state would be between \$0.04 billion (with 25% take-up and not-for-profits firms only) and \$1.13 billion (with 75% take-up and small firms defined as those with fewer than 100 employees) across 2026 – 2035. Overall spending on the Partnership Plan 3.0 would need to see a reduction of approximately 15 percent to put the plan on secure financial footing or potential underfunding would need to be covered by other sources. The analysis explored one way to achieve this deduction, cutting provider reimbursement rates, and estimated a 19 percent reduction would be required. The reduction in spending, referred to as unaccounted health expenditures, would range from \$0.09 billion (with 25% take-up and not-for-profits firms only) and \$16.20 billion (with 75% take-up and small firms defined as those with fewer than 100 employees) across 2026 – 2035.

The additional state revenue required under the Partnership Plan 3.0 to replace lost tax revenue and ensure financial sustainability of the plan without reducing provider reimbursement rates was also estimated. For the scenario with 75 percent take-up and small firms defined as those with fewer than 100 employees, we estimated that the state may need to collect an extra \$17.33 billion across 2026 – 2035. For the scenario with 25% take-up and small firms defined as those with fewer than 50 employees, we estimate that the state may need to collect an extra \$0.57 billion.

With respect to coverage, we project that the number of uninsured individuals among the population eligible for the new Partnership Plan 3.0 would increase in all scenarios of 25% take-up (and the not-for-profit scenario only with 50% take-up), ranging from an increase in uninsured from 17.3 thousand (1% increase; eligibility: < 100 employees; take-up: 25%) to 54 thousand (3%; eligibility: not-for-profit only; take-up: 25%). While an increase in uninsured may seem counter intuitive, it is the result of changes in ESI premiums and other costs because of changes in the risk pools. For example, premiums could increase for workers and their families either under the Partnership Plan 3.0 or, more likely, for workers whose employers do not take-up the Partnership Plan 3.0. We found that as the take-up of the Partnership Plan 3.0 rate increases, the uninsured rate decreases as larger employers switch to offer the Partnership Plan 3.0. That is, the offer of private ESI under baseline was only slightly more attractive than choosing to remain uninsured; even a slight increase in annual premiums was enough to induce individuals to switch from ESI to uninsured. Also, some of the switch to uninsured comes from people with non-group coverage, who are also seeing increases in out-of-pocket spending resulting from federal legislation.

The results reported in this brief are the output of the KNG-HRM and are dependent on the assumptions stated earlier in the report. Additional factors that could influence the outcome of a Partnership Plan 3.0

include temporary state premium assistance which could influence coverage choice and potential legal challenges to Partnership Plan 3.0 under the Employee Retirement Income Security Act of 1974 (ERISA), which could increase administrative costs.

Temporary Premium Assistance. The microsimulation was conducted using the expiration of the Enhanced Premium Tax Credits as the baseline. The one-year temporary premium assistance, offered through Access Health CT, aids eligible Connecticut residents not already enrolled in non-group insurance coverage offered on the state’s public insurance exchange.¹⁹ The temporary premium assistance program may influence Connecticut residents newly seeking coverage in 2026 to enroll in non-group coverage offered through Access Health CT, as opposed to the Partnership Plan 3.0. Because the assistance is limited to the first year and does not replace the federal support entirely, the modeling of the Partnership Plan 3.0 did not account for the temporary premium assistance.

Employee Retirement Income Security Act of 1974 (ERISA). Expanding Partnership Plan 3.0 to include participation by private employers could raise legal questions regarding whether the plan continues to qualify as a governmental plan under ERISA. 29 U.S. Code § 1003(b)(1) states that governmental plans are exempt from ERISA requirements. If Partnership Plan 3.0 were determined to fall outside that exemption, it could become subject to ERISA’s federal requirements, such as reporting and disclosure obligations and even potential litigation. Additional compliance requirements and litigation risk could increase administrative costs, resulting in additional financial pressure for the Partnership Plan 3.0. The modeling in this analysis did not account for such costs due to uncertainty about reasonable assumptions for the size of these costs and their likelihood of occurring.

¹⁹ https://help.accesshealthct.com/en_US/premium-assistance