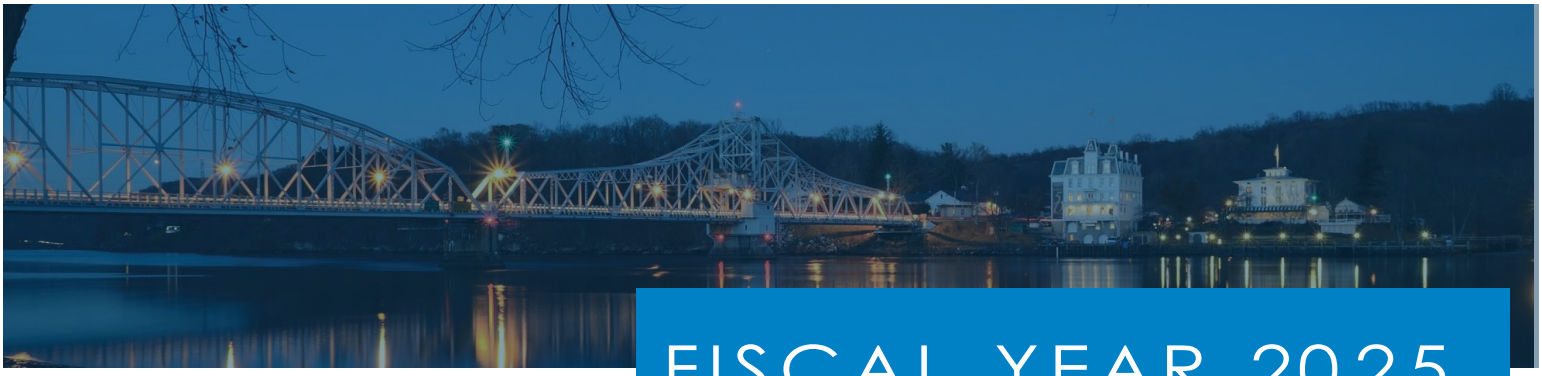
CONNECTICUT PARTNERSHIP PLAN 2.0

REPORT ON THE STATUS *of the* CONNECTICUT PARTNERSHIP PLAN

FY25

PREPARED BY:
THE OFFICE *of the* STATE COMPTROLLER

OSC.CT.GOV/CTPARTNER



FISCAL YEAR 2025

EXECUTIVE SUMMARY

The Connecticut Partnership Plan offers non-state public employers the choice to participate in the state employee health plan. Participating groups rely on the same programs as the state health plan, and all claims from both plans are pooled to determine premium rates. All eligible groups that apply are admitted to the plan as long as they include all of their covered lives.

The Partnership Plan has allowed Connecticut cities and towns to obtain quality health insurance for their employees at affordable rates by accessing the contract terms and pricing available to the state as a large purchaser. In addition, participating groups get access to innovative programs, like the state's Health Enhancement Program (HEP), which provides lower premiums and cost share in exchange for members agreeing to receive preventive care and screenings. This program has shown significant positive impacts on preventive cancer screening rates and improvements in health equity.

THE BASICS

PLAN OPENED IN 2016

28,723 EMPLOYEES

68,043 MEMBERS

187 ENROLLED GROUPS

For only the second time in seven years, in Fiscal Year (FY) 2025, the plan paid out more in claims than it collected in premiums. In total, the plan took in approximately $707 million in premiums from enrolled members and paid out approximately $731 million in claims. The Medical Loss Ratio (MLR)–the percent of premiums the health plan spends on medical and pharmacy claims–was 103.5 percent. Claims and utilization costs exceeded the premium projections established with the plan's actuary. Increased costs were driven by rising per unit medical and pharmacy costs, increased utilization in inpatient and outpatient services, and sustained specialty drug spending. This overall increase in utilization and cost is not unique to the State of Connecticut health plan.

Interest and participation in the plan continues to grow at an exponential rate. In FY 2025, seventeen new groups joined the plan, adding 3,100 new employees and 7,400 new lives. Just in the month of July 2025, fifteen new groups joined the plan. These new groups added approximately 2,800 new employees and 6,500 members in total. As of July 2025, participation now represents 187 groups, 28,900 employees, and 68,000 lives.

In FY 2025 the plan continued to focus on member satisfaction, value-based care, targeted point solutions, strategic communications, and vendor performance auditing. These programs will be discussed under the offered benefits section.

ABOUT THE PARTNERSHIP PLAN

The Connecticut Partnership Plan is a point-of-service (POS) health plan available to non-state public employers and their employees. This includes municipalities, boards of education, quasi-public agencies, housing authorities, public libraries, and other public entities. The plan shares benefits, administration, and programs with the state health plan.

Claims from Partnership groups are pooled with those of the state health plan and used to establish rates.

The current Partnership Plan was established under Public Act 15-93 and began enrolling members on January 1, 2016. The Office of the State Comptroller administers the plan and contracts with private companies to manage benefits and claims processing, actuarial services, and health care programs.

Leveraging the size and negotiating power of the state employee health plan to benefit municipalities and other non-state public employers is a common practice across states, including Connecticut's neighbors: Massachusetts, Vermont and New Jersey.

Participating Groups

As of December 1, 2025, the Partnership Plan has 68,043 enrolled employees and dependents representing 187 groups. By statute, the plan must admit all complete groups that apply.

Enrolled groups range in size from over 8,000 total members (City of Bridgeport and Board of Education) to one (Several Housing Authorities).

Offered Benefits

Partnership Plan members have access to the same POS health plan as state employees. The plan has no- or low-deductibles for all services. Medical and pharmacy coverage are provided for all members, but individual groups may also choose to add dental coverage or a vision rider.

The cost-saving and wellness programs created by the state health plan are available to Partnership members as well. This includes:

Health Navigation and Advocacy: Quantum Health operates the plan's "Health Navigator" program, a benefits concierge service to answer member questions about coverage and assist in connecting patients with the care they need. Quantum is also the administrator of the Health Enhancement Program (HEP). They manage claims tracking for required preventive services and chronic disease management and related compliance. Quantum has a 59% member engagement success rate with Partnership members and 98% of high-cost claimants (over 100k) are engaged.

The Health Enhancement Program (HEP): A preventive health initiative that incentivizes members to receive several age-based services, such as physicals, dental cleanings, and cholesterol screenings, to maintain long-term health. The requirements in the program were reviewed and adjusted for calendar year 2025 to align with U.S. Preventive Services Task Force Recommendations. The preventive physical exam visit will be required every two years across all age brackets for the employee or retiree and their spouse, and the mammogram requirement will have a baseline at age 40 with follow-up screenings every two years. HEP is reviewed on a calendar year basis, the compliance rate with program requirements for Partnership members in the most recent completed calendar year – 2024 was 91%.

FlyteHealth: Starting on July 1, 2023, the state rolled out FlyteHealth to its state and partnership members, a weight management program that is available to members who are 18 years and older. These medical professionals consist of physicians, nurse practitioners, and registered dieticians who specialize in helping people manage their weight as well as treat some of the complications that come with excess weight, including diabetes, heart disease, sleep apnea, and liver disease. The plan only covers anti-obesity medications for those enrolled in the program. The clinical results for those who have completed a full 24 months in the program have been impressive, with an average reduction in weight of 17.3% . Patients with elevated systolic blood pressure (≥ 140) showed a 17.7% improvement at 24 months and those with elevated diastolic blood pressure (≥ 90) showed a 16.3% improvement. As of June 2025, there are approximately 11,000 members enrolled between both the state and partnership populations.

Diabetes Management Programs: programs to prevent and manage diabetes including the online Diabetes Prevention Program and Virta Health, which provides access to coaching, a free connected glucose meter and supplies. The plan also offers pre-diabetes programming to help members avoid becoming diabetic altogether.

Digital Orthopedic Services: Hinge Health and Upswing Health are orthopedic resources that offer no-cost at home treatments to prevent surgery.

Firefighter Cancer and Disease Screening Coverage: Firefighters enrolled on the plan are eligible every two years for no cost cancer and disease screenings. These screenings may identify issues early ensuring timely care and increasing the chance of a healthy outcome.

PrudentRx: a specialty drug discount program that applies manufacturer assistance to reduce member and plan costs for high-cost specialty drugs. The program began July 1, 2022, and has been saving money on the State Plan and Partnership Plan ever since. In FY 24 PrudentRx saved the partnership plan approximately $6 million and reduced member cost shares by approximately $400,000.

Primary Care Initiative: a pilot program that gives primary care providers additional financial resources to invest in improved care management, coordination, and access for members to improve the care experience, improve outcomes and reduce total health care costs. Providers enrolled in the program area also responsible for managing their patients' total cost of care, through better care coordination and patient engagement. The total cost of care targets are set to align with the state's health care cost growth benchmark, which seeks to ensure statewide health care cost growth is sustainable moving forward. The program operates on a calendar year basis. In the most recently completed calendar year participating primary care groups beat the total cost of care targets, earning over $2.2 million in bonus payments for themselves and reducing the state and Partnership plan costs by $5.2 million. At the same time groups saw marked improvement in quality metrics tracked by the program.

Public-Private Partnerships

The Office of the State Comptroller has contractual agreements with a host of private companies to assist in the administration of the Partnership Plan and provide programs for members.

Anthem Blue Cross Blue Shield (Anthem) is the plan's third-party administrator. Anthem manages eligibility and billing for medical and pharmacy coverage and offers its same POS plan design available to state employees.

Cigna provides fully insured dental and vision options to Partnership groups and manages the related eligibility and billing.

CVS Caremark is the pharmacy benefit manager for both the state health plan and the Partnership Plan. CVS utilizes a tiered prescription pricing plan and a maintenance drug network to allow members to receive maintenance drugs at local pharmacies at reduced costs.

Segal is an independent actuarial firm contracted to assist in monitoring financials and setting plan rates.

FINANCIAL REPORT

The Partnership Plan in FY25, paid more in claims than it collected in premiums. The plan ended FY25 with a MLR of 103.5 percent — meaning for every $1 collected in premiums, $1.035 was expended on medical and pharmacy claims.

SPAN	PREMIUMS	CLAIMS	MLR
7/1/17 – 6/30/18	$140,669,124	$150,040,021	106.7%
7/1/18 – 6/30/19	$358,398,841	$380,547,450	106.2%
7/1/19 – 6/30/20	$512,762,495	$484,097,446	94.4%
7/1/20 – 12/31/20	$272,319,765	$236,120,985	86.7%
7/1/20 – 6/30/21	$557,177,149	$508,175,960	91.2%
7/1/21 – 6/30/22	$622,034,873	$659,088,796	106%
7/1/22 – 6/30/23	$634,853,318	$611,544,939	96.3%
7/1/23 – 6/30/24	$613,297,541	$572,151,282	93.3%
7/1/24 – 6/30/25	$708,831,018	$731,394,943	103.5%

Funding

The Partnership Plan is funded by premiums paid by enrolled groups. Premium payments are deposited into the Partnership account. The Partnership account balance as of June 30, 2025, is approximately -$18 million.

Administrative Costs

Enrolled Partnership Plan groups have administrative costs included in their premiums. Those costs cover the state employees who support the program, as well as fees for the vendors and consultants.

In FY25, administrative costs were approximately 3.3 percent.

FISCAL YEAR	FAD YEAR-END BALANCE
FY 2016	$384,269
FY 2017	$8,831,813
FY 2018	$2,230,584
FY 2019	$8,040,047
FY 2020	$23,668,462
FY 2021	$31,575,411
FY 2022	$33,262,723
FY 2023	$14,494,114
FY 2024	$27,275,851
FY 2025	-$18,640,715

OVERSIGHT & REPORTING

The Office of the State Comptroller is required to submit annual reports on the Partnership Plan to the Health Care Cost Containment Committee (HCCCC), the Office of Policy and Management (OPM) and the legislature's Appropriations Committee.

The state selected Segal to perform actuarial services for both the Partnership Plan and the State Plan after a competitive bidding process. Segal provides independent financial analysis to determine the fiscal state of the plan and calculates all premium rates for Partnership groups.

The State Auditors of Public Accounts maintain oversight authority into all functions of the Office of the State Comptroller, including the Partnership Plan. Additionally, the Comptroller must provide legal statements of fact on the financial status of the agency and the office, and its employees must comply with all Freedom of Information laws as a public agency.

The plan independently audits all adjudicated claims and financial payments made by its third-party administrators for medical, dental and pharmacy services to ensure all payments align with contractual agreements and are consistent with the plans benefit design.

Each vendor payment made on behalf of the Partnership Plan is also updated to OpenConnecticut, the Comptroller's transparency website that updates checkbook-level payment information on a nightly basis. Summary plan enrollment and utilization information is also posted on OpenConnecticut for each fiscal year and calendar year time period, providing the public with a comprehensive view of plan performance.

FUTURE OUTLOOK

The Partnership Plan provides top-quality health care benefits at reasonable rates to 167 groups including municipal, boards of education, and other non-state public employers in Connecticut. It allows smaller public groups to access the state's low administrative costs and aggressive discounts as well as innovative programming like the Health Enhancement Plan, Primary Care Initiative and PrudentRx.

Our county level rates were implemented 5 years ago and will continue to be factored into the 7/1/25 and 7/1/26 renewals to ensure that these spreads are accurate. The remaining regional adjustment factor will be included in the 7/1/26 renewal and will be recalculated every 5 years going forward.

7/1/25 renewal rates on the conventional plans experienced a 10.3% average increase on active medical and 2.6% on non-Medicare retirees. Also, our ancillary dental plans averaged a 3% renewal increase and vision rider was flat. The State of Connecticut health plan renewal performed similarly to one of the largest U.S. public sector health plans, CalPERS. CalPERS announced an average increase of 11.9% in their comparable PPO plans effective January 1, 2026.

Additional Program and Market Considerations:

Dental: The Basic plan was updated to reduce out-of-network plan benefits and improve in-network benefits. This update was completed to encourage member use of participating in-network providers. Additionally, the payment schedule for out-of-network dental providers was updated to 90% of Cigna's maximum reimbursable charge (MRC). The anticipated plan savings associated with these updates resulted in a better than anticipated premium renewal.

Competitive Procurement: A competitive bid process is currently underway for services for medical claims administration, utilization and care management, health advocacy, and administration of the Primary Care Initiative. Final results are expected January 2026.

The Office of the State Comptroller completed a competitive bid process for the Medicare Advantage Plan (MAPD) in FY2025. The process resulted in award to the current incumbent, Aetna, effective 1/1/26. To take advantage of additional

CMS subsidies the Medicare Advantage Plan will split the medical and prescription benefits to a Medicare Advantage medical plan and separate Prescription Drug Plan (PDP). The benefits associated with the plan remain the same, and resulted in a lower than anticipated increase of the per member per month premium of $116.94 PMPM.

Prescription Formulary Modernization: The plan is undertaking initiatives to update and optimize prescription drug formularies to reflect clinical effectiveness, cost-efficiency, and emerging treatment categories.

High-Quality, Lower-Cost Provider Incentives: Strategies are being developed to guide members toward high-value providers and care locations, including ambulatory surgery centers, preferred imaging sites, and integrated primary care practices.

Medical Pharmacy Review: A comprehensive evaluation of medical specialty drug utilization is underway, including site-of-care optimization and enhanced prior authorization controls.

Cost Pressure Concerns: Systemic cost drivers include escalating specialty drug prices, increased inpatient utilization, rising outpatient surgical expenditures, and growth in professional services.

ADDENDUM

Sec. 3-123yyy of the Connecticut General Statutes requires the Comptroller's Office to "include a plan to ensure the fiscal adequacy of the premium rate structure" for participants in the Partnership Plan, when "the profit loss ratio demonstrates inadequacy in premium payments." As reported above, the Partnership Plan incurred losses in FY25. The Comptroller's Office recommends taking a deliberative approach to addressing the reported financial deficiencies.

Over the long-term, the combined State and Partnership Plans will cover their costs as understated projections in a given year are covered by the plan's reserve funds. The resultant lower reserve fund balances are incorporated into future year rate increases to replenish the reserve funds.

The real risk to the long-term financial stability of the Partnership Plan is if the Partnership Plan's per member health care costs are consistently higher than those of the State Plan after regional cost adjustments are applied. Should this occur, the Partnership Plan premiums, as applied under current statute, would be consistently too low to cover the plan's costs. As a preventive measure the regional adjustment is reviewed every 5 years to remain consistent with current trends.

The primary factor driving losses in FY25 were higher than anticipated increased claims utilization and cost projection by the plan's actuary. The losses in FY25 will be accounted for in developing the rates for FY26.

While unfortunate, this loss does not indicate long-term challenges to the financial stability or performance of the Partnership Plan. Moreover, higher than projected claims costs were an issue faced by many health plans across the state and nation. Across public-sector health plans, market dynamics continue to be shaped by rising medical and pharmacy costs, increasing utilization of acute and outpatient services, and sustained pressure from specialty drug spending. Plans are experiencing elevated inpatient hospital utilization and costs, driven by case mix severity and inflationary pressures on hospital labor. Outpatient surgery volumes continue to grow as services shift from hospital-based to ambulatory settings, though unit cost inflation persists. Additionally, professional services—including Evaluation and Management (E&M)—are trending upward due to increased care complexity.

In the short-term, the Comptroller's Office will take steps within its existing authority to strengthen the plan and will continue to monitor the cost variation between the plans. Should cost differentials prove persistent overtime, with the Partnership Plan consistently more costly than the State Plan, the Comptroller's Office will require additional flexibility in order to avoid long-term financial losses in the Partnership Plan.

Any changes to the premium calculation for Partnership would require a statutory change. The current statute requires premiums to "be the same as those paid by the state inclusive of any premiums paid by state employees" with allowable adjustments for regional cost differentials or differences in covered benefits. The current law provides no allowance to adjust the Partnership Plan's premium due to differences in the underlying claims costs of the Partnership Plan relative to the State Plan, thus a consistent cost differential will result in an imbalance between Partnership premiums and plan costs.

The existing premium development requirements have certain benefits and are not unique to Connecticut. Many other states, including New Jersey, Massachusetts and Vermont, allow non-state public employers to buy into their state employee health care plan, and many offer a single combined premium, just like the state of Connecticut. The current design for premium calculations has real and meaningful benefits. First, it creates a simple premium that prospective groups and unions can use to assess the potential financial benefit of joining the plan. Second, it provides increased year to year stability for Partnership groups as premiums are based on a 220,000-member group, which in general will have more moderate year to year premium fluctuations than a single small or medium sized group. Third, the plan provides predictable annual premium costs as the premium is fixed for the year, making annual health care budgeting predictable for participating groups.

Any modifications to the premium calculation in the future should retain, as best as possible, the benefits of the current process. Potential options that could address long-term imbalances between claims costs and premiums for the Partnership Plan include:

1. Creating a limited number of additional premium tiers. For example, a high, medium and low premium tier. Groups would pay the premium amount that corresponds with their historic claims costs. Higher cost groups would pay higher rates than the State Plan, while lower cost groups would pay less. This type of structure should use multiple years of experience to place groups in each tier and limit the overall premium differential between each tier. Creating premium tiers would allow the Partnership Plan to better attract and retain lower risk groups because they would get a relatively lower premium rate than available today. In addition, it would allow the Partnership Plan to collect more in premiums when the membership, on average, is more costly than the State Plan. This is because a higher percentage of the participating groups would fall into the higher cost premium tier, increasing the premium amount collected and keeping premiums in line with total projected claims costs.

2. Allowing the Comptroller to set independent reserve fund adjustments for the Partnership and State Plans. A reserve fund adjustment is an adjustment to the premium calculation to account for the current reserve fund balance of a health plan. If the reserve fund has more funds than necessary to cover claims runout (claims incurred but not yet paid) and reasonable claims fluctuations, then the reserve fund adjustment will result in a reduction in the premium. Alternatively, if the reserve fund is too low, then the adjustment will result in an increase in the premium. Currently, the Partnership Plan premiums are calculated using the combined reserve fund balance of the State Plan and Partnership Plan accounts. Should the plans continue to have divergent claims experience, with the State Plan less costly than the Partnership Plan, then the combined adjustment will result in a persistent and growing surplus in the State Plan reserve fund and a consistently growing deficit in the Partnership Plan reserve fund. Allowing the Comptroller to make independent reserve fund adjustments for each plan would avoid this issue, as any annual losses in the Partnership Plan would be accounted for in the following year's premium through the reserve fund adjustment. This would prevent continuous and growing deficits in the Partnership Plan account regardless of differentials in the claims experience between the Partnership Plan and the State Plan.

Both above options retain the core elements of the current Partnership Plan—predictable annual premiums, stable year to year premium fluctuations and simple pooled premium rates. Should the Partnership Plan continue to see higher average costs than the State Plan, it will be necessary to consider plan improvements in order to avoid long-term financial losses.

In closing, the Partnership Plan remains a significant and meaningful benefit for tens of thousands of first

responders, teachers and other public servants and their families. The plan provides contractual terms and innovative programing that would not otherwise be available to individual municipalities or boards of education. Consistent with the statutory requirement in Sec. 3-123yyy, this report offers possible options to resolve financial deficits in the Partnership Plan, however the current state of the Partnership Plan does not necessitate immediate legislative action. The existing rate development structure has worked well in other states over long periods of time. Moreover, the primary driver of the financial challenges to the Partnership Plan in FY25 was the instability of health care costs. The Comptroller's Office will continue to monitor the financial performance of the Partnership Plan to determine if additional action is required to strengthen its financial stability. In the meantime, the Comptroller will continue to promote the benefits of the plan to enrolled and eligible groups to sustain and grow the Plan.

Again, the Partnership Plan remains a significant benefit to municipal and board of education employees and their dependents, including police, firefighters, teachers and other essential workers. Combined, the State Plan and Partnership Plan is the largest group plan in Connecticut and has notable market strength that results in favorable contractual terms and innovative programs for enrollees. Enrolled Partnership groups will continue to benefit from being part of that larger pool.

Experience by Group (part 1 of 2)
Medical/Pharmacy
July 01, 2024 through June 30, 2025

Group Name	Average Subscribers	Average Members	Annual Premium	Annual Medical Claims	Annual Pharmacy Claims Net of Rebates	Annual Total Claims	Loss Ratio
Ashford BOE	63	184	$1,931,489	$2,562,924	$261,600	$2,824,524	146.2%
Bethel Town	133	311	$3,797,414	$2,623,797	$505,019	$3,128,816	82.4%
Bloomfield BOE	205	491	$5,062,599	$4,065,404	$708,631	$4,774,035	94.3%
Bolton Town & BOE	140	333	$3,504,695	$3,868,553	$478,980	$4,347,533	124.0%
Branford BOE	379	889	$10,202,103	$9,177,391	$1,842,503	$11,019,894	108.0%
Branford Town	169	374	$4,606,266	$4,983,850	$1,142,403	$6,126,253	133.0%
Bridgeport BOE	2,390	4,578	$63,257,890	$60,555,403	$11,791,606	$72,347,009	114.4%
Bridgeport City	1,448	2,919	$40,085,893	$32,214,102	$6,087,471	$38,301,573	95.5%
Brookfield BOE	315	840	$9,194,249	$8,191,041	$1,238,800	$9,429,841	102.6%
Brookfield Town	115	281	$3,342,511	$2,533,500	$454,165	$2,987,665	89.4%
Canterbury Public Schools	66	145	$1,591,248	$1,743,352	$201,242	$1,944,594	122.2%
Clinton Public Schools	229	642	$6,715,095	$6,669,431	$1,143,083	$7,812,514	116.3%
Clinton Town	55	126	$1,452,682	$1,594,235	$254,988	$1,849,223	127.3%
Columbia Town & BOE	84	200	$1,954,830	$1,443,570	$232,234	$1,675,804	85.7%
East Hampton Town	68	168	$1,864,677	$1,117,187	$276,998	$1,394,185	74.8%
East Lyme Town & BOE	484	1,184	$9,913,694	$11,835,467	$1,942,086	$13,777,553	139.0%
Easton Windsor BOE	177	415	$4,338,801	$2,520,196	$619,288	$3,139,484	72.4%
East Windsor Town	68	170	$1,829,206	$2,434,211	$1,404,884	$3,839,095	209.9%
Easton Town	53	123	$1,517,885	$1,082,546	$190,395	$1,272,941	83.9%
Fairfield PS	1,318	3,567	$39,899,156	$34,042,564	$6,977,485	$41,020,049	102.8%
Greater Bridgeport Transit (GBTD)	135	242	$3,193,947	$2,570,731	$403,627	$2,974,358	93.1%
Greater New Haven Transit	86	166	$2,084,802	$1,019,487	$253,623	$1,273,110	61.1%
Greenwich Town & BOE	2,135	5,315	$62,674,400	$57,986,569	$9,872,654	$67,859,223	108.3%
Housatonic Area Transit Auth	59	102	$1,335,252	$919,161	$223,756	$1,142,917	85.6%
Middletown BOE	505	1,201	$12,969,238	$8,375,099	$1,528,658	$9,903,757	76.4%
Monroe BOE	392	1,059	$11,965,079	$8,399,039	$1,876,605	$10,275,644	85.9%
Monroe Town	109	258	$2,958,130	$1,980,139	$770,130	$2,750,269	93.0%
New Haven Housing Authority	104	236	$2,806,792	$4,618,173	$372,562	$4,990,735	177.8%
New London Public Schools	382	806	$9,842,977	$8,223,329	$1,515,489	$9,738,818	98.9%
New Milford Town & BOE	582	1,417	$10,457,172	$14,079,060	$2,365,896	$16,444,956	157.3%
North Branford BOE	176	422	$4,866,190	$4,103,025	$629,180	$4,732,205	97.2%
Norwalk City	833	2,015	$24,990,467	$19,966,202	$3,298,890	$23,265,092	93.1%
Norwalk Public Schools	504	1,052	$13,338,626	$12,905,355	$1,955,227	$14,860,582	111.4%

Experience by Group (part 2 of 2)
Medical/Pharmacy
July 01, 2024 through June 30, 2025

Group Name	Average Subscribers	Average Members	Annual Premium	Annual Medical Claims	Annual Pharmacy Claims Net of Rebates	Annual Total Claims	Loss Ratio
Norwalk Transit District	70	167	$2,077,943	$3,271,338	$510,603	$3,781,941	182.0%
Park City Communities / Bridgeport HA	113	204	$2,785,889	$2,280,210	$507,734	$2,787,944	100.1%
Plainville BOE	331	827	$8,409,705	$8,860,136	$1,226,570	$10,086,706	119.9%
Plainville Town	105	253	$2,607,896	$1,825,965	$365,715	$2,191,680	84.0%
Region One BOE	133	334	$3,457,982	$2,567,370	$536,998	$3,104,368	89.8%
Region School District #13	239	628	$6,770,153	$5,863,742	$1,478,105	$7,341,847	108.4%
Rocky Hill Public Schools	298	755	$7,730,226	$4,751,456	$1,882,709	$6,634,165	85.8%
Rocky Hill Town/AFSCME	139	363	$3,671,773	$2,642,454	$542,008	$3,184,462	86.7%
Somers BOE	177	435	$4,471,120	$2,946,958	$1,031,045	$3,978,003	89.0%
Southeast Area Transit (SEAT)* (effective 9/1/2024)	61	107	$1,339,837	$770,560	$296,064	$1,066,624	79.6%
Stafford Town	53	141	$1,317,374	$938,993	$86,064	$1,025,057	77.8%
Stamford City	1,506	3,620	$44,544,358	$43,342,317	$8,048,688	$51,391,005	115.4%
Stamford Public Schools	1,735	4,043	$47,915,554	$46,052,852	$7,991,323	$54,044,175	112.8%
Thompson BOE	123	276	$3,132,776	$1,596,604	$567,670	$2,164,274	69.1%
Town of Ellington	64	164	$1,650,451	$1,295,797	$281,784	$1,577,581	95.6%
Trumbull BOE	782	2,139	$23,982,311	$18,582,258	$5,567,672	$24,149,930	100.7%
Trumbull Town	256	647	$7,654,159	$5,412,817	$1,666,836	$7,079,653	92.5%
Watertown BOE* (effective April 1, 2025)	93	232	$2,495,988	$1,148,993	$342,457	$1,491,450	59.8%
Watertown Town* (effective April 1, 2025)	34	78	$916,389	$567,132	$110,486	$677,618	73.9%
West Hartford BOE	1,336	3,505	$35,596,892	$30,057,272	$5,162,999	$35,220,271	98.9%
West Hartford Town	326	869	$8,804,163	$6,427,297	$1,473,288	$7,900,585	89.7%
West Haven BOE	636	1,396	$16,325,312	$11,241,431	$2,317,282	$13,558,713	83.1%
West Haven City	304	693	$8,262,796	$8,406,176	$1,644,954	$10,051,130	121.6%
Westport BOE	789	2,102	$23,483,876	$18,034,484	$3,964,019	$21,998,503	93.7%
Wilton Town	125	320	$3,760,426	$5,050,534	$598,160	$5,648,694	150.2%
Woodstock BOE	97	224	$2,518,611	$1,772,292	$179,463	$1,951,755	77.5%
Small Groups Combined (<50 Subscribers)	1,649	3,623	$50,804,351	$36,311,459	$6,523,731	$42,835,190	84.3%
Terminated Groups (Runout Experience)	95	208	$797,252	$857,578	$389,790	$1,247,368	N/A
Total	25,632	60,584	$706,831,018	$613,280,568	$118,114,375	$731,394,943	103.5%

*Group was in effect for less than 12 months during plan year. Average subscribers and average members reflect total for the year divided by 12 months resulting in counts that are lower than actual monthly enrollment.

Experience by Group (part 2 of 2)
Medical/Pharmacy
July 01, 2024 through June 30, 2025

Data Sources

1. Segal's SHAPE Claims Database from Anthem and CVS: Subscribers, Members, Medical Claims and Pharmacy Claims on paid basis.
2. Anthem medical claims include Rx rebates for drugs that run through the medical plan.
3. CVS pharmacy claims reflect Point of Sale Rebates and savings from the PrudentRx program.
4. Premium: Anthem billed premium
5. This report is subject to change in the future as enrollment and claims are restated with the State's data aggregator.

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Memorandum

To: State of Connecticut - Office of the State Comptroller (OSC)

From: Mark Noonan, ASA, MAAA

Date: December 5, 2025

Re: Actuarial Certification

Segal has been retained to provide FY 2025 loss ratios on behalf of the State of Connecticut for the Partnership 2.0 plan. The calculations in this report were completed in accordance with generally accepted actuarial principles and practices, consistently applied, based on the data described in this report.

Loss ratios reflect actual premiums, medical claims and pharmacy claims net of rebates provided to Segal paid through June 30, 2025. Segal has not audited the information provided. Costs also include adjustments for pharmacy rebates for drugs that run through the medical plan and savings from the PrudentRx program.

This report has been prepared for the exclusive use and benefit of the State of Connecticut, based upon information provided by you and your other service providers or otherwise made available to Segal at the time this report was created. Segal makes no representation or warranty as to the accuracy of any forward-looking statements and does not guarantee any particular outcome or result. Except as may be required by law, this document should not be shared, copied or quoted, in whole or in part, without the consent of Segal. This document does not constitute legal, tax or investment advice or create or imply a fiduciary relationship. You are encouraged to discuss any issues raised with your legal, tax and other advisors before taking, or refraining from taking, any action.

I am an Associate of the Society of Actuaries and member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion herein.

Mark J. Noonan, ASA, MAAA
Vice President and Consulting Actuary