

The Connecticut Health Insurance Exchange dba Access Health CT

Early Childhood Educator Healthcare Subsidy Program Study

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Introduction

Section 15 of Public Act 25-93 requires the Connecticut Health Insurance Exchange d/b/a Access Health CT (AHCT) to study the need for, and then establish, a health insurance subsidy program for the fiscal year ending June 30, 2027 (FY27) for qualifying employees of early care and education (ECE) programs. ECE programs are licensed by the Office of Early Childhood (OEC), and include licensed child care centers, group child care homes, and family child care homes.

AHCT retained Wakely Consulting Group, LLC (“Wakely”), to model and estimate the cost of Early Care and Education healthcare subsidy program. In Phase 1 of this study, we analyzed results from the OEC survey to assess the current healthcare coverage, affordability challenges, and unmet needs of the ECE workforce.

This report presents the findings from Phase 2 of the study, which builds on the Phase 1 results by evaluating potential health insurance subsidy options for the ECE workforce. Phase 2 quantifies participation assumptions, estimates funding levels under the proposed subsidy strategies, and assesses the fiscal implications of each approach.

This document has been prepared for the use of AHCT and the Work Group for their discussions on early care and education employee health benefit subsidy program. Wakely does not intend to benefit third parties and assumes no duty or liability to those third parties. Any third parties receiving this work should consult their own experts in interpreting the results. This report, when distributed, must be provided in its entirety and include caveats. This document contains the results, data, assumptions, and methods used in our analyses and satisfies the Actuarial Standard of Practice (ASOP) 41 reporting requirements. Use of the information in this report for other purposes may not be appropriate.

Executive Summary

ECE employees face persistent challenges in accessing affordable health insurance due to modest incomes, high premiums, and significant out-of-pocket costs. Many employees experience coverage instability, and financial pressures often limit their ability to maintain continuous insurance. This report provides an overview of the insured and economic status of the ECE workforce and evaluates potential strategies to improve affordability.

Initial discussions considered several approaches to provide financial support for health coverage, including Health Savings Account (HSA) contributions to offset high deductibles, premium assistance for non-HSA health plans, and employer-based Health Reimbursement Arrangements (HRAs) such as Individual Coverage HRA (ICHRA) or Qualified Small Employer HRA (QSEHRA). These approaches were evaluated for their potential to improve affordability for employees enrolled in employer-sponsored coverage as well as those purchasing coverage through the Access Health CT (AHCT) Individual Marketplace. Please refer to the Glossary for definitions of these terms.

Through ongoing discussions, the Work Group expressed growing interest in exploring an alternative approach suggested by Wakely in which subsidies would be based primarily on income rather than plan type. An income-based subsidy framework could simplify program design and reduce the complexity and unpredictability associated with subsidies tied to specific plan designs (such as HSA-eligible versus non-HSA plans). Such a structure may also improve equity by aligning assistance more directly with employees' financial need.

The Work Group also discussed the potential for a hybrid model that applies different mechanisms depending on the source of coverage. For example, employees enrolled in employer-sponsored plans could receive support through employer-facilitated arrangements, while those purchasing coverage in the individual market could receive assistance structured to complement existing federal and state marketplace subsidies.

A key consideration in program design is administrative complexity and the associated cost of implementation. Programs that require detailed eligibility verification, such as income verification or plan-specific subsidy rules, may require third-party vendors and ongoing administrative oversight. These administrative costs can significantly reduce the amount of funding that ultimately reaches ECE workers.

Given these considerations, an additional option is a further simplified approach that minimizes administrative burden by eliminating income verification altogether. Under this model, eligible ECE employees would receive a uniform, flat-dollar subsidy regardless of income level or plan type. While such an approach may be less precisely targeted, it could substantially reduce administrative costs, improve program transparency, and allow a greater portion of available funding to flow directly to workers. The potential solutions under discussion are summarized below:

Solutions	Target Population	Approach
Plan-based subsidy	Employees with HSA-compliant health plans	Provide subsidies as HSA contributions to offset high deductibles for HSA-qualified plans.
Plan-based subsidy	Employees with Non-HSA health plans	Provide premium assistance for non-HSA plans; subsidies are paid directly to the carrier (or employer on behalf of the enrollee) and not issued as cash to individuals.
ICHRA (Individual Coverage HRA)	Employees enrolled in employer-sponsored coverage	Use Access Health CT's BusinessPlus platform to support adoption and administration of ICHRA.
Income-based subsidy	All eligible ECE workers	Provide income-tiered subsidies, with higher support for lower-income employees.
Universal subsidy	All eligible ECE workers	Provide a flat-dollar subsidy regardless of income level or plan type.

A further implementation consideration relates to timing: The statute states that the healthcare subsidy be structured on a fiscal year basis, while Marketplace coverage operates on a calendar year (January–December) plan cycle. This misalignment may introduce nuances such as partial-year coordination, administrative complexity, and impacts on enrollment and subsidy application. The Advisory Board may wish to consider whether aligning the subsidy start date with the January Marketplace plan year could simplify administration and improve the overall member experience.

This report outlines the methodologies and assumptions used to evaluate each approach, presents assessments of potential benefits and drawbacks, and highlights strategic considerations to guide policy design. By providing this structured analysis, the report aims to inform thoughtful decision-making and support the development of solutions that are both equitable and sustainable for Connecticut's ECE workforce.

Methodology and Data Limitations

Available data on the health coverage status and benefit design of early childhood educators is limited. The OEC conducted two surveys to gather information: one targeting individual employees and another directed at employers with more than 50 employees. The individual employee survey received approximately 2,100 responses across child care centers and family child care homes, while the employer survey yielded only seven responses.

The survey data, particularly regarding detailed plan benefits, contains credibility concerns. Many respondents were unable to accurately report key benefit parameters (e.g. cost-sharing structures such as deductibles, maximum out of pocket amounts, etc.), likely due to limited familiarity with their coverage. In addition, the small number of employer responses limits the representativeness and reliability of employer-sponsored insurance information.

Given these limitations, the survey results were not considered sufficiently credible to support actuarial estimates. Wakely therefore supplemented the survey findings with publicly available information and relevant industry benchmarks to develop reasonable assumptions for this analysis.

To account for the significant uncertainty inherent in the available data, we developed baseline, low, and high scenarios reflecting a range of plausible enrollment, coverage, and cost assumptions. This scenario-based approach provides a reasonable range of potential outcomes rather than a single point estimate. The scenario framework is intended to inform policymakers of the range of possible state funding needs under varying assumptions.

ECE Workforce Insurance and Economic Status

Section 1. Insurance Status

1.1 SIZE OF CURRENT INSURED WORKFORCE

The OEC estimates that there are approximately 31,000 licensed ECE employees statewide. Based on survey responses, 68% of ECE workforce are employed in child care centers and 32% work in home-based (family child care) settings.

Survey results indicate that roughly 73% of the workforce report having some form of health insurance coverage, implying that approximately 27% are uninsured. However, due to the relatively small survey sample and potential non-representativeness of the broader statewide workforce, these survey results were not considered fully reliable on their own. To strengthen the analysis, we supplemented the survey findings with national publications and additional research on coverage rates among the ECE workforce and insurance coverage by income level.

For the purposes of this study, we assume that 18% of the ECE workforce is uninsured, a figure the Work Group considered reasonable based on findings from the Phase 1 study. Based on an estimated total workforce of 31,000 employees, the resulting numbers of insured and uninsured employees are shown below.

Table 1: Current Distribution of Insured and Uninsured ECE Workforce

Insurance Status	Distribution	Total Workforce
Insured ECE Employees	82%	25,400
Uninsured ECE Employees	18%	5,600
Total	100%	31,000

1.2 SOURCES OF INSURANCE

The distribution of coverage sources as a percentage of the total ECE workforce, along with the uninsured rate, is shown below.

Table 2: Current Distribution of Insured and Uninsured ECE Workforce

Source of Coverage	Distribution**	Employee Count
Through My Employer	20%	6,201
Through AHCT Individual Marketplace	17%	5,165
Through Spouse/Partner's or Other* Plans	28%	8,824
Through Medicaid or Husky Health	15%	4,566
Medicare	2%	664
Uninsured	18%	5,580
Grand Total	100%	31,000

* "Other" source of coverage include parent's plan, COBRA, from another job, Tricare, and unspecified sources.

** Percentages are based on the entire ECE workforce.

1.3. PROJECTED SUBSIDY-ELIGIBLE WORKFORCE

For the purposes of this report, because the proposed state subsidies are expected to primarily affect ECE employees obtaining coverage through ECE employers and the AHCT Individual Marketplace, we estimated the number of employees insured through these two sources. We assumed that implementation of the subsidy program would increase the insured share in employer-sponsored plans and the AHCT Individual Marketplace by approximately 5 percentage points, reflecting both take-up among currently uninsured employees and potential shifts from spouse- or partner-based coverage to ECE employer-sponsored coverage.

Given the uncertainty in consumer behavior and potential plan migration as a result of the implementation of this subsidy, a sensitivity analysis will be needed to examine the effects of different take-up rates. This analysis can be conducted once subsidy program parameters are finalized in the subsequent phase of the study. In the current report, to account for uncertainty in these assumptions and potential variability in the survey data, we evaluated low- and high-range scenarios using a ± 3 percentage-point sensitivity around the assumed insured rates.

According to the 2026 enrollment figures announced by Access Health CT on February 19, 2026, a total of 157,246 individuals enrolled in a Qualified Health Plan (QHP) during the 2026 Open Enrollment Period. Of these, 51,629 residents were enrolled in the Covered CT program, which is available to individuals with household income at or below 175% of the Federal Poverty Level (FPL). This indicates that approximately one-third of Individual Market enrollees are insured under Covered CT.

<https://agency.accesshealthct.com/access-health-ct-enrolls-record-number-of-connecticut-residents-in-health-insurance-for-2026>

Because Covered CT enrollees pay zero premium and have no cost sharing, they are excluded from the population that would benefit from the proposed state subsidy. The table below summarizes the key assumptions and the projected number of insured ECE employees who would potentially benefit from the subsidy. Projections are developed separately for employer plan enrollees and individual Marketplace enrollees.

Table 3: Projected Insured ECE Workforce

Projected Employees with Employer's Plan	Low	Baseline	High
% of ECE Workforce in Employer's Plan*	22%	25%	28%
Projected ECE Employees Potentially Benefit from Subsidy**	6,800	7,800	8,700

Projected Employees with Individual Marketplace Plan	Low	Baseline	High
% of ECE Workforce with Individual Marketplace Plan*	19%	22%	25%
% of Enrollees in Individual Marketplace Not Having Covered CT	67%	67%	67%
Projected ECE Employees Potentially Benefit from Subsidy**	4,000	4,600	5,200

Total Projected Insured Employees Benefit from the Subsidy	10,800	12,400	13,900
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* Percentages reflect the share of total ECE workforce.

** Estimated employee counts rounded to the nearest hundred.

Section 2. Economic Status of ECE Workforce

2.1 2026 FEDERAL POVERTY LEVEL

For context, the 2026 Federal Poverty Level (FPL) guidelines for households of one through four persons are provided below, along with corresponding income thresholds at selected percentages of FPL. These reference points will be used in later comparisons to evaluate how estimated ECE employee wages and household incomes align with FPL-based eligibility thresholds.

The 2026 FPL guidelines will be used to determine ACA subsidy eligibility for 2027; accordingly, we propose using the same thresholds for the ECE subsidy framework to ensure consistency and administrative alignment.

Table 4: 2026 Federal Poverty Level and Income Threshold

Family Type	100% FPL	150% FPL	175% FPL	200% FPL	250% FPL	300% FPL	400% FPL
1 person	\$15,960	\$23,940	\$27,930	\$31,920	\$39,900	\$47,880	\$63,840
2 people	\$21,640	\$32,460	\$37,870	\$43,280	\$54,100	\$64,920	\$86,560
3 people	\$27,320	\$40,980	\$47,810	\$54,640	\$68,300	\$81,960	\$109,280
4 people	\$33,000	\$49,500	\$57,750	\$66,000	\$82,500	\$99,000	\$132,000

2.2 ESTIMATED ECE EMPLOYEE WAGES

Because wage information was not collected in the OEC survey, we relied on nationally published data sources to develop wage estimates for ECE employees. These sources provide benchmarks for affordability analysis. The key publications used and their reported wage estimates are summarized below.

- Center for the Study of Child Care Employment (CSCCE)*
Early Childhood Workforce Index 2024
<https://cscce.berkeley.edu/workforce-index-2024/>
 CSCCE reported Nationally, early educators earned a median wage of \$13.07 per hour in 2022. Wages vary substantially across states, ranging from \$10.60 to \$18.23 per hour, reflecting differences in cost of living and labor market conditions. Connecticut ranks above the national average, with an estimated median hourly wage of \$15.01 in 2022.
- Connecticut Department of Labor*
<https://www1.ctdol.state.ct.us/lmi/wages/20231/0901000009/39-9011.htm>
 Connecticut Department of Labor reported the median hourly wage of child care workers was \$15.34 in 2022.
- U.S. Bureau of Labor Statistics (BLS)*
Occupational Outlook Handbook (2024)
<https://www.bls.gov/ooh/personal-care-and-service/childcare-workers.htm>
 According to US Bureau of Labor Statistics, 2024 median pay for child care workers is \$15.41 per hours, \$32,050 per year. The lowest 10 percent earned less than \$11.01, and the highest 10 percent earned more than \$21.42.

To estimate the 2026 median hourly wage for ECE employees in Connecticut, we began with the median wage reported by the Connecticut Department of Labor, as this reflects state-specific wage levels. We then projected the wage trend from 2023 to 2026 using

the same growth rate as the Connecticut minimum wage over this period, which increased by 12.9%. This growth rate was applied to the 2023 median wage to derive the 2026 median wage for ECE employees. Based on this method, the estimated 2026 median hourly wage is \$17.30 (rounded to the nearest dime).

Table 5: Connecticut Minimum Wage and Trend

Year	Hourly Wage	Annual Wage Trend
2023	\$15.00	
2024	\$15.69	4.6%
2025	\$16.35	4.2%
2026	\$16.94	3.6%

Table 6: ECE Worker Average Hourly Wage Estimate

Year	Median Hourly Wage	Source
2023	\$15.34	<i>Connecticut Department of Labor</i>
<i>Wage Trend from 2023 to 2026</i>	<i>12.9%</i>	<i>Connecticut Minimum Wage Trend</i>
2026*	\$17.30	

* Rounded to the nearest dime.

To account for uncertainty in wage growth and underlying data, we developed a range around the baseline estimate, using the Connecticut minimum wage as the lower bound and a +5% adjustment as the upper bound. Under this approach, the estimated 2026 median hourly wage for ECE employees in Connecticut ranges from approximately \$16.94 to \$18.20 per hour. Assuming standard full-time employment of 2,080 hours per year (40 hours per week for 52 weeks), this corresponds to an estimated median annual wage of approximately \$35,000 to \$38,000.

Table 7: ECE Worker Average Income Estimate Scenarios

	Low	Baseline	High
Median Hourly Wage*	\$16.94	\$17.30	\$18.20
Median Annual Income**	\$35,000	\$36,000	\$38,000
% of FPL	219%	226%	238%

* Rounded to the nearest dime.

** Rounded to the nearest thousand.

The median wage represents the point at which half of employees earn below and half earn above. According to the 2026 Salary Guide from Salary.com, annual salaries for child care workers in Connecticut vary widely, ranging from \$30,085 to \$40,763. Most professionals earn between the 25th percentile (\$32,435) and 75th percentile (\$38,024).

Although these figures may not exactly reflect the earnings of early childhood educators specifically, they are directionally consistent with our estimated wage range.

Estimates of median hourly wages by coverage cohort: employees enrolled in employer-sponsored plans versus those covered through the Individual Marketplace - are not available from published sources. However, survey results indicate that employees with employer-sponsored coverage, who are predominantly employed in child care centers, tend to have higher wages than home-based providers.

2.3 ESTIMATED ECE HOUSEHOLD INCOME

The ECE survey collected information on household income ranges and coverage type (single, dual, and family). We analyzed two distinct cohorts: employees enrolled in coverage through an ECE employer and those obtaining coverage through the individual Marketplace. Covered CT enrollees are included in the Marketplace cohort, as they cannot be separately identified in the survey data.

These cohorts show meaningful differences in both income distribution and coverage mix. Employees enrolled in employer-sponsored plans - primarily child care center employees, are more concentrated in single coverage and tend to have higher household incomes. In contrast, ECE employees purchasing coverage through the individual Marketplace (including both center-based employees and home-based providers) are more concentrated in lower income ranges and are more likely to enroll in dual or family coverage compared to those covered through employer plans.

Very few national publications report median household income specifically for early care and education workforce. Recent analyses, such as the *Early Childhood Workforce Index 2024* (based on American Community Survey data), highlight the economic insecurity of early educators through elevated reliance on public assistance programs, which is strongly associated with lower household income levels. The Iowa Association for the Education of Young Children (Iowa AEYC) sponsored a statewide early childhood workforce study in 2023. The study shows 53% of employees live in households with incomes below \$50,000, putting them below the federal poverty threshold for a household of three. Over 80% of unmarried providers have a household income of less than \$50,000. 40% of employees rely on at least one public benefit.

<https://i2d2.iastate.edu/wp-content/uploads/2023/03/IWS-Preliminary-Findings-Data-Brief-230223-pdf>

Based on the survey results, supplemented by relevant national and state-level publications, we developed baseline estimates using the observed income distribution and the midpoint of each reported income range. Sensitivity scenarios were constructed to reflect uncertainty around these estimates, with Low and High scenarios defined as 5% below and 5% above the Baseline, respectively. Average household income was estimated separately for employees enrolled in ECE employer-sponsored coverage and for those covered through the Individual Marketplace, with results rounded to the nearest thousand. Detailed results are presented below.

**Table 8: Household Income Range
Employees Having Coverage Through ECE Employer Plan**

Household Income Range	Single	Dual	Family	Total
Less than \$40,000	19%	7%	4%	15%
\$40,000–\$59,999	27%	11%	11%	22%
\$60,000–\$79,999	21%	43%	13%	21%
\$80,000–\$99,999	17%	18%	22%	18%
\$100,000+	16%	21%	51%	23%
Grand Total	100%	100%	100%	100%

Distribution by Coverage Type	72%	7%	21%	100%
Baseline Number of Employees	5,600	580	1,630	7,800

Annual Household Income Scenarios	Single	Dual	Family	Total
Average Household Income - Low	\$64,000	\$75,000	\$90,000	\$70,000
Average Household Income - Baseline	\$67,000	\$79,000	\$95,000	\$74,000
Average Household Income - High	\$70,000	\$83,000	\$100,000	\$78,000

Household Income % of FPL	Single	Dual	Family*
Average Household Income - Low	401%	347%	329%
Average Household Income - Baseline	420%	365%	348%
Average Household Income - High	439%	384%	366%

* Assuming family of three.

**Table 9: Household Income Range
Employees Having Coverage Through Individual Marketplace**

Household Income Range	Single	Dual	Family	Total
Less than \$40,000	42%	10%	19%	30%
\$40,000–\$59,999	36%	6%	21%	27%
\$60,000–\$79,999	10%	49%	15%	17%
\$80,000–\$99,999	10%	27%	19%	15%
\$100,000+	3%	8%	26%	10%
Grand Total	100%	100%	100%	100%

Distribution by Coverage Type	56%	16%	28%	100%
Baseline Number of Employees	2,590	710	1,300	4,600

Annual Household Income Scenarios	Single	Dual	Family	Total
Average Household Income - Low	\$43,000	\$69,000	\$69,000	\$54,000
Average Household Income - Baseline	\$45,000	\$73,000	\$73,000	\$57,000
Average Household Income - High	\$47,000	\$77,000	\$77,000	\$60,000

Household Income % of FPL	Single	Dual	Family*
Average Household Income - Low	269%	319%	253%
Average Household Income - Baseline	282%	337%	267%
Average Household Income - High	294%	356%	282%

* Assuming family of three.

Based on information published by *HometownLocator*, the median household income in Connecticut is approximately \$95,000, and the average is approximately \$138,000. The average family size in the state is three persons. Compared to these statewide benchmarks, the estimated household income levels for ECE workforce are materially lower than the Connecticut average, indicating that this workforce earns significantly below the broader state household income distribution.

<https://connecticut.hometownlocator.com/census/>

Section 3. Employee Premium Contribution

Approximately 600 survey respondents reported their share of healthcare premiums. While the sample size is limited when segmented by market type (employer-sponsored vs. individual market) and coverage tier (single, dual, family), the results still offer

meaningful directional insights into employee contributions. The tables below summarize the distribution of employee portion of premiums by coverage tier for employer-sponsored and individual marketplace plans separately.

For single coverage, 75% of employees in employer-sponsored plans pay less than \$300 per month, compared with 82% of individuals purchasing coverage in the individual market. To provide a basis for comparison, we estimated average premiums by coverage tier using the midpoint of each reported contribution range, assuming \$750 for the open-ended \$500+ category. Across all tiers, single, dual, and family, average premiums are lower in the individual market than in employer-sponsored plans, reflecting the impact of federal premium subsidies and the Covered CT program that help reduce costs for eligible enrollees.

Table 10: Employee Monthly Premium Contribution for Employer Sponsored Plan

Monthly Contribution Range	Single	Dual	Family	Total
Less than \$100	18%	0%	4%	14%
\$100–\$299	57%	28%	32%	50%
\$300–\$499	19%	34%	14%	19%
\$500+	6%	38%	50%	17%
Grand Total	100%	100%	100%	100%

Distribution by Type of Coverage	72%	8%	21%	100%
Average Employee Monthly Premium	\$215	\$464	\$481	\$289

Table 11: Employee Monthly Premium Contribution for Individual Marketplace Plan

Contribution Range	Single	Dual	Family	Total
Less than \$100 *	41%	28%	23%	33%
\$100–\$299	41%	17%	20%	31%
\$300–\$499	4%	31%	19%	12%
\$500+	15%	24%	38%	23%
Grand Total	100%	100%	100%	100%

Distribution by Type of Coverage	56%	13%	31%	100%
Average Employee Monthly Premium	\$207	\$345	\$400	\$286

* Including Covered CT enrollees.

Affordability Standard for Employer Sponsored Plans

Under the Affordable Care Act (ACA), affordability standards are commonly used to assess whether employer-sponsored coverage is affordable. For plan year 2026, coverage is generally considered affordable if the employee’s required contribution for self-only coverage does not exceed 9.96% of household income. Because employers usually don’t know their employee’s household income, the IRS allows employers to assess affordability using safe harbors based on employee wages.

For Applicable Large Employers (generally those with 50 or more full-time equivalent employees), offering unaffordable coverage may result in employer shared responsibility penalties if employees receive premium tax credits through the Individual Marketplace.

Small employers, while not subject to these penalties, may still use the same affordability threshold as a benchmark to evaluate the reasonableness of employee premium contributions. It is important to note that if an affordable offer of employer-sponsored coverage (either through a group plan or an ICHRA or QSEHRA) is made by the employer, the employee will not be eligible for federal premium subsidies through Access Health CT.

The table below illustrates the maximum affordable monthly premium based on estimated average household income levels for single, dual, and family coverage, as well as corresponding affordability thresholds calculated using median employee wages under IRS-approved safe harbor methods. Based on survey results, approximately 75% of employees with employer-sponsored coverage report paying less than \$299 per month, which aligns with the estimated safe harbor maximum of \$299. This suggests that, for most employees enrolled in employer-sponsored plans, premium contributions fall within established affordability thresholds and are generally considered affordable under ACA standards.

Table 12: Maximum Affordable Monthly Premium

Estimated Average Household Annual Income	% of Income (as of 2026)	Maximum Affordable Monthly Premium	
Single Adult	\$67,000	9.96%	\$556
Dual	\$79,000	9.96%	\$656
Family of Three	\$95,000	9.96%	\$789
Safe Harbor - Median Employee Wage	\$36,000	9.96%	\$299

State Subsidy Strategy

The Work Group is interested in assessing the feasibility of two potential approaches: a Cost-Sharing Subsidy for HSA enrollees and a Premium Subsidy for non-HSA enrollees, as well as exploring the potential role of employer-based HRAs.

To support the analysis of potential subsidy strategies and funding requirements, we evaluated two distinct coverage cohorts: employer-sponsored plans and AHCT Individual Marketplace plans. These cohorts differ meaningfully in benefit richness and premium levels, which has important implications for both affordability and the design of effective subsidy approaches.

We evaluated each potential approach in detail, considering design features, anticipated impacts on affordability, equity, and administrative feasibility, while taking into account for limitations due uncertainty. Based on this assessment, we identified strategic considerations to guide the Work Group's discussion and support well-informed decision-making regarding the most suitable subsidy options for the ECE workforce.

Solution 1. Cost Sharing Subsidy for HSA Enrollees

One solution is to structure the subsidy to offset a portion of the deductible, capped so that the combined amount of the state subsidy and any employer HSA contribution does not exceed the plan deductible.

Key Modeling Assumptions and Data Limitations

- *Wide Range of HSA Plan Deductibles.* Deductibles for HSA-qualified plans vary substantially, ranging from \$1,750 to over \$10,000. If the subsidy is calculated as a percentage of the deductible, it should include a maximum cap to prevent disproportionately large subsidies for enrollees with very high deductibles.
- *Subsidy Based on Single-Coverage Deductible.* For modeling purposes, we assume the subsidy is determined using the single-coverage deductible amount.
- *Limited Data on Employer HSA Contributions.* Information on employer HSA contributions is very limited and not captured in the survey data. As a result, we are unable to estimate the extent to which employer contributions may already offset a portion of the deductible, potentially reducing the amount of state subsidy

needed. This interaction is not reflected in the illustrative estimates presented in this report; consequently, actual funding requirements may be slightly lower than the amounts shown.

Program Highlights:

- ECE employees who enroll in an HSA plan receive direct state contributions to their HSAs, significantly reducing annual deductible cost.
- Employees can make additional tax-free HSA contributions, and lower taxable income while building savings for healthcare expenses.
- HSA funds roll over year to year, enabling long-term accumulation for future medical needs.

By combining state contributions, tax advantages, and rollover savings, this solution improves affordability, helps manage out-of-pocket costs, and strengthens the financial security of ECE employees' healthcare coverage.

For purposes of projecting the funding level, we estimated HSA plan enrollment and the average HSA deductible. The underlying assumptions and methodology are detailed in the sections that follow.

1. HSA PLAN ENROLLMENT

The prevalence of Health Savings Accounts differs between employer-sponsored and individual marketplace plans. According to the ECE worker survey, 26% of employees with employer-sponsored coverage have an HSA, compared with just 6% of individuals purchasing coverage in the individual marketplace. Nationwide research shows similar patterns.

According to the U.S. Bureau of Labor Statistics, the availability of high-deductible health plans (HDHPs) and Health Savings Accounts (HSAs) varies significantly by wage group, with lower-wage workers having less access. For example, in 2024, the first and second quartile wage group had an average HSA availability of 20% to 36%, closely aligning with the survey findings. The table below provides a detailed breakdown by wage group.

In "Expansion of HSA Eligibility Under OBBB Act to Improve Marketplace Coverage, Affordability, and Access," published by the White House in September 2025, only 2% of HealthCare.gov Marketplace enrollees selected HSA-eligible plans. While this is even

lower than the survey results for individual marketplace coverage, it is directionally consistent with the observed trends

<https://www.bls.gov/ebs/factsheets/high-deductible-health-plans-and-health-savings-accounts.htm>

Effective January 1, 2026, the OBBB Act reclassifies Bronze and Catastrophic Individual Market plans as HSA-eligible, substantially expanding HSA access in AHCT Individual Marketplace. Based on insurance carriers' 2026 projections, enrollment in HSA-eligible plans is expected to increase from approximately 9% under current eligibility rules to about 29% of total Individual Marketplace enrollment.

While this change creates significant potential for increased HSA participation, not all enrollees in HSA-qualified plans are expected to open an HSA. In addition, plan migration may occur depending on the design and incentives of the proposed subsidy. As a result, the actual percentage of enrollees with HSA accounts is expected to be below 29%. This expansion does not apply to ACA Small Group plans.

<https://www.whitehouse.gov/research/2025/09/expansion-of-hsa-eligibility-under-obbb-act-to-improve-marketplace-coverage-affordability-and-access/>.

The impact of the subsidy on plan migration is uncertain, which presents challenges for enrollment projections. Using available survey results and national benchmarks as reference points, we developed low- and high-range scenarios to account for this uncertainty, including the potential increase in HSA enrollment associated with the 2026 expansion of HSA eligibility.

Table 13: HSA Enrollment Projection

Percentage of Employees with HSA	Low	Baseline	High
Employer Sponsored Plans	24%	26%	29%
AHCT Individual Marketplace Plans	13%	15%	18%
Number of Employees with HSA	Low	Baseline	High
Employer Sponsored Plans	1,600	2,000	2,500
AHCT Individual Marketplace Plans	500	700	900
Total HSA Employees	2,100	2,700	3,400

2. AVERAGE DEDUCTIBLE OF HSA PLANS

➤ ***Employer Sponsored Plan Deductible***

Due to the limited survey sample size and response rate, the survey results alone were not sufficient to reliably estimate average deductibles for HSA plans. We

supplemented the survey findings with additional external data sources. Specifically, we analyzed average deductibles for HSA plans using a combination of OEC survey results, Connecticut small group rate filings, and relevant public studies and surveys. Together, these sources provide a more comprehensive and credible basis for informing the subsidy analysis.

- OEC Survey results

We analyzed plan cost-sharing parameters using survey responses from individuals enrolled in employer-sponsored plans, as well as responses from seven ECE employers with more than 50 full-time (or full-time equivalent) employees. The reported cost-sharing parameters span a broad range, with deductibles for Single (employee-only) coverage ranging from approximately \$1500 to more than \$10,000.

However, we identified potential data quality concerns among the individual survey responses. Some respondents may have entered incorrect deductible, copay, and maximum out-of-pocket amounts, possibly due to unfamiliarity with their plan benefits or insurance terminology.

Survey results indicate that the average deductible for single coverage under HSA-eligible plans is approximately \$3,700, with enrollment heavily concentrated in single coverage. When averaged across all coverage tiers (single, dual, and family), the estimated deductible is approximately \$4,500, rounded to the nearest hundred.

- Small Group Rate Filings

We also reviewed small group rate filings from the two major carriers - Anthem and UnitedHealthcare. Based on the projected 2026 enrollment for HSA plans, the weighted average deductible for Single coverage is around \$4800.

- Public Sources:

- 2025 Employer Health Benefits Survey
by Kaiser Family Foundation, published Oct. 22, 2025
<https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>

Based on the national 2025 Employer Health Benefits Survey, the average annual deductible for single coverage is \$2,578 for HSA-qualified HDHPs. State level data is not available.

- *U.S Bureau of Labor Statistics*
<https://www.bls.gov/ebs/factsheets/high-deductible-health-plans-and-health-savings-accounts.htm>

U.S Bureau of Labor Statistics published results of annual deductible amount for private industry workers participating in medical plans in 2024. The median deductible is \$2,750.

Based on the information from the sources above, estimated average deductibles for single coverage span a wide range, from approximately \$2,600 to \$4,800. To account for uncertainty related to survey limitations and the possibility that the available data do not fully represent the Connecticut ECE workforce, we selected \$3,700 as the baseline deductible for single coverage, with low and high scenarios defined as \$500 below and above the baseline, respectively.

➤ ***AHCT Individual Marketplace Plans Deductible***

Due to the low response rate for cost-sharing details among survey respondents with Individual Marketplace HSA plans, the reported parameters were not considered sufficiently reliable and were therefore excluded from this analysis. Instead, we relied on the 2026 Individual Marketplace rate filings to estimate average deductibles for HSA-eligible plans. Based on carriers' enrollment projections and plan-level deductibles, the estimated average deductible for HSA plans in 2026 is approximately \$6,800. To account for uncertainty in enrollment mix and plan selection, we selected \$6,000 as the baseline deductible for single coverage, with low and high scenarios defined as \$500 below and above the baseline, respectively.

The estimated average deductible ranges for employer sponsored HSA plans and AHCT Individual Marketplace HSA plans are summarized below.

Table 14: HSA Average Single Deductible

Average Single Deductible	Low	Baseline	High
Employer Sponsored Plans	\$3,200	\$3,700	\$4,200
AHCT Individual Marketplace Plans	\$5,500	\$6,000	\$6,500

3. RECOMMENDATIONS

➤ 1. Subsidy as Percent of Deductible

Based on the estimated number of employees enrolled in HSA plans and their associated deductibles, a subsidy equal to 25% of the deductible is shown below. Please note that this calculation uses average deductibles and is provided for illustration purposes only.

Table 15: Subsidy as Percentage of Deductible Illustration

Average Single Deductible	Low	Baseline	High
Employer Sponsored Plans	\$3,200	\$3,700	\$4,200
AHCT Individual Marketplace Plans	\$5,500	\$6,000	\$6,500

Subsidy Percentage of Single Deductible	25%
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Subsidy Amount Per Employee	Low	Baseline	High
Employer Sponsored Plans	\$800	\$925	\$1,050
AHCT Individual Marketplace Plans	\$1,375	\$1,500	\$1,625

Number of Employees with HSA	Low	Baseline	High
Employer Sponsored Plans	1,600	2,000	2,500
AHCT Individual Marketplace Plans	500	700	900
Total HSA Employees	2,100	2,700	3,400

Total Subsidy Amount	Low	Baseline	High
Employer Sponsored Plans	\$1,280,000	\$1,850,000	\$2,625,000
AHCT Individual Marketplace Plans	\$687,500	\$1,050,000	\$1,462,500
Total HSA Subsidy on Deductible	\$1,967,500	\$2,900,000	\$4,087,500

Pros

- Scales with plan generosity: higher deductibles receive more support
- Aligns benefit with actual cost-sharing exposure

Cons

- High administrative complexity, requires plan-specific deductible verification
- Creates uneven subsidies across employees with similar incomes
- Incentivize selection of higher-deductible plans to maximize subsidy
- Not tied to income or financial need
- Budgeting unpredictable for the state

➤ **2. Subsidy as Flat Dollar Amount**

Given the wide variation in deductibles for HSA-eligible plans, particularly with the expansion of HSA eligibility to Bronze and Catastrophic plans in the Individual Marketplace, which often have very high deductibles, a flat dollar subsidy provides a more predictable and administratively straightforward approach.

Based on the estimated number of employees enrolled in HSA plans through employer-sponsored coverage or the AHCT Individual Marketplace, an illustrative subsidy amount of \$1000 per employee per policy year is shown below:

Table 16: Subsidy as Flat Dollar Amount Illustration

Subsidy as Flat Dollar Amount	\$1,000		
Total Subsidy Amount	Low	Baseline	High
Employer Sponsored Plans	\$1,600,000	\$2,000,000	\$2,500,000
AHCT Individual Marketplace Plans	\$500,000	\$700,000	\$900,000
Total HSA Subsidy on Deductible	\$2,100,000	\$2,700,000	\$3,400,000

Pros

- Simple to administer and explain
- Promotes equity across employees, regardless of plan design
- Avoids incentivizing higher deductibles
- Enables predictable state budgeting
- Aligns well with HSA contributions, which are inherently dollar-based

Cons

- Does not fully offset very high deductibles
- Subsidies not based on income

Solution 2. Premium Subsidy for Non-HSA Enrollees

For employees enrolled in non-HSA plans, one potential approach is to structure the state subsidy to offset a portion of the gross premium, capped so that the combined amount of the state subsidy, any employer contributions, and available federal or other state subsidies does not exceed the plan's gross premium.

Due to lack of information, this analysis does not account for the potential reduction in the state subsidy that may occur when existing subsidies or employer contributions already cover a portion of the premium. As a result, the illustrative estimates presented here may overstate the funding required, and actual program costs could be lower than the amounts shown.

Program Highlights:

- ECE employees enrolled in non-HSA plans receive a state subsidy, applied after any other eligible state and federal subsidies, that helps cover a portion of their monthly premiums, improving affordability of coverage.
- To avoid unintended tax burdens, the subsidy is used to offset the employee's share of the premium that is deducted from the employee's paychecks. Subsidy for AHCT Individual marketplace enrollees will be directly paid to the insurance companies.

This approach helps ECE employees manage ongoing healthcare costs, supports continuous coverage, and enhances overall access to affordable health insurance.

1. EXISTING SUBSIDIES

ECE employees purchasing coverage through the Individual Marketplace currently have access to federal and state subsidies.

- Federal Subsidies: Premium Tax Credits and Cost Sharing Reduction
 - Income eligibility: 100% to 400% federal poverty level
- Covered Connecticut Program cost-sharing and premium assistance
 - Income eligibility: Below 175% of federal poverty level

Given that the average annual household income of ECE employees ranges from approximately 250% to 450% FPL, many may not qualify for existing federal or Covered Connecticut subsidies. A targeted premium subsidy for ECE employees is therefore essential to improve affordability, promote consistent enrollment in health coverage, and reduce financial barriers to accessing necessary care.

For purposes of projecting the funding level, we estimated non-HSA plan enrollment and the corresponding average premium. Non-HSA enrollment is estimated as the total projected insured employees minus the estimated HSA enrollment described in the prior section. The estimate of the average non-HSA premium is described below.

2. NON-HSA AVERAGE PREMIUMS

Because 2026 health care premium information is not available from the survey, we relied on rate filings and publicly available information to estimate average gross premiums prior to subsidies.

➤ *Employer Sponsored Non-HSA Plan Premiums*

To estimate average Small Group Fully Insured plan premiums, we reviewed the 2026 small group rate filings and calculated weighted average premiums based on carrier-projected enrollment by plan and by rating area. Because detailed information on ECE worker demographics and geographic distribution is not available, we assume the ECE population follows the same enrollment and rating-area distribution as the overall insured small-group population. The average premium for non-HSA plans is about \$1,010 per member per month, which is equivalent to about \$12,100 annually.

For other forms of employer-sponsored coverage - including large employers with fully insured or self-funded plans and small employers using alternative funding arrangements - premium information is not directly available from the survey data or rate filings. To inform our analysis, we referenced the most recent data from the State Health Access Data Assistance Center (SHADAC), which reports an average annual employer-sponsored premium of \$8,953 for single coverage in Connecticut in 2023. After accounting for continued premium growth since 2023 and recognizing that non-HSA plans generally have higher premiums than HSA-eligible plans, this benchmark implies an estimated annual premium that is broadly consistent with the premium levels observed in the small group market.

<https://statehealthcompare.shadac.org/table/34/average-annual-employer-sponsored-insurance-premium-by-plan-type#8/57,58/83/65>

Another point of reference is the 2025 Employer Health Benefits Survey conducted by the Kaiser Family Foundation (KFF). According to the survey, the average annual premium for employer-sponsored health insurance in 2025 is \$9,325 for single coverage and \$26,993 for family coverage. The KFF employer survey does not report state-specific premium estimates. However, findings from other publications indicate that health care premiums in Connecticut are generally higher than the national average, suggesting that employer-sponsored premiums in the state are likely above these national benchmarks. <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>

To reflect uncertainty in premium levels, we use the small group filing results as the baseline and apply a $\pm 5\%$ range to illustrate potential low and high average premium scenarios.

Table 17: Average Non-HSA Premium – Employer Sponsored Plans

Average Monthly Premium for Single Coverage	Low	Baseline	High
Employer Sponsored Plans	\$960	\$1,010	\$1,060

➤ **AHCT Individual Marketplace Plans Non-HSA Plan Premiums**

To estimate the average Individual Marketplace plan premium, we reviewed the 2026 Individual Market rate filings and calculated weighted average premiums based on carrier-projected enrollment by plan and rating area. Using this approach, the estimated average premium for non-HSA plans is approximately \$1,130 per member per month, or about \$13,600 annually.

To reflect uncertainty in premium levels, we use this estimate as the baseline and apply a $\pm 5\%$ range to illustrate potential low and high average premium scenarios, rounded to the nearest ten.

Table 18: Average Non-HSA Premium – AHCT Individual Marketplace

Average Monthly Premium for Single Coverage	Low	Baseline	High
AHCT Individual Marketplace Plans	\$1,070	\$1,130	\$1,190

3. RECOMMENDATIONS

For traditional non-HSA plans, the state would provide a premium subsidy to reduce the cost of health insurance coverage for eligible early childhood educators. The subsidy is

paid directly to the insurance carrier or employer on behalf of the enrollee and is not issued to the individual as cash assistance.

➤ **Subsidy as a Percent of Gross Premium for Single Coverage**

The subsidy can be structured as a percentage of the gross premium, capped at the employee’s required contribution after accounting for employer contributions and any applicable state or federal subsidies, so that the employee’s premium liability is not reduced below zero. For illustration purposes, we applied a 5% premium subsidy in the example below, though the exact percentage could be adjusted based on program goals, budget, and enrollment patterns.

Table 19: Subsidy as Percentage of Premium Illustration

Average Monthly Premium for Single Coverage	Low	Baseline	High
Employer Sponsored Plans	\$960	\$1,010	\$1,060
AHCT Individual Marketplace Plans	\$1,070	\$1,130	\$1,190
Subsidy Percentage of Premium		5%	
Annualized Subsidy Amount Per Employee	Low	Baseline	High
Employer Sponsored Plans	\$576	\$606	\$636
AHCT Individual Marketplace Plans	\$642	\$678	\$714
Projected Non-HSA Employees	Low	Baseline	High
Employer Sponsored Plans	5,200	5,800	6,200
AHCT Individual Marketplace Plans	3,500	3,900	4,300
Total Non-HSA Employees	8,700	9,700	10,500
Total Annualized Subsidy Amount	Low	Baseline	High
Employer Sponsored Plans	\$2,995,000	\$3,515,000	\$3,943,000
AHCT Individual Marketplace Plans	\$2,247,000	\$2,644,000	\$3,070,000
Total Annualized Premium Subsidy	\$5,242,000	\$6,159,000	\$7,013,000

* Annualized premium subsidies are rounded to thousand.

The total funding for non-HSA premium subsidies is potentially higher than HSA cost sharing subsidies, due to large number of employees having non-HSA plans, especially the employees having coverage through AHCT Individual Marketplace.

4. PROS AND CONS

Pros:

- Scales with plan cost: Higher-premium plans receive proportionally higher subsidies, helping employees afford more expensive coverage.
- Targets employee cost burden: The subsidy directly offsets the portion of the premium employees are responsible for, after employer or federal contributions.
- Flexible design: The percentage can be adjusted over time to meet budget or policy goals.

Cons:

- Administrative complexity: Requires ongoing calculation of each employee's premium share after accounting for employer contributions and federal/state subsidies.
- Unpredictable state costs: Total subsidy expenditures vary with premium levels and plan choices, making budgeting less certain.
- Potential inequity across employees: Employees selecting lower-cost plans receive smaller subsidies, even if their financial need is similar.
- Incentivizes higher-cost plans: Employees might choose more expensive plans to receive a larger subsidy.

Solution 3. Engage Individual Coverage HRAs (ICHRA) and Qualified Small Employer HRAs (QSEHRA)

1. OVERVIEW

An HRA (Health Reimbursement Arrangement) is an employer-funded account used to reimburse employees for qualified medical expenses including health insurance premiums. Individual Coverage HRAs (ICHRA) and Qualified Small Employer HRAs (QSEHRA) are employer-funded HRAs that allow employees to use pre-tax employer contributions to purchase individual health insurance or pay for qualified medical expenses. Both programs offer flexible alternatives to traditional group coverage, but they differ in structure and applicability.

ICHRA:

- Employers of any size can offer ICHRA to employees, with no annual cap on contributions.
- Contributions can vary by employee class (e.g., full-time, part-time, geographic location).
- Employees use the funds to purchase individual coverage, including plans on or off the ACA Marketplace.
- Can be offered alongside traditional group coverage for certain employee classes.

QSEHRA:

- Designed for small employers (fewer than 50 full-time equivalent employees).
- Annual contribution limits are capped by IRS rules (\$6,450 for single coverage and \$13,100 for family coverage in 2026).
- Employees can use contributions for premiums or other qualified medical expenses.
- Doesn't allow employers to adjust allowances by employee class.

2. FEASIBILITY FOR ECE WORKFORCE

Given the median income range of \$35,000–\$38,000 for ECE employees, both HRAs could meaningfully improve affordability.

- **ICHRA:** Offers flexibility to accommodate part-time and full-time employees. It allows state contributions to be integrated, potentially supplementing coverage costs for employees not eligible for employer-sponsored plans.
- **QSEHRA:** Provides a simpler structure for small employers, though annual contribution caps may limit its effectiveness for higher-premium plans or family coverage.

Employees are responsible for selecting and purchasing their own coverage, which may require additional support for employees unfamiliar with Individual Marketplace plans.

3. LARGE EMPLOYERS - ACA AFFORDABILITY AND PENALTIES

For large employers offering an ICHRA, plan affordability is critical:

- ACA requires that full-time employees of Applicable Large Employers (ALEs, ≥50 FTEs) have access to coverage that is affordable and provides minimum value. Affordable coverage means the employee's share of the premium for self-only coverage does not exceed 9.96% of household income in 2026 (updated annually).
- Employers must ensure that their ICHRA contributions allow employees to purchase individual coverage within ACA affordability limits, or they risk penalties. Properly designed ICHRAs provide flexibility while meeting both employee coverage needs and compliance obligations.
- Employers can mitigate risk by tailoring ICHRA contributions by employee class (e.g., full-time, part-time, geographic location) to ensure affordability for all employees.

4. SMALL EMPLOYERS

- Small employers, generally those with fewer than 50 full-time equivalent employees, are not subject to the ACA affordability requirement or employer penalties.
- Employees of small employers may be eligible for premium tax credits through the ACA Marketplace if the employer does not offer coverage or if the offered coverage is unaffordable. This creates an opportunity for employees, particularly those in lower income ranges, to access federal and state subsidies for individual-market coverage.
- Small employers can voluntarily offer a Qualified Small Employer HRA (QSEHRA) to reimburse employees for individual insurance premiums and qualifying medical expenses. QSEHRAs allow employers to provide tax-advantaged contributions without triggering ACA penalties, and can help encourage employees to take advantage of available ACA subsidies, improving overall coverage and affordability.

5. PROS AND CONS

Pros:

- Flexible contributions tailored by employee class (ICHRA).
- Portability: employees retain coverage if they change employers.
- Tax advantages: pre-tax contributions increase take-home pay.
- Can complement state and federal subsidies to improve purchasing power.
- Suitable for part-time or non-traditional workforce common in ECE sector.

Cons:

- Administrative complexity for employees selecting coverage.
- High contributions can reduce ACA premium tax credits if not coordinated.
- Large employers must ensure affordability to avoid ACA penalties.

6. AHCT ICHRA PLATFORM

Access Health CT has created a new platform, BusinessPlus, to facilitate the adoption and administration of ICHRA among employers, with a particular focus on small businesses and nonprofit organizations. This platform is designed to streamline the process for brokers and employers to offer ICHRA, lowering administrative barriers and expanding access to employer-sponsored coverage options.

A key feature of the BusinessPlus platform is its ability to guide employers and brokers in setting contribution levels by illustrating whether an employer's defined contribution would be considered "affordable" under Affordable Care Act standards. This functionality is critical, as affordability determinations directly impact an employee's eligibility for federal Advanced Premium Tax Credits (APTC). By enabling employers to better understand these thresholds, the platform creates flexibility for contribution strategies - allowing some employees, particularly in lower-wage segments, to qualify for APTC in lieu of employer support.

The platform is fully integrated with the AHCT enrollment system, allowing employees offered an ICHRA to seamlessly shop, compare, and enroll in Qualified Health Plans (QHPs) available through the AHCT marketplace.

7. SUMMARY

ICHRA and QSEHRA offer feasible pathways for the state to enhance healthcare affordability for ECE employees. Particularly, supported by Access Health CT's BusinessPlus platform, ICHRA enables employers to provide defined contributions while allowing employees to access flexible individual market coverage, including potential eligibility for federal subsidies, creating a more adaptable and sustainable model for the employer sponsored healthcare.

Access Health CT also offers small business employers the opportunity to purchase group health insurance plans through its Small Employer Health Options Program (SHOP) for their employees. An ECE Worker subsidy through small business employers could also be implemented through the Access Health CT SHOP.

Strategic Considerations

After evaluating both the HSA cost-sharing subsidy approach and the non-HSA premium subsidy approach, it becomes clear that significant data limitations and behavioral uncertainty constrain the effectiveness of either option. In particular, limited information on employer HSA contributions, wide variation in plan design, and uncertainty regarding consumer plan migration make it difficult to reliably estimate subsidy impacts or funding requirements.

Key Concerns

- **Potential for Unintended Plan Selection Incentives**

The potential impact of the proposed subsidy structure is uncertain. If the HSA subsidy is tied to deductible levels while the non-HSA subsidy is tied to premium levels, these differential incentives could lead to unintended plan migration. Individuals might be incentivized to enroll in higher-deductible plans solely to receive larger subsidies, potentially distorting plan choices in ways that do not align with their risk tolerance or health care needs.

- **Inconsistent Support for Individuals with Similar Economic Status**

Under a structure that provides cost-sharing subsidies for HSA plans and premium subsidies for non-HSA plans, individuals with similar incomes could receive

materially different subsidy amounts depending solely on plan type selection. This may create inequities and undermine the policy objective of directing assistance to low-income households.

- **Subsidy May Not Target Those Most in Need**

Subsidies linked to deductible amounts or premium levels are not necessarily aligned with an individual's financial vulnerability. As a result, higher subsidies may flow to individuals who select plans with higher cost-sharing rather than to those with the greatest economic need.

- **Administrative Complexity and Cost**

Programs that require eligibility verification, such as confirming employee income levels, verifying enrollment in specific plan types, or coordinating subsidies with existing federal and state marketplace assistance, can involve significant operational effort. These processes often require third-party administrators or specialized vendors, systems for collecting and validating documentation, ongoing compliance monitoring, and coordination among employers, employees, and state agencies. The resulting administrative expenses can be substantial and may reduce the share of available funding that ultimately reaches ECE workers.

- **Reduced Predictability in State Funding**

Because subsidy amounts depend on plan characteristics (e.g., deductible levels and premiums) and on how consumers respond to these incentives, state funding obligations may become less predictable and harder to budget accurately.

Recommended Alternative: Income-Based Subsidy Design

To promote equity, simplicity, and predictability, we recommend structuring subsidies solely on the basis of income rather than plan type (HSA vs. non-HSA), deductible level, or premium amount.

An income-based subsidy framework could:

- Apply a sliding scale from 175% up to a certain percentage of FPL eligible for subsidy
- Provide a flat-dollar subsidy amount within defined income bands.

This approach would:

- More directly target assistance to low-income families,
- Avoid unintended plan selection incentives,
- Ensure individuals with similar incomes receive comparable levels of support, and
- Improve predictability of state funding requirements.

The following section presents an illustrative example of how such a program could operate in practice. Given that income information is only available through the individual market exchange, the work group noted that an income-based subsidy structure would be operationally feasible only for individuals enrolled in on-exchange individual market coverage. The ECE subsidy applies to the enrollee portion of the premium after state and federal premium subsidies and is capped such that it cannot reduce the enrollee’s premium below zero.

The 2026 Federal Poverty Level guidelines will be used to determine eligibility for the 2027 benefit year. Table 20 provides a reference showing estimated household income levels by percentage of the Federal Poverty Level for households of one, two, and three persons.

Table 20: Household Income as % of FPL

Household Income % FPL	Household Income Range by Size		
	1 person	2 persons	3 persons
175%-250% FPL	\$27,930 to \$39,900	\$37,870 to \$54,100	\$47,810 to \$68,300
250% to 400% FPL	\$39,901 to \$63,840	\$54,101 to \$86,560	\$68,301 to \$109,280
Over400% FPL	Over \$63,841	Over \$86,561	Over \$109,281

The committee emphasized that the primary objective of the subsidy is to improve affordability for uninsured and lower-income ECE workers, with a particular focus on home-based child care providers. Targeted community outreach will be a critical factor in driving enrollment among uninsured ECE workers.

Based on the OEC survey, approximately 40% of home-based child care workers are uninsured, compared with about 20% among child care center workers. While the true uninsured rates are likely lower than reported due to limitations in survey sample size and representativeness, the results still indicate a potentially sizable uninsured population. Among the insured home-based child care workers in the survey, coverage is distributed across multiple sources: roughly one-quarter are enrolled in the individual marketplace,

one-third are covered under a spouse’s plan, and another one-third are enrolled in Medicare or Medicaid, with the remainder reporting other or unspecified coverage.

For illustrative purposes, the baseline scenario assumes:

- Current individual market enrollees (17% of the total ECE workforce) potentially eligible for the ECE subsidies (those above 175% FPL, estimated at 67%),
- A 80% uptake rate among currently uninsured ECE workers (18% of the total ECE workforce), assuming 80% are above 175% FPL, and
- A 15% migration rate of ECE workers from ECE employer-sponsored plans into the individual market exchange, driven by subsidy incentives.

The baseline assumptions are summarized in Table 21 below. Low and high scenarios are modeled as ±10% variations from the baseline enrollment to reflect potential uncertainty in participation. Enrollment estimates are rounded to the nearest hundred.

Table 21: Income Based Subsidy Program – Baseline Enrollment Estimate

Source of Coverage	% of Total ECE Workforce	Income >175% FPL*	Potential Eligible ECE Workers	Take-Up Rate	Potential Enrollees
Through AHCT Individual Marketplace	17%	67%	3,500	100%	3,500
Uninsured	18%	80%	4,500	80%	3,600
ECE Employer Sponsored Plan	20%	100%	6,200	15%	900
All Other Sources **	45%	NA	NA	NA	NA
Baseline Enrollment Estimate	100%		14,200		8,000

* Individuals with income below 175% FPL are assumed eligible for the Covered CT program.

** “Other sources” include coverage through a spouse’s or parent’s plan, COBRA, TRICARE, Medicare, Medicaid, Husky, and other unspecified sources.

Important Modeling Considerations:

1. Individuals in the lower-income band (175%–400% FPL) are more likely to be eligible for federal premium tax credits as well as any potential state premium assistance. In many cases, these subsidies may already substantially offset the enrollee’s premium responsibility, therefore reducing the incremental value and utilization of the ECE subsidy.

Following the expiration of the enhanced Premium Tax Credits in 2026, individuals above 400% FPL are expected to be responsible for the full unsubsidized premium. The temporary state premium assistance offsets approximately 50% of the loss of the enhanced subsidy for individuals in the 400%–500% FPL range for 2026. If the state

support is extended into 2027, even with this support, it is anticipated that the above 400% FPL population would use the full amount of the ECE subsidy.

Based on the above considerations, the assumed enrollment distribution for the 175%–250% FPL and 250%–400% FPL cohorts is reduced to reflect lower utilization of the ECE subsidy due to overlap with existing federal and state subsidy programs. Given limited data availability, the adjustment to the enrollment distribution is a high-level, directional assumption used solely for illustrative purposes.

2. Some HMA employers may adopt arrangements such as ICHRA (Individual Coverage HRA) or QSEHRA (Qualified Small Employer HRA), where employees currently enrolled in employer-sponsored coverage may transition to individual market coverage to utilize their employer’s ICHRA contribution, and also to qualify for the ECE subsidy. These individuals may not be eligible for federal subsidies, but could still be eligible for the ECE subsidy along with the ICHRA contribution. In addition, large employers (generally those with 50 or more full-time or full-time equivalent employees) should be aware of potential employer mandate and penalty implications when employees subsequently qualify for federal premium tax credits. ACA rules on federal premium tax credits prohibit eligibility where there is an affordable offer from the employer.

Table 22 presents a sample subsidy schedule by income range and illustrates the corresponding program impacts under baseline, low, and high participation scenarios. These scenarios are intended for illustrative purposes only, demonstrating how an income-based subsidy framework could operate.

Final decisions regarding subsidy amounts and income eligibility thresholds are policy determinations to be made by the committee. Once established, these parameters can be incorporated into the modeling framework to produce refined estimates of the cost.

Table 22: Illustrative Income Based Subsidy Program

Household Income % FPL	Enrollment %	Employees	Annual State Subsidy
175%-250% FPL	15%	1,200	\$1,200
250% to 400% FPL	35%	2,800	\$1,100
Over 400% FPL	50%	4,000	\$1,000
Baseline Scenario	100%	8,000	\$8,520,000

Household Income % FPL	Enrollment %	Employees	Annual State Subsidy
175%-250% FPL	15%	1,100	\$1,200
250% to 400% FPL	35%	2,500	\$1,100
Over 400% FPL	50%	3,600	\$1,000
Low Scenario	100%	7,200	\$7,670,000

Household Income % FPL	Enrollment %	Employees	Annual State Subsidy
175%-250% FPL	15%	1,300	\$1,200
250% to 400% FPL	35%	3,100	\$1,100
Over 400% FPL	50%	4,400	\$1,000
High Scenario	100%	8,800	\$9,370,000

3. Access Health CT will incur administrative costs to implement the ECE Worker Subsidy program including changes required for its online enrollment system, and also for outreach to potentially eligible ECE workers. Access Health CT has a wealth of experience conducting outreach for new affordability programs including the Covered CT program that started in 2021, and the 2026 Temporary Premium Assistance program available through the state. Targeted outreach would include sending letters to the licensed Family Child Care Home providers to reach the ECE worker audience most likely to be uninsured, and hosting in person events to promote awareness and education on the new subsidy program as well as enrollment events to assist with enrollment. Estimated costs are listed below and may vary depending upon final parameters for the subsidy program and the outreach needed to reach the audience of eligible ECE workers.

Implementation Costs	Amount
AHCT Online System Changes	\$340,000
Outreach	
• Mailing Letters to Family Child Care Home providers	\$9,000
• Print Collateral Materials for Centers and Distribution	\$35,000
• Paid Social Media Campaign	\$9,000
• Hosting Outreach Events (depending on number of events and sites for events)	\$30,000
Total Cost	\$423,000

Disclosures and Limitations

Responsible Actuaries. Ren Zhong is the actuary responsible for this communication. She is a Member of the American Academy of Actuaries and Associate of the Society of Actuaries. She meets the Qualification Standards of the American Academy of Actuaries to issue this report.

Intended Users. This information has been prepared for the sole use of AHCT and Early Childhood Educator Healthcare Work Group. Distribution to parties should be made in its entirety and should be evaluated only by qualified users. The parties receiving this report should retain their own actuarial experts in interpreting results.

Risks and Uncertainties. The assumptions and resulting estimates included in this report and produced by the modeling are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Connecticut will attain the estimated values included in the report. It is the responsibility of those receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, I am financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to the AHCT.

Data and Reliance. We have relied on others for data and assumptions used in the assignment. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. These analyses are based on the implicit assumption that the ACA will continue to be in effect in future years with no material change. Material changes in

state or federal laws and regulations regarding health benefit plans may have a material impact on the results. There are no other known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document (the report, including appendices) constitutes the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPs. Wakely completed the analyses using sound actuarial practice. To the best of our knowledge, the report and methods used in the analyses are in compliance with the appropriate ASOPs with no known deviations. A summary of ASOP compliance is listed below:

ASOP No. 23, Data Quality

ASOP No. 41, Actuarial Communication

ASOP No. 56, Modeling

Sincerely,



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Glossary

Health Savings Account (HSA)

A tax-advantaged personal savings account designed for individuals with a High Deductible Health Plan (HDHP) to pay for qualified medical expenses. Contributions are typically tax-deductible, earnings grow tax-free, and withdrawals for eligible healthcare costs are not taxed. Funds roll over year to year and remain with the individual.

Health Reimbursement Arrangement (HRA)

An employer-funded account that reimburses employees for qualified medical expenses and, in some cases, health insurance premiums. Contributions are made solely by the employer, and reimbursements are generally tax-free to employees. Unused funds may roll over depending on plan design.

Individual Coverage Health Reimbursement Arrangement (ICHRA)

An employer-funded HRA that reimburses employees for individual market health insurance premiums and qualified medical expenses. Employees must be enrolled in individual coverage to participate. Reimbursements are generally tax-free.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

An employer-funded arrangement available to small employers (fewer than 50 full-time equivalent employees) that do not offer a group health plan. It reimburses employees for individual health insurance premiums and qualified medical expenses on a tax-free basis, subject to annual contribution limits set by the IRS.