



**NovaRest**  
ACTUARIAL CONSULTING

NOVAREST REPORT TO THE NEW  
HAMPSHIRE INSURANCE  
DEPARTMENT

HEALTH INSURANCE INDIVIDUAL  
MARKET STUDY AND 1332 WAIVER  
ANALYSIS

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## I. EXECUTIVE SUMMARY

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### *Intent of This Report*

NovaRest Actuarial Consulting (NovaRest) partnered with the New Hampshire Department of Insurance (New Hampshire) and Public Consulting Group (PCG) to analyze the impact of a Section 1332 Waiver (1332 Waiver or Waiver). This actuarial report is a requirement for an actuarial certification to be included in New Hampshire's 1332 Waiver application. It addresses section 45 CFR 155.1308(f)(4)(i)-(iii) of the checklist for the 1332 Waiver, including actuarial analyses and actuarial certifications, economic analyses, and data and assumptions. Reliance on this report should include a review of the full report and the report should only be reproduced in its entirety.

### *New Hampshire's 1332 Reinsurance Waiver*

It is New Hampshire's desire that its 1332 Waiver will reduce individual market premiums making insurance more affordable. New Hampshire intends to accomplish this using a reinsurance mechanism to help fund high cost claims. The result, therefore, should be more individuals staying in the individual market, and more issuers being willing to write policies in New Hampshire counties. Both of these results will help maintain stability in the individual health insurance market in New Hampshire.

More details on the methodology and assumptions used are contained below in Section III.

### *Reinsurance Mechanism*

Under New Hampshire's 1332 Waiver, New Hampshire would implement a reinsurance mechanism similar to the temporary ACA Transitional Reinsurance program that operated between 2014 and 2016. For 2021, the proposed reinsurance program would cover 74% of paid claims between \$60,000 and \$400,000. The reinsurance is estimated to reduce premiums approximately 16.3% before assessment in 2021 compared to the projected baseline premium (without the waiver). This premium reduction impact is reduced to approximately 15.8% due to the assessment, which will also impact the individual market. Due to the reduced premium, NovaRest projects that membership in the 2021 individual market will increase 2.4% compared to the baseline without the waiver.

The reinsurance mechanism would be what has been referred to as "invisible" reinsurance. The approach of an "invisible" reinsurance allows enrollees to remain in the individual market with their current plan and issuer, but a portion of their claims are reimbursed back to the issuer by the reinsurance program. The enrollee is not aware that their claim is being paid via the reinsurance pool; meaning there is no effect on the enrollee as the task of ceding claims to the reinsurance pool is completed on the back end of the process and is without consequence to the enrollee.



The premium reduction is funded by both state funds raised through assessments and federal pass-through funds under the 1332 Waiver. If claims subject to reinsurance are more than the federal pass-through and assessments less and administrative costs, then the State will adjust the reinsurance coinsurance so that all of the calculated State funds are used, but there will be no additional funding from the State. For example, enrollee movement from the group market due to the HRA would cause the State to revise the coinsurance. If claims subject to reinsurance are more than federal pass-through and assessments less administrative costs, the State would also adjust the reinsurance coinsurance to pay out all calculated State funds (less administrative costs).

The reinsurance payable under the 1332 Waiver is estimated to be approximately \$46.3 million in 2021. It will increase over the next ten years due to medical inflation. Based on NovaRest projections, the reinsurance paid in future years is estimated in Table 1. These estimates assume that reinsurance parameters are adjusted annually to produce a sustainable level of reinsurance. Since claims in the range of \$60,000 to \$400,000 increase at a higher rate than health care trends, an adjustment to the reinsurance parameters is necessary. Also, claims will likely increase at a higher rate than National Health Expenditure NHE trend estimates in New Hampshire requiring an adjustment to reinsurance factors.

### ***Meeting the 1332 Waiver Guardrails***

CMS has specified four “guardrails” that must be met before a 1332 Waiver can be approved.

As this report shows, the proposed Waiver will meet the required guardrail conditions:

- The Waiver does not make alterations to the required scope of benefits offered in the insurance market in New Hampshire and will result in an increase in the number of individuals with coverage that meets the ACA’s Essential Health Benefits requirements.
- The Waiver will reduce premiums and increase affordability.
- The Waiver will cover more individuals in New Hampshire than would be covered absent the Waiver.
- The Waiver will not result in increased spending, administrative, or other expenses to the federal government.

Based on NovaRest’s analyses, the New Hampshire proposed reinsurance program satisfies all four guardrails.

### ***Funding***

A portion of the funding for the reinsurance would come from the federal government through a federal pass-through amount due to the reduction in advanced premium tax credits (APTCs). The reduction in premiums for the second lowest Silver plan directly reduces the APTC for the individuals eligible for APTCs. APTCs are adjusted to final premium tax credits (PTCs) based on income information collected by the IRS at the end of the year. Actual federal savings (and



resulting federal pass-through amounts) are calculated from the reduction in PTCs less reductions in federal exchange fee revenues. Estimated federal pass-through funding amounts are developed from NovaRest’s program modeling for the 1332 Waiver application. Actual federal funding amounts are based on calculations by the federal government based on review of the projected rate impact of the waiver (from the application), the actual rate filings and the government’s projected enrollment.

In order to secure the required state funding, New Hampshire will assess all insurance writers and insurance administrators on a per member per month (PMPM) basis, in accordance with its existing assessment authority. The assessment will be set to equal 60 basis points times the prior year’s age 40 2nd lowest cost Silver rate (without the waiver) times the assessment membership base (member months), or an estimated \$14.3 million for 2021. Issuers will submit rate filings with and without the premium decrease resulting from the 1332 Waiver program, and the assessment will be calculated using the without Waiver rate. The estimated assessment funds include a margin for assessment base fluctuations and administrative expenses. State funds remaining after provision for administration will be paid out to the issuers by adjusting the reinsurance parameters on a retrospective basis.

If the state assessment less administration costs is not sufficient to cover the expected state funding, such as if movement of enrollees from the group markets into the individual market due to the recent HRA regulation, reinsurance parameters would be adjusted so that available funds less administrative cost will be distributed through the program. This method of setting the assessment will be re-evaluated each year based on modeling of the assessment adequacy. Reinsurance parameters will also be evaluated based on annual projections of claims for the following policy year. Tables 1a and 1b present projected assessment total reinsurance, federal funding, and state funding for years 2021 through 2030.

<b>Table 1a</b>					
<b>Projected Federal Pass-Through, New Hampshire Subsidy and Total Reinsurance</b>					
	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>
Assessment	\$14,288,400	\$15,031,397	\$15,737,872	\$16,477,552	\$17,251,997
Federal Funding	\$32,922,477	\$34,474,011	\$36,102,609	\$37,807,773	\$39,632,038
State Funding	\$13,377,598	\$14,002,167	\$14,651,948	\$15,332,249	\$16,058,705
<b>Total Reinsurance</b>	<b>\$46,300,074</b>	<b>\$48,476,178</b>	<b>\$50,754,558</b>	<b>\$53,140,022</b>	<b>\$55,690,743</b>



<b>Table 1b</b>					
<b>Projected Federal Pass-Through, New Hampshire Subsidy and Total Reinsurance</b>					
	<b>2026</b>	<b>2027</b>	<b>2028</b>	<b>2029</b>	<b>2030</b>
Assessment	\$18,080,093	\$18,984,098	\$19,857,366	\$20,770,805	\$21,726,262
Federal Funding	\$41,624,557	\$43,543,318	\$45,554,513	\$47,658,228	\$49,858,716
State Funding	\$16,850,724	\$17,621,825	\$18,424,227	\$19,263,534	\$20,141,447
<b>Total Reinsurance</b>	<b>\$58,475,280</b>	<b>\$61,165,143</b>	<b>\$63,978,740</b>	<b>\$66,921,762</b>	<b>\$70,000,163</b>

## *In Summary*

New Hampshire’s 1332 Waiver would reduce premiums and enhance stability in the New Hampshire individual market.

The reinsurance would be funded by a combination of federal reduction in APTCs and a State assessment. New Hampshire will assess all insurance writers and insurance administrators on a per member per month basis, in accordance with its existing assessment authority.

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## II. Background

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### *Section 1332 Waivers*

Section 1332 of the Affordable Care Act (ACA) permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing its residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA.<sup>1</sup>

### *Guardrails*

Section 1332 of the Affordable Care Act (ACA) authorizes states to waive certain requirements of the ACA, under an approved waiver program. The section allows states to pursue innovative strategies for providing their residents with access to high quality, affordable health insurance. States can request a waiver related to benefits, subsidies, the marketplaces, and the individual and employer mandates. In 2012, the Department of Health and Human Services (HHS) issued regulations for Section 1332 Waivers.<sup>2</sup> In 2015, the Department of Treasury and HHS released guidance on how they would interpret the law’s guardrail requirements.<sup>3</sup> On October 24, 2018, the Department of Treasury and HHS released additional guidance providing more flexibility in

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<sup>1</sup> “Section 1332: State Innovation Waivers.” The Center for Consumer Information & Insurance Oversight. [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section\\_1332\\_State\\_Innovation\\_Waivers-.html](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-.html)

<sup>2</sup> <https://www.govinfo.gov/content/pkg/FR-2012-02-27/pdf/2012-4395.pdf>

<sup>3</sup> <https://www.govinfo.gov/content/pkg/FR-2015-12-16/pdf/2015-31563.pdf>



meeting the Waiver guardrails<sup>4</sup> and this 2018 guidance supersedes the 2015 guidance. According to the National Conference of State Legislatures, “As of late October 2018 at least 35 states have **considered** legislation to initiate the 1332 Waiver application process.”<sup>5</sup> As of November 2019, thirteen States have received approved waivers: Alaska, Colorado, Delaware, Hawaii, Maine, Maryland, Minnesota, Montana, New Jersey, North Dakota, Oregon, Rhode Island, and Wisconsin.<sup>6</sup> Georgia has a pending waiver, and California, Iowa and Oklahoma filed Waivers but subsequently withdrew their applications. There are a variety of waiver approaches other states have examined.

According to CMS guidelines, New Hampshire must demonstrate that the waiver meets the four guardrails to be approved. The four guardrails are:

Comprehensive Coverage – 1332(b)(1)(A). The proposed waiver cannot make alterations to the required scope of benefits offered in the New Hampshire insurance market and cannot result in a decrease in the number of individuals with coverage that meet the ACA’s Essential Health Benefits requirements.

Affordability – 1332(b)(1)(B). The proposed waiver cannot decrease existing coverage or cost-sharing protections against excessive out-of-pocket spending. The waiver cannot result in any decrease in affordability for individuals.

Scope of Coverage – 1332(b)(1)(C). The proposed waiver must provide coverage to at least a comparable number of residents as would be provided coverage absent the waiver.

Federal Deficit Neutrality – 1332(b)(1)(D). The proposed waiver cannot result in increased spending, administrative, or other expenses to the federal government.

When examining the options available to stabilize the individual health insurance market in New Hampshire each of these guardrails must be met.

If approved, a state can receive a “pass-through” of federal funds that would have otherwise been applied to premium tax credits had the state not received the waiver. The pass-through amount will depend on the structure of the waiver, specifically the net savings to the federal government.

### *Actuarial Certification*

A 1332 Waiver also requires an actuarial certification. The requirements of the actuarial certification have also changed since 2012. The requirements are listed in Appendix C.

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<sup>4</sup> <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-23182.pdf>

<sup>5</sup> <http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx>

<sup>6</sup> Tracking Section 1332 State Innovation Waivers. Kaiser Family Foundation. 11/6/2019.

<https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/>



## *Current Environment*

### *Current State of the Affordable Care Act (ACA)*

As federal healthcare reform efforts continue to face significant challenges, changes to the ACA have put a strain on state individual health insurance markets including that in New Hampshire. Regulations have removed the individual mandate penalty and defunded the federal cost-sharing reduction payments (CSR). Most recently, new regulations grant states the ability to expand short-term limited duration insurance (STLDI) and association health plans (AHPs).<sup>7</sup> Additionally, there are several outstanding court cases that could destabilize the market. Nationally, ACA market conditions have resulted in issuers leaving the market and New Hampshire is making efforts to prevent that in the future, as currently three issuers offer individual market ACA plans following the loss of one issuer at the end of 2017.<sup>8</sup>

Additionally, New Hampshire's Medicaid Expansion population participated in the New Hampshire individual ACA market until 2019 when it moved to a Medicaid managed care program,<sup>9</sup> which could affect the stability of the market. The Medicaid Expansion population purchasing in the individual ACA market until 2019 prohibited New Hampshire pursuing a 1332 Waiver in past years.

According to Kaiser Family Foundation, nationally the unsubsidized premium for the lowest-cost gold, silver, and bronze plans decreased about 3% between 2019 and 2020.<sup>10</sup> New Hampshire premiums increased significantly from 2016 to 2018 and have since decreased in 2019 and 2020.<sup>11</sup>

### *New Hampshire Characteristics*

According to Census.gov, New Hampshire's total population increased by 3.0% from April 1, 2010 to July 1, 2018, compared to 6.0% for the entire United States over the same period.<sup>12</sup> As of July 1, 2018, the New Hampshire population is estimated to be 1,356,458.<sup>13</sup> Table 2 provides a breakdown of the population demographics.<sup>14</sup>

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<sup>7</sup> <https://www.federalregister.gov/documents/2017/10/17/2017-22677/promoting-healthcare-choice-and-competition-across-the-united-states>

<sup>8</sup> Message to NH Health Care Providers on Minuteman Health, From Insurance Commissioner Sevigny. August 3, 2017. [https://www.nh.gov/insurance/legal/documents/nhid\\_comm\\_nhmsandnhha.pdf](https://www.nh.gov/insurance/legal/documents/nhid_comm_nhmsandnhha.pdf)

<sup>9</sup> Louise Norris. "New Hampshire and the ACA's Medicaid expansion." August 2, 2019. <https://www.healthinsurance.org/new-hampshire-medicaid/>

<sup>10</sup> "How premiums are Changing in 2020." Kaiser Family Foundation. November 7, 2019. <https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2020/>

<sup>11</sup> Based on an analysis of New Hampshire historical premium rates across metal levels.

<sup>12</sup> "Quickfacts: New Hampshire; United States". United States Census Bureau.

<https://www.census.gov/quickfacts/fact/table/NH.US/PST045218>

<sup>13</sup> Ibid.

<sup>14</sup> American Community Survey. "Age and Sex". United States Census Bureau. <https://www.data.census.gov/>.



<b>Table 2 Population by Age</b>	
Under 20 years	300,496
20 to 24 years	85,214
25 to 29 years	85,482
30 to 34 years	82,340
35 to 39 years	79,354
40 to 44 years	75,611
45 to 49 years	89,056
50 to 54 years	100,662
55 to 59 years	111,581
60 to 64 years	101,506
65 years and over	245,156
<b>Total</b>	<b>1,356,458</b>

The 2018 median household income in New Hampshire was \$74,991, which is higher than the \$61,937 median household income for the entire United States.<sup>15</sup> The income distribution for New Hampshire’s population, in 2018 inflation adjusted dollars, is shown in the table below:

<b>Table 3 Population by Income</b>		
	<b>Estimate</b>	<b>Percent</b>
<b>Total Households</b>	531,212	100%
Less than \$10,000	22,311	4.2%
\$10,000 to \$14,999	16,999	3.2%
\$15,000 to \$24,999	40,903	7.7%
\$25,000 to \$34,999	42,497	8.0%
\$35,000 to \$49,999	56,308	10.6%
\$50,000 to \$74,999	86,588	16.3%
\$75,000 to \$99,999	73,307	13.8%
\$100,000 to \$149,999	99,337	18.7%
\$150,000 to \$199,999	44,622	8.4%
\$200,000 or more	48,340	9.1%
<b>Median household income (dollars)</b>	74,991	
<b>Mean household income (dollars)</b>	97,994	

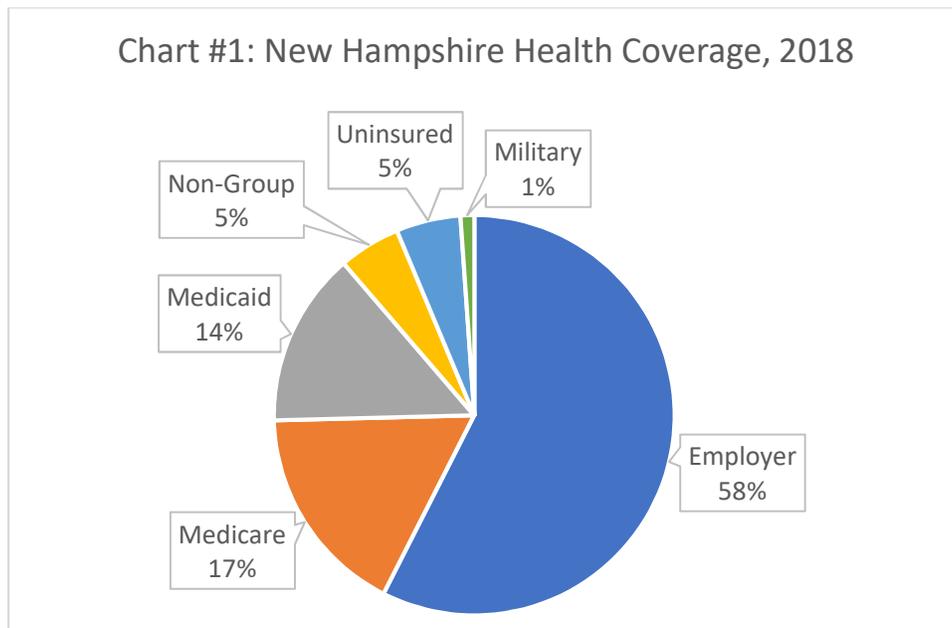
<sup>15</sup> American Community Survey. “Income In The Past 12 Months (In 2018 Inflation-Adjusted Dollars)”. United States Census Bureau. <https://www.data.census.gov/>.



Per the most recent U.S. Census Bureau estimates, the number of persons in poverty in New Hampshire is 7.6%, which is lower than the estimated 11.8% for the entire United States.<sup>16</sup>

New Hampshire operates a partnership exchange with the federal government, so enrollments are completed via HealthCare.gov. The ACA provided federal funding to states that expanded their Medicaid programs. This expansion provided coverage to many who could not afford health insurance premiums. New Hampshire opted to expand Medicaid to 138% FPL utilizing federal funding as of mid-year 2014.<sup>17</sup> New Hampshire obtained a Section 1115 Waiver, which allowed the State to purchase individual market QHPs for the Medicaid expansion population under a program called the Premium Assistance Program (PAP) from 2016-2018. Beginning in 2019, New Hampshire transitioned to a Medicare managed care model. There were approximately 40,000 PAP enrollees in 2018.<sup>18</sup>

A 2018 breakdown of the health insurance coverage in New Hampshire is shown below:<sup>19</sup>



<sup>16</sup> “Quickfacts: New Hampshire; United States”. United States Census Bureau.

<https://www.census.gov/quickfacts/fact/table/NH.US/PST045218>

<sup>17</sup> Louise Norris. “New Hampshire and the ACA’s Medicaid expansion.” August 2, 2019.

<https://www.healthinsurance.org/new-hampshire-medicaid/>.

<sup>18</sup> Louise Norris. “New Hampshire and the ACA’s Medicaid expansion.” August 2, 2019.

<https://www.healthinsurance.org/new-hampshire-medicaid/>.

<sup>19</sup> “Health Insurance Coverage of the Total Population.” Henry J Kaiser Family Foundation.

<https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22north-dakota%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Uninsured%22,%22sort%22:%22desc%22%7D>.

“Other Public” includes those covered under the military of Veterans Administration.



The approved 2019 average rate increases for the individual market, including off-exchange are included in Table 4 below.<sup>20</sup>

<b>Table 4</b>	
<b>New Hampshire 2019 Final Average Individual Market Rate Increases by Company</b>	
<b>Company</b>	<b>2019 Rate Increase</b>
Celtic Insurance Company	-15.23%
Harvard Pilgrim Health Care of NE	-7.40%
Matthew Thornton Health Plan (Anthem BCBS)	-8.10%

The approved 2020 average rate increases for the individual market, including off exchange, are included in Table 5 below.<sup>21</sup>

<b>Table 5</b>	
<b>New Hampshire 2020 Final Average Individual Market Rate Increases by Company</b>	
<b>Company</b>	<b>2020 Rate Increase</b>
Celtic Insurance Company	4.53%
Harvard Pilgrim Health Care of NE	-4.32%
Matthew Thornton Health Plan (Anthem BCBS)	-2.39%

Under the ACA, if a family income falls between 100% and 400% of the Federal Poverty Level (FPL), they may be eligible for cost sharing reductions and premium subsidies.<sup>22</sup> Cost sharing reductions (CSR) lower the amount of cost sharing that an individual pays out of pocket. The CSR's are available to those between 100% to 250% of the FPL, with families with lower incomes paying less out-of-pocket. APTCs reduce the premium that a family pays based on their income level and are available up to 400% of FPL.

The three New Hampshire issuers provided NovaRest with a summary of membership and premiums as of May/June 2019.<sup>23</sup> Based on the data received, the ACA individual insurance market membership, average premium, and total premium are shown in the following Table 6. Since the premium is the average based on the age mix in the category, the premiums are not totally

<sup>20</sup> New Hampshire. Rate Review Submissions. <https://ratereview.healthcare.gov/>. Note: Rate increases are provided at the product level. Product rate increases are weighted by projected membership in the URRT to determine the average carrier increases.

<sup>21</sup> Ibid.

<sup>22</sup> "2018 Federal Poverty Level". Obamacare.net. <https://obamacare.net/2018-federal-poverty-level/>

<sup>23</sup> Harvard Pilgrim and Matthew Thornton provided data as of May 2019, Celtic provided as of June 2019.



comparable, but give a sense of what individuals are paying in each market segment. New Hampshire uses the federal standard uniform age curve.

<b>Table 6</b> <b>Current (2019) New Hampshire Individual Market</b>	
Membership Active on Census Date	May/June 2019 <sup>24</sup>
APTC On Exchange	29,608
Non-APTC (> 400%) On Exchange	10,427
On-Exchange	40,035
Off-Exchange	5,398
<b>Total ACA</b>	<b>45,433</b>
<b>Average Premium PMPM</b>	
APTC Aggregate Premium Rate	\$563.28
APTC Maximum Premium Paid	\$157.19
APTC Premium Rate	\$406.09
Non-APTC (> 400%)	\$472.61
On-Exchange	\$539.67
Off-Exchange	\$519.00
<b>Total ACA</b>	<b>\$537.21</b>
<b>Total Annual Premium</b>	
APTC Aggregate Premium	\$200,131,650
APTC Maximum Premium	\$55,849,571
APTC Premium	\$144,282,078
Non-APTC (> 400%)	\$59,134,991
On-Exchange	\$259,266,640
Off-Exchange	\$33,618,594
<b>Total ACA</b>	<b>\$292,885,234</b>

New Hampshire currently has only three issuers as noted above, after one issuer ceased operations at the end of 2017. With the removal of the individual mandate penalty, the new rules around STLDI and AHPs, and the loss of the funding of CSRs, and moving the Medicaid Expansion population from the individual ACA market into Medicaid managed care, pressures continue to create uncertainty with respect to future sustainability of the ACA market, nationally as well as in New Hampshire. New Hampshire has continued to allow for transition plans in the individual

<sup>24</sup> Harvard Pilgrim and Matthew Thornton provided data as of May 2019, Celtic provided as of June 2019.



market. We assumed that these transition plans will end and many will enter the ACA market in 2021. New Hampshire is pursuing a Section 1332 Waiver to ensure continued stability in its individual health insurance market.

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### III. New Hampshire's Reinsurance 1332 Waiver

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#### *Reinsurance Design*

Under its 1332 Waiver, New Hampshire proposes to implement a reinsurance mechanism that is projected to reduce premiums approximately 16% (after assessment) in 2021, compared to the projected baseline premium without the waiver.

The reduction in premiums in New Hampshire results in the reduction in Advanced Premium Tax Credits (APTC). The APTCs funded by the federal government are the difference between the second lowest Silver premium in a region and the maximum amount that a family pays in premium based on its income and family size. As the Silver premiums are reduced, the APTC is reduced due to the reduction in premiums. The reduction in APTC is slightly offset by exchange user fees, which the federal government will not be able to collect. The fourth guardrail - Federal Deficit Neutrality, requires that any savings from APTC be offset by any loss of income.

The proposed reinsurance program would be funded by the reduction in federal PTC and per member per month assessments against all insurance writers and insurance administrators including the individual market plans, in accordance with New Hampshire's existing assessment authority. The assessment rate will be set as 60 basis points of the prior year's age 40 2<sup>nd</sup> lowest cost silver plan without the premium reduction for the reinsurance program. Therefore, for 2021, the State would use the 2020 2<sup>nd</sup> lowest cost silver plan premium at age 40 (\$404.60 PMPM), resulting in an assessment rate of \$2.43 PMPM. For future years the assessment will be based on the age 40 2<sup>nd</sup> lowest silver plan premium not reduced for the reinsurance program, meaning issuers will submit two rate filings, one with the 1332 reinsurance program and one without the 1332 reinsurance program. The assessment will be based on the one without waiver premium rates.

With an assessment base of approximately 490K lives (provided by New Hampshire based on current other assessments), the total 2021 assessment funds are expected to be approximately \$14.3M which would include amounts for administration costs. For purposes of estimating the amount available for reinsurance claims, this amount is reduced by 2% as a measure of conservatism and further reduced by \$500,000 to provide for administration. This method of estimating the State funds available for payments will be re-evaluated from time to time. The entire assessment amount less administrative costs would be paid out to carriers by adjusting the reinsurance parameters. Similarly, the state will not pay out more than the assessment less administrative costs.



The reinsurance program would reduce premiums, making insurance more affordable. The result therefore, should be more individuals staying in the market, which will help maintain stability in the individual health insurance market. The hope is that a more stable individual insurance market will attract more insurers to participate thereby increasing competition.

## *NovaRest Analysis Process and Assumptions*

### *Data*

#### Issuer Data Call

NovaRest performed two separate data calls regarding the individual ACA market issuers in New Hampshire, which include: Celtic, Harvard Pilgrim, and Matthew Thornton (Anthem). The first data call requested 2017 annual claims by member (with Personal Identifying Information (PII) removed) for the ACA non-Medicaid Expansion individual ACA market. Experience of the Medicaid expansion members in the individual ACA plans was removed by the issuers prior to the data submission. As Minuteman Health is no longer participating in the New Hampshire market, we imputed their experience using the New Hampshire all-payer claims database (NH CHIS).

A second data call provided premium and membership data as of May/June of 2019 for ACA business by metal level and exchange status. We also received data on the active transitional and grandfathered business in 2018. Only Matthew Thornton (Anthem) reported grandfathered or transitional business. The Medicaid Expansion population did not participate in the individual market in 2019 and did not need to be removed from 2019 data.

We also collected rate filing information for all carriers from plan year 2017 to 2020.

The data call also provided premium and membership for the following FPL ranges. Those from 0% of the FPL to 138% of the FPL are covered by Medicaid. Members are eligible for APTC up to 400% FPL. Members at the 100% CSR level who are eligible for APTC (of which there were 22 according to the data call) were evenly distributed between the 138% to 400% FPL ranges.

## *Market Projections and Assumptions*

#### Membership Projections

Individuals that were eligible for 94% CSR, 87% CSR, 73% CSR and APTC non-CSR were determined to be the ones most likely to retain coverage, although many circumstances can arise that result in turnover in this market segment, such as becoming employed by an employer that offers health insurance or moving out of state. Since NovaRest cannot predict employment or what percentage of the population might move out of state, we treated these members as a stable block.

For all other individuals NovaRest used the elasticity by metal level presented at a Society of Actuaries (SOA) training session.<sup>25</sup> The elasticity estimates the percentage of membership that

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<sup>25</sup> Murawski, Engel, Liner. Session 76 L, Understanding Stakeholder Behavior: Hidden Forces in the U.S. Healthcare System. June 12-14, 2017. <https://www.soa.org/globalassets/assets/files/e-business/pd/events/2017/health-meeting/pd-2017-06-health-session-076.pdf>. Accessed December 18, 2019.



will reduce coverage (buy-down) based on the percent of rate increase. We assume individuals who buy-down will only reduce by one metal level at a time, i.e. Gold to Silver, Silver to Bronze, Bronze and Catastrophic to uninsured. We assume individuals will maintain their exchange status, so that those who purchase coverage on exchange, when buying-down, would continue to purchase on exchange, except the Silver level where on-exchange premiums are loaded for the federal defunding of CSRs. In this case, a non-subsidized member enrolled at the Gold coverage level on exchange is assumed to buy-down to the Silver level but purchase off-exchange where the premiums are not loaded.

Similarly, we assumed a rate decrease might incentivize uninsured to purchase insurance or members to purchase additional coverage (buy-up). We also assume they would buy-up one metal level at a time with uninsured moving into the Bronze metal tier (on and off exchange equally). Enrollees would continue to maintain their exchange status except for Silver on exchange. The buy-up rates use the same elasticities as buying-down, calibrated so the uninsured moving to Bronze is consistent with the rate determined in the January 2017 Council of Economic Advisors Issue Brief.<sup>26</sup> This provides buy-up rates that are significantly less than buy-down rates as we believe enrollees are much more sensitive to price increases than decreases.

Individuals with Catastrophic coverage may age out or, based on the rate increase, decide to drop coverage and become uninsured. For the loss of membership due to aging, NovaRest used a steady state and decided that new entrants would replace individuals aging out. For the portion of the individuals deciding to drop coverage NovaRest used a Catastrophic specific elasticity.

The recent HRA regulation may have an impact if employers decide to implement HRA arrangements in which their health plan enrollees may enter the individual market. We reviewed the projections of such migration contained in the regulation, but we believe that growth rates derived from those projections are likely higher than what the New Hampshire market may experience. After discussion with New Hampshire regulators and issuers, we believe that such migration will be small in the next few years. To the extent that there is migration from employer sponsored coverage into the individual market, we believe that such enrollees will likely not be eligible for federal subsidies. Thus, federal pass-through amounts would not be impacted. New Hampshire will modify the reinsurance parameters for future years to make up for actual or expected growth in the market and associated increased expected reinsurance eligible claims, such that the total reinsurance pay-out will not exceed the federal pass-through funding plus the state funding from the set assessments.

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<sup>26</sup> Understanding Recent Developments in the Individual Health Insurance Market. Council of Economic Advisers Issue Brief. January 2017.



### Premium and Claims Trend

To trend APTC and non-APTC premium rates from 2019 to 2020, NovaRest used the New Hampshire specific actual average rate increases by metal tier.<sup>27</sup> For 2021-2030, National Health Expenditure (NHE) trends were used so the same trend was applied to all metal tiers.<sup>28</sup> We assumed the second lowest cost Silver plan would trend at the same rate as the other plans at the Silver level. The exact trends used are provided in Appendix A.

For paid claims from 2017-2020, we found issuer projected trends from rate filings were higher than NHE trends. However, carriers' experience included the PAP population which likely impacted issuer projected trends. Therefore, for 2017-2020 we used the highest annual NHE trend (5.6%) for all years. For 2021-2030, we trended the paid claims using the NHE trends consistent with the premiums. The assessment from 2022-2030 is also trended using the NHE trends. Because we are using NHE and not trend or projected premium increases, we did not include any HIT adjustment.

### APTC and PTC Projections

From the issuer data call, NovaRest received the aggregate premium rate for individuals and families that are eligible for APTCs and the maximum that a family will actually pay.

The aggregate premium rate is the premium that the individuals would pay, if they did not receive the APTC, which is the second lowest Silver rate in each region. For 2020, the second lowest Silver premium rate is \$404.60 PMPM. New Hampshire only has one rating area. The tobacco rate charged to smokers was not considered since it is not used in the APTC determination.

We have assumed a Federal Poverty Level (FPL) increase of 2% a year, which we have used to trend the maximum premium that a family will pay. The family FPL in 2019 is \$12,490 for the first person plus \$4,420 for each additional person.<sup>29</sup> A family of 4 is \$12,490 plus 3 times \$4,420 or \$25,750. The single person FPL rate has been increasing by 1% to 3% a year and the additional person has been increasing by 2% to 4% a year.<sup>30</sup>

An individual's APTC is the difference between the second lowest cost Silver plan in the region for the individual's age and the maximum premium for an individual. For a family it is the sum of all of the second lowest cost Silver plans in the region for the individual's age for each individual and the maximum family premium.

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<sup>27</sup> Using KFF Interactive Files and HIXCompare

<sup>28</sup> NHE Projections 2018-2027. Centers for Medicare and Medicaid Services. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected>.

<sup>29</sup> "Prior HHS Poverty Guidelines And Federal Register References". Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references>

<sup>30</sup> Ibid.



For the waiver scenario, the reinsurance program is expected to reduce the second lowest Silver premium, which reduces the APTC. The reinsurance lowers the premiums for all plans, but the second lowest Silver plan is the one that impacts the APTC. NovaRest assumed that the premium reduction was the same percentage for all plans due to the single risk pool requirement.<sup>31</sup> The difference in the premiums for the second lowest Silver plans with and without the reinsurance is the difference in the APTC between the two scenarios. We estimated PTC reductions assuming that PTCs are 98% of APTCs. We derived this adjustment from published information on APTC vs. PTC for 2018. This is the amount that CMS will save in PTC and that can be applied to the reinsurance funding.

The amount that the federal government can contribute and remain budget neutral is the savings from the reduced PTCs less the loss of the exchange user fees. Exchange user fees for the individual market are 3.0% of premium paid on exchange plans in 2020.<sup>32</sup> Thus, when the premium is reduced, this income to the federal government is also reduced. The amount of federal budget savings is the reduction in PTC less the exchange user fees. For example, if PTC has a 15% reduction in premiums the net amount of savings to the federal government is 15% less the 3.0%, which is 12%.

#### Non-ACA Business

Based on discussions with New Hampshire insurance regulators, we assume all remaining transitional business will enter the market in 2021 and will enter at the Bronze tier equally on and off exchange. The 2018 transitional membership and average premium were provided in the data call. Premiums were trended using the NHE trends to 2021. We used the Bronze elasticity to determine the transitional members who would become uninsured prior to 2021 and to determine which transitional members would join the ACA market in 2021 by comparing the average 2021 transitional premium rate to the average 2021 Bronze premium rate.

We assume all enrollees still enrolled in grandfathered plans would keep their grandfathered plans and would not transition into the ACA individual market.

#### Assessment

As described above, the state subsidy is based on the second lowest Silver rate for the prior year without consideration of reduction in premium resulting from the reinsurance program, meaning the assessment for plan year 2021 is expected to be \$2.43 PMPM. We assume the second lowest cost Silver premium will increase annually at the NHE trend rate, and therefore the assessment would increase at this rate as well.

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<sup>31</sup> Rate increases are rarely the same for all plans due to changes such as differences in morbidity that vary between plans and geographic factor changes. It is not possible to predict these types of factors with an appropriate amount of accuracy.

<sup>32</sup> “HHS Notice of Benefit and Payment Parameters for 2020.” The Centers for Medicare & Medicaid Services.



Reinsurance

We developed reinsurance parameters such that the total estimated reinsurance amount, and resulting estimated average premium reduction would result in the target state responsibility amounts and estimated federal passthrough funding. To develop the reinsurance amount from current ACA plans, we trended the claims for each enrolled individual (provided by the issuers) and applied reinsurance parameters to each trended claim.

For the current transitional plans, using the data provided by the one issuer with transitional plans, we estimated the total members with claims above the attachment point and the associated total claims, and trended the claims amount to 2021. We then applied the cap and coinsurance parameters to estimate the 2021 reinsurance amount for transitional enrollees.



2020 and 2021 Projections

Using the actual 2019-2020 rate increases, our 2020 market projections are provided below:

<b>Table 7 2020 Projection</b>	
<b>Membership Active on Census Date</b>	
APTC On Exchange	29,608
Non-APTC (> 400%) On Exchange	10,484
On-Exchange	40,092
Off-Exchange	5,515
<b>Total ACA</b>	<b>45,607</b>
<b>Average Premium PMPM</b>	
APTC Aggregate Premium Rate	\$585.81
APTC Maximum Premium Paid	\$160.34
APTC Premium Rate	\$425.48
Non-APTC (> 400%)	\$459.10
On-Exchange	\$552.68
Off-Exchange	\$513.56
<b>Total ACA</b>	<b>\$547.95</b>
<b>Total Annual Premium</b>	
APTC Aggregate Premium	\$208,136,916
APTC Maximum Premium	\$56,966,563
APTC Premium	\$151,170,353
Non-APTC (> 400%)	\$57,759,237
On-Exchange	\$265,896,153
Off-Exchange	\$33,986,917
<b>Total ACA</b>	<b>\$299,883,070</b>



Our projected 2021 market is presented below, with and without the proposed reinsurance waiver.

<b>Table 8 2021 Projection</b>			
<b>Membership Active on Census Date</b>	<b>Without Waiver</b>	<b>With Reinsurance Waiver, After Assessment</b>	<b>% Change</b>
APTC On Exchange	29,608	29,608	0%
Non-APTC (> 400%) On Exchange	9,865	10,613	8%
<b>On-Exchange</b>	<b>39,473</b>	<b>40,221</b>	<b>2%</b>
Off-Exchange	7,886	8,253	5%
<b>Total ACA</b>	<b>47,359</b>	<b>48,474</b>	<b>2%</b>
<b>Average Premium PMPM</b>			
APTC Aggregate Premium Rate	\$616.27	\$518.23	-16%
APTC Maximum Premium Paid	\$163.54	\$163.54	0%
<b>APTC Premium Rate</b>	<b>\$452.73</b>	<b>\$354.69</b>	<b>-22%</b>
Non-APTC (> 400%)	\$485.18	\$406.20	-16%
<b>On-Exchange</b>	<b>\$583.51</b>	<b>\$488.67</b>	<b>-16%</b>
Off-Exchange	\$517.93	\$435.19	-16%
<b>Total ACA</b>	<b>\$572.59</b>	<b>\$479.56</b>	<b>-16%</b>
<b>Total Annual Premium</b>			
APTC Aggregate Premium	\$218,960,035	\$184,124,782	-16%
APTC Maximum Premium	\$58,105,894	\$58,105,894	0%
<b>APTC Premium</b>	<b>\$160,854,141</b>	<b>\$126,018,888</b>	<b>-22%</b>
Non-APTC (> 400%)	\$57,433,268	\$51,732,806	-10%
<b>On-Exchange</b>	<b>\$276,393,303</b>	<b>\$235,857,589</b>	<b>-15%</b>
Off-Exchange	\$49,014,148	\$43,099,583	-12%
<b>Total ACA</b>	<b>\$325,407,450</b>	<b>\$278,957,171</b>	<b>-14%</b>

The total ACA premium is lower than the projected 16% reduction after assessment due to shifts in membership.

NovaRest estimates that if the New Hampshire 1332 Waiver is not implemented that there will be approximately 800 additional uninsured in 2021. With the Waiver, we expect over 300 uninsured to enter the market (i.e. 1100 less uninsured with the waiver than in the baseline).



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#### IV. Meeting the Section 1332 Waiver Guardrails

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This report demonstrates that the four 1332 Waiver guardrails will be met by New Hampshire's proposed 1332 Waiver structure.

***Comprehensive Coverage*** – The proposed Waiver does not make alterations to the required scope of benefits offered in the insurance market in New Hampshire. It will result in a projected increase in the number of individuals with coverage that meets the ACA's EHB requirements, as seen in Table 8.

#### ***Affordability – 1332(b)(1)(B)***

The Waiver will reduce premiums and increase affordability. We estimate the Waiver will lower premiums by approximately 16.3% in 2021, although it will be funded by an assessment against all members for all insurance writers and insurance administrators including ACA individual market plans meaning the actual premium decrease will be slightly lower, or about 15.8%. The premium decrease can be seen in Table 8 above.

#### ***Scope of Coverage – 1332(b)(1)(C)***

The proposed Waiver is projected to cover more individuals in New Hampshire than would be covered absent the Waiver. Lower premiums will result in individuals retaining coverage rather than dropping coverage due to unaffordable premium rates. As can be seen in Table 8, we expect approximately 1100 additional covered members in 2021.

#### ***Federal Deficit Neutrality – 1332(b)(1)(D)***

The proposed Waiver will not result in increased spending, administrative, or other expenses to the federal government. There will be no increase in federal expense. The federal funding will be calculated based on actual PTC subsidized enrollment and will be reduced by any reductions in exchange user fees. We project that the Waiver will lower premiums by approximately 15% after assessment, which will reduce the APTC that would be paid by the federal government. Since the exchange user fees are a percentage of premium, the reduced premium will reduce the exchange user fees collected by the federal government. The intention is for the lower PTCs less the reduced exchange user fees be passed to New Hampshire and used to fund the reinsurance program under the Waiver.

The reduced APTC saves the federal government money. To partially offset this savings are some potential losses to income for the federal government in terms of lower exchange fees.



The shared responsibility or individual mandate penalty would be reduced if individuals remain insured rather than becoming uninsured and subject to the penalty. In December 2017, Republican lawmakers passed [H.R.1](#), the Tax Cuts and Jobs Act, which set the individual mandate penalty to \$0.<sup>33</sup> This is effective for 2021 plan year. Therefore, there is no impact on the federal deficit for individuals remaining insured.

The Exchange User Fee is a federally mandated fee used to fund the federal and state exchanges. Because New Hampshire did not establish a state-based exchange, the exchange is facilitated by the federal government. The fee is calculated as a percent of on-exchange premiums. Although the fee is calculated on on-exchange business, it is included in the premium for all non-grandfathered on-and-off exchange ACA business. The current fee rate in the individual market is 3.0%.<sup>34</sup>

Tables 9a and 9b show the development of the projected PTC savings, state funding, and total reinsurance for years 2020 through 2030. The projections provided under the Reinsurance Waiver scenario also include the impact of the assessment that will affect all markets including the individual market.

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<sup>33</sup> Norris, Louise. "With the GOP tax bill and the president's 2017 executive order, will the IRS still enforce the individual mandate penalty?" HealthInsurance.org. January 22, 2018.

<https://www.healthinsurance.org/faqs/does-the-presidents-executive-order-mean-the-irs-wont-enforce-the-individual-mandate-penalty/>

<sup>34</sup> "HHS Notice of Benefit and Payment Parameters for 2020." The Centers for Medicare & Medicaid Services. April 18, 2019. <https://www.cms.gov/newsroom/press-releases/cms-issues-final-rule-2020-annual-notice-benefit-and-payment-parameters>



**Table 9a**  
**Budget Neutrality Projection, 2020-2030**

<b>Base</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>
<b>APTC Agg Prem</b>	\$208,136,916	\$218,960,035	\$229,251,157	\$240,025,961	\$251,307,181	\$263,369,926
<b>APTC Max Prem Paid</b>	\$56,966,563	\$58,105,894	\$59,268,012	\$60,453,372	\$61,662,440	\$62,895,688
<b>Total APTC</b>	\$151,170,353	\$160,854,141	\$169,983,145	\$179,572,589	\$189,644,742	\$200,474,238
<b>Total PTC</b>	\$148,146,946	\$157,637,058	\$166,583,482	\$175,981,137	\$185,851,847	\$196,464,753
<b><u>Reinsurance Waiver, After Assessment</u></b>						
<b>APTC Agg Prem</b>	\$208,136,916	\$184,124,782	\$192,782,964	\$201,843,763	\$211,330,420	\$221,473,284
<b>APTC Max Prem Paid</b>	\$56,966,563	\$58,105,894	\$59,268,012	\$60,453,372	\$61,662,440	\$62,895,688
<b>Total APTC</b>	\$151,170,353	\$126,018,888	\$133,514,952	\$141,390,391	\$149,667,980	\$158,577,596
<b>Total PTC</b>	\$148,146,946	\$123,498,510	\$130,844,653	\$138,562,583	\$146,674,621	\$155,406,044
<b>PTC Savings</b>	\$0	\$34,138,548	\$35,738,829	\$37,418,554	\$39,177,226	\$41,058,709
<b>Exchange fee decrease</b>	\$0	\$1,216,071	\$1,264,819	\$1,315,945	\$1,369,454	\$1,426,671
<b>Net Federal Funding</b>	\$0	\$32,922,477	\$34,474,011	\$36,102,609	\$37,807,773	\$39,632,038
<b>State Funding</b>	\$0	\$13,377,598	\$14,002,167	\$14,651,948	\$15,332,249	\$16,058,705
<b>Total Reinsurance</b>		<b>\$46,300,074</b>	<b>\$48,476,178</b>	<b>\$50,754,558</b>	<b>\$53,140,022</b>	<b>\$55,690,743</b>



**Table 9b**  
**Budget Neutrality Projection, 2020-2030**

<u>Base</u>	<b>2026</b>	<b>2027</b>	<b>2028</b>	<b>2029</b>	<b>2030</b>
<b>APTC Agg Prem</b>	\$276,538,422	\$289,259,190	\$302,565,113	\$316,483,108	\$331,041,331
<b>APTC Max Prem Paid</b>	\$64,153,602	\$65,436,674	\$66,745,408	\$68,080,316	\$69,441,922
<b>Total APTC</b>	\$212,384,820	\$223,822,516	\$235,819,705	\$248,402,792	\$261,599,409
<b>Total PTC</b>	\$208,137,124	\$219,346,065	\$231,103,311	\$243,434,736	\$256,367,420
<b><u>Reinsurance Waiver, After Assessment</u></b>					
<b>APTC Agg Prem</b>	\$232,544,864	\$243,246,297	\$254,435,627	\$266,139,666	\$278,382,091
<b>APTC Max Prem Paid</b>	\$64,153,602	\$65,436,674	\$66,745,408	\$68,080,316	\$69,441,922
<b>Total APTC</b>	\$168,391,262	\$177,809,623	\$187,690,219	\$198,059,350	\$208,940,168
<b>Total PTC</b>	\$165,023,436	\$174,253,431	\$183,936,415	\$194,098,163	\$204,761,365
<b>PTC Savings</b>	\$43,113,687	\$45,092,635	\$47,166,896	\$49,336,573	\$51,606,055
<b>Exchange fee decrease</b>	\$1,489,131	\$1,549,316	\$1,612,382	\$1,678,345	\$1,747,339
<b>Net Federal Funding</b>	\$41,624,557	\$43,543,318	\$45,554,513	\$47,658,228	\$49,858,716
<b>State Funding</b>	\$16,850,724	\$17,621,825	\$18,424,227	\$19,263,534	\$20,141,447
<b>Total Reinsurance</b>	<b>\$58,475,280</b>	<b>\$61,165,143</b>	<b>\$63,978,740</b>	<b>\$66,921,762</b>	<b>\$70,000,163</b>



V. Ten Year Projections

To develop the projections from 2020-2030, we used the process and assumptions described above.

The tables below show the membership and premiums for 2020-2030 for both the baseline without the waiver and with the waiver.

<b>Table 10a</b>						
<b>2020-2030 Base Line Without Waiver</b>						
<b>Membership</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>
94% CSR (138% to 150% FPL)	4,396	4,396	4,396	4,396	4,396	4,396
87% CSR (150% to 200% FPL)	6,989	6,989	6,989	6,989	6,989	6,989
73% CSR (200% to 250% FPL)	4,125	4,125	4,125	4,125	4,125	4,125
APTC Non-CSR (250% to 400% FPL)	14,097	14,097	14,097	14,097	14,097	14,097
<b>Total APTC</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>
Total Non-APTC	10,484	9,865	9,343	8,854	8,394	7,951
<b>Total On-Exchange</b>	<b>40,092</b>	<b>39,473</b>	<b>38,951</b>	<b>38,462</b>	<b>38,002</b>	<b>37,559</b>
Off Exchange	5,515	7,886	7,564	7,258	6,967	6,685
<b>Total ACA</b>	<b>45,607</b>	<b>47,359</b>	<b>46,515</b>	<b>45,720</b>	<b>44,969</b>	<b>44,244</b>
<b>Average Premium PMPM</b>						
APTC Agg Prem	\$585.81	\$616.27	\$645.24	\$675.57	\$707.32	\$741.27
APTC Max Prem	\$160.34	\$163.54	\$166.81	\$170.15	\$173.55	\$177.02
<b>APTC</b>	<b>\$425.48</b>	<b>\$452.73</b>	<b>\$478.43</b>	<b>\$505.42</b>	<b>\$533.77</b>	<b>\$564.25</b>
Non-APTC	\$459.10	\$485.18	\$509.82	\$535.50	\$562.27	\$590.78
<b>Total On-Exchange</b>	<b>\$552.68</b>	<b>\$583.51</b>	<b>\$612.76</b>	<b>\$643.32</b>	<b>\$675.28</b>	<b>\$709.41</b>
Off Exchange	\$513.56	\$517.93	\$543.81	\$570.81	\$598.99	\$629.04
<b>Total ACA</b>	<b>\$547.95</b>	<b>\$572.59</b>	<b>\$601.55</b>	<b>\$631.81</b>	<b>\$663.46</b>	<b>\$697.27</b>
<b>Total Annual Premium</b>						
Total APTC Agg Prem	\$208,136,916	\$218,960,035	\$229,251,157	\$240,025,961	\$251,307,181	\$263,369,926
Total APTC Max Prem	\$56,966,563	\$58,105,894	\$59,268,012	\$60,453,372	\$61,662,440	\$62,895,688
<b>Total APTC</b>	<b>\$151,170,353</b>	<b>\$160,854,141</b>	<b>\$169,983,145</b>	<b>\$179,572,589</b>	<b>\$189,644,742</b>	<b>\$200,474,238</b>
Total Non-APTC	\$57,759,237	\$57,433,268	\$57,161,194	\$56,894,964	\$56,633,408	\$56,367,174
<b>Total On Exchange</b>	<b>\$265,896,153</b>	<b>\$276,393,303</b>	<b>\$286,412,351</b>	<b>\$296,920,925</b>	<b>\$307,940,589</b>	<b>\$319,737,100</b>
Off Exchange	\$33,986,917	\$49,014,148	\$49,359,421	\$49,715,138	\$50,080,603	\$50,461,227
<b>Total ACA</b>	<b>\$299,883,070</b>	<b>\$325,407,450</b>	<b>\$335,771,772</b>	<b>\$346,636,064</b>	<b>\$358,021,193</b>	<b>\$370,198,327</b>
<b>Exchange Fees</b>	<b>\$7,976,885</b>	<b>\$8,291,799</b>	<b>\$8,592,371</b>	<b>\$8,907,628</b>	<b>\$9,238,218</b>	<b>\$9,592,113</b>



<b>Table 10b</b>					
<b>2020-2030 Base Line Without Waiver</b>					
<b>Membership</b>	<b>2026</b>	<b>2027</b>	<b>2028</b>	<b>2029</b>	<b>2030</b>
94% CSR (138% to 150% FPL)	4,396	4,396	4,396	4,396	4,396
87% CSR (150% to 200% FPL)	6,989	6,989	6,989	6,989	6,989
73% CSR (200% to 250% FPL)	4,125	4,125	4,125	4,125	4,125
APTC Non-CSR (250% to 400% FPL)	14,097	14,097	14,097	14,097	14,097
<b>Total APTC</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>
Total Non-APTC	7,517	7,141	6,786	6,449	6,130
<b>Total On-Exchange</b>	<b>37,125</b>	<b>36,749</b>	<b>36,394</b>	<b>36,057</b>	<b>35,738</b>
Off Exchange	6,405	6,160	5,926	5,702	5,488
<b>Total ACA</b>	<b>43,530</b>	<b>42,909</b>	<b>42,320</b>	<b>41,760</b>	<b>41,226</b>
<b>Average Premium PMPM</b>					
APTC Agg Prem	\$778.33	\$814.14	\$851.59	\$890.76	\$931.73
APTC Max Prem	\$180.56	\$184.18	\$187.86	\$191.62	\$195.45
<b>APTC</b>	<b>\$597.77</b>	<b>\$629.96</b>	<b>\$663.73</b>	<b>\$699.14</b>	<b>\$736.29</b>
Non-APTC	\$621.80	\$651.65	\$682.79	\$715.27	\$749.17
<b>Total On-Exchange</b>	<b>\$746.64</b>	<b>\$782.56</b>	<b>\$820.11</b>	<b>\$859.37</b>	<b>\$900.42</b>
Off Exchange	\$661.76	\$693.28	\$726.18	\$760.52	\$796.38
<b>Total ACA</b>	<b>\$734.15</b>	<b>\$769.74</b>	<b>\$806.96</b>	<b>\$845.87</b>	<b>\$886.57</b>
<b>Total Annual Premium</b>					
Total APTC Agg Prem	\$276,538,422	\$289,259,190	\$302,565,113	\$316,483,108	\$331,041,331
Total APTC Max Prem	\$64,153,602	\$65,436,674	\$66,745,408	\$68,080,316	\$69,441,922
<b>Total APTC</b>	<b>\$212,384,820</b>	<b>\$223,822,516</b>	<b>\$235,819,705</b>	<b>\$248,402,792</b>	<b>\$261,599,409</b>
Total Non-APTC	\$56,086,993	\$55,842,195	\$55,598,625	\$55,355,770	\$55,113,192
<b>Total On Exchange</b>	<b>\$332,625,415</b>	<b>\$345,101,385</b>	<b>\$358,163,738</b>	<b>\$371,838,878</b>	<b>\$386,154,523</b>
Off Exchange	\$50,862,943	\$51,248,293	\$51,640,880	\$52,040,315	\$52,446,249
<b>Total ACA</b>	<b>\$383,488,358</b>	<b>\$396,349,679</b>	<b>\$409,804,618</b>	<b>\$423,879,193</b>	<b>\$438,600,772</b>
<b>Exchange Fees</b>	<b>\$9,978,762</b>	<b>\$10,353,042</b>	<b>\$10,744,912</b>	<b>\$11,155,166</b>	<b>\$11,584,636</b>



**Table 11a**  
**2020-2030 With Reinsurance Waiver, After Assessment**

<b>Membership</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>	<b>2025</b>
94% CSR (138% to 150% FPL)	4,396	4,396	4,396	4,396	4,396	4,396
87% CSR (150% to 200% FPL)	6,989	6,989	6,989	6,989	6,989	6,989
73% CSR (200% to 250% FPL)	4,125	4,125	4,125	4,125	4,125	4,125
APTC Non-CSR (250% to 400% FPL)	14,097	14,097	14,097	14,097	14,097	14,097
<b>Total APTC</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>
Total Non-APTC	10,484	10,613	10,044	9,511	9,010	8,530
<b>Total On-Exchange</b>	<b>40,092</b>	<b>40,221</b>	<b>39,652</b>	<b>39,119</b>	<b>38,618</b>	<b>38,138</b>
Off Exchange	5,515	8,253	7,914	7,593	7,289	6,993
<b>Total ACA</b>	<b>45,607</b>	<b>48,474</b>	<b>47,566</b>	<b>46,712</b>	<b>45,907</b>	<b>45,131</b>
<b>Average Premium PMPM</b>						
APTC Agg Prem	\$585.81	\$518.23	\$542.60	\$568.10	\$594.80	\$623.35
APTC Max Prem	\$160.34	\$163.54	\$166.81	\$170.15	\$173.55	\$177.02
<b>APTC</b>	<b>\$425.48</b>	<b>\$354.69</b>	<b>\$375.79</b>	<b>\$397.95</b>	<b>\$421.25</b>	<b>\$446.33</b>
Non-APTC	\$459.10	\$406.20	\$427.04	\$448.73	\$471.34	\$495.42
<b>Total On Exchange</b>	<b>\$552.68</b>	<b>\$488.67</b>	<b>\$513.33</b>	<b>\$539.08</b>	<b>\$566.00</b>	<b>\$594.74</b>
Off Exchange	\$513.56	\$435.19	\$457.10	\$479.94	\$503.76	\$529.15
<b>Total ACA</b>	<b>\$547.95</b>	<b>\$479.56</b>	<b>\$503.97</b>	<b>\$529.46</b>	<b>\$556.11</b>	<b>\$584.57</b>
<b>Total Annual Premium</b>						
Total APTC Agg Prem	\$208,136,916	\$184,124,782	\$192,782,964	\$201,843,763	\$211,330,420	\$221,473,284
Total APTC Max Prem	\$56,966,563	\$58,105,894	\$59,268,012	\$60,453,372	\$61,662,440	\$62,895,688
<b>Total APTC</b>	<b>\$151,170,353</b>	<b>\$126,018,888</b>	<b>\$133,514,952</b>	<b>\$141,390,391</b>	<b>\$149,667,980</b>	<b>\$158,577,596</b>
Total Non-APTC	\$57,759,237	\$51,732,806	\$51,468,765	\$51,212,338	\$50,961,719	\$50,708,120
<b>Total On-Exchange</b>	<b>\$265,896,153</b>	<b>\$235,857,589</b>	<b>\$244,251,728</b>	<b>\$253,056,101</b>	<b>\$262,292,139</b>	<b>\$272,181,404</b>
Off Exchange	\$33,986,917	\$43,099,583	\$43,410,699	\$43,731,815	\$44,062,136	\$44,406,565
<b>Total ACA</b>	<b>\$299,883,070</b>	<b>\$278,957,171</b>	<b>\$287,662,428</b>	<b>\$296,787,916</b>	<b>\$306,354,274</b>	<b>\$316,587,969</b>
<b>Exchange Fee</b>	<b>\$7,976,885</b>	<b>\$7,075,728</b>	<b>\$7,327,552</b>	<b>\$7,591,683</b>	<b>\$7,868,764</b>	<b>\$8,165,442</b>



<b>Table 11b</b>					
<b>2020-2030 With Reinsurance Waiver, After Assessment</b>					
<b>Membership</b>	<b>2026</b>	<b>2027</b>	<b>2028</b>	<b>2029</b>	<b>2030</b>
94% CSR (138% to 150% FPL)	4,396	4,396	4,396	4,396	4,396
87% CSR (150% to 200% FPL)	6,989	6,989	6,989	6,989	6,989
73% CSR (200% to 250% FPL)	4,125	4,125	4,125	4,125	4,125
APTC Non-CSR (250% to 400% FPL)	14,097	14,097	14,097	14,097	14,097
<b>Total APTC</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>	<b>29,608</b>
Total Non-APTC	8,059	7,652	7,268	6,905	6,561
<b>Total On-Exchange</b>	<b>37,667</b>	<b>37,260</b>	<b>36,876</b>	<b>36,513</b>	<b>36,169</b>
Off Exchange	6,701	6,445	6,201	5,967	5,743
<b>Total ACA</b>	<b>44,368</b>	<b>43,705</b>	<b>43,077</b>	<b>42,480</b>	<b>41,912</b>
<b>Average Premium PMPM</b>					
APTC Agg Prem	\$654.51	\$684.63	\$716.12	\$749.06	\$783.52
APTC Max Prem	\$180.56	\$184.18	\$187.86	\$191.62	\$195.45
<b>APTC</b>	<b>\$473.95</b>	<b>\$500.45</b>	<b>\$528.26</b>	<b>\$557.45</b>	<b>\$588.07</b>
Non-APTC	\$521.60	\$546.81	\$573.08	\$600.48	\$629.07
<b>Total On Exchange</b>	<b>\$626.07</b>	<b>\$656.33</b>	<b>\$687.93</b>	<b>\$720.97</b>	<b>\$755.51</b>
Off Exchange	\$556.78	\$583.41	\$611.18	\$640.16	\$670.43
<b>Total ACA</b>	<b>\$615.61</b>	<b>\$645.57</b>	<b>\$676.88</b>	<b>\$709.62</b>	<b>\$743.85</b>
<b>Total Annual Premium</b>					
Total APTC Agg Prem	\$232,544,864	\$243,246,297	\$254,435,627	\$266,139,666	\$278,382,091
Total APTC Max Prem	\$64,153,602	\$65,436,674	\$66,745,408	\$68,080,316	\$69,441,922
<b>Total APTC</b>	<b>\$168,391,262</b>	<b>\$177,809,623</b>	<b>\$187,690,219</b>	<b>\$198,059,350</b>	<b>\$208,940,168</b>
Total Non-APTC	\$50,442,855	\$50,211,211	\$49,982,030	\$49,754,386	\$49,527,799
<b>Total On-Exchange</b>	<b>\$282,987,719</b>	<b>\$293,457,508</b>	<b>\$304,417,657</b>	<b>\$315,894,052</b>	<b>\$327,909,890</b>
Off Exchange	\$44,770,503	\$45,119,576	\$45,475,404	\$45,837,572	\$46,205,732
<b>Total ACA</b>	<b>\$327,758,222</b>	<b>\$338,577,085</b>	<b>\$349,893,061</b>	<b>\$361,731,624</b>	<b>\$374,115,622</b>
<b>Exchange Fees</b>	<b>\$8,489,632</b>	<b>\$8,803,725</b>	<b>\$9,132,530</b>	<b>\$9,476,822</b>	<b>\$9,837,297</b>



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## VI. Limitations

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There were a number of limitations in the data received and the assumptions used in developing the projections. Even with these limitations, NovaRest believes that the projections included in this report are reasonable and appropriate for decision-making purposes. NovaRest performed sensitivity testing to verify that varying the assumptions used would not significantly change the results. Actual federal funding through reduced PTC will be based on government projected enrollment and filed premiums rather than on NovaRest's or other projections, so the actual federal pass-through funding may vary from that developed in our modeling and included in our projections. Also, actual issuer-developed rates for 2021 may vary from those assumed.

Additional limitations and considerations include:

1. The data that NovaRest used were snap shots as of May 2019 for Matthew Thornton (Anthem) and Harvard Pilgrim and as of June 2019 for Celtic. With the turnover in the individual market this may overstate 2019 due to later 2019 migration from the market.
2. NovaRest had little information on individuals eligible for 100% CSR (there are 22 based on the data from the issuers). From the data provided NovaRest knows that they are all eligible for APTCs, but not their actual poverty level. NovaRest allocated the 100% CSR to the CSR levels for the non-100% CSR individuals.
3. NovaRest assumed that grandfathered plan enrollees would continue to purchase grandfathered coverage, and we have not assumed migration of such enrollees into the ACA market. As of 2018, only Matthew Thornton (Anthem) reported grandfathered business with approximately 2,700 members.
4. NovaRest assumed transitional plan members will remain in the transitional market until 2021, when they would enter the individual ACA market at the Bronze coverage level. We have trended average transitional premiums using NHE trend and compared the projected 2021 transitional premium against the SOA elasticity for the bronze tier to determine migration into the ACA market. We assume half will move to on-exchange and half to off-exchange. As of 2018, only Matthew Thornton (Anthem) reported transitional business with approximately 3,000 members.
5. NovaRest has estimated federal pass-through funding by estimating federal savings achieved through the reduction in estimated PTCs offset by estimated loss of federal revenue. Actual issuer premiums may deviate from that resulting from our projections. Additionally, actual federal calculation of savings may vary from our projections.



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## VII. Actuarial Certification

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### **Reliance**

In the analysis described in this report, we relied on information provided by New Hampshire, information published by the Federal government, and information provided by insurers offering coverage in the Individual market in New Hampshire.

We relied upon this information without independent investigation or audit. If information is inaccurate or incomplete, our findings and conclusions may need to be revised. We have reviewed the data for consistency and reasonableness. Where data was inconsistent or unreasonable, we requested clarification.

### **Subsequent Events**

There are no known subsequent events which impact the analyses described in this report or the results presented.

### **ASOPS**

In performing our analyses, NovaRest used sound actuarial judgement and principles, and complied with all current Actuarial Standards of Practice (ASOPs). In particular, we have complied with ASOP 23 Data Quality, and ASOP 41 Actuarial Communication.

### **Actuarial Certification**

Donna Novak, President and Al Bingham, Principal of NovaRest Actuarial Consulting are the actuaries responsible for this report. We are both Members of the Society of Actuaries and the American Academy of Actuaries. We both meet the Qualifications Standards to render this opinion.

We are providing this report solely for the use of supporting New Hampshire's 1332 Waiver application. The intended users of this report are New Hampshire and those federal agencies to which the application is submitted. Distribution of this report to any other parties does not constitute advice from or by us to those parties. The reliance of other parties on any aspect of our work is not authorized by us and is done at the other party's own risk.



We believe the current New Hampshire Waiver proposal complies with the following requirements:

- The coverage provided under this 1332 Waiver is at least as comprehensive as the coverage available absent the 1332 Waiver.
- The coverage provided under this 1332 Waiver is at least as affordable as the coverage available absent the 1332 Waiver.
- The 1332 Waiver will provide coverage to at least a comparable number of residents as would be available absent the 1332 Waiver.
- The 1332 Waiver will not increase the federal deficit.

The actuarial methodologies utilized in order to arrive at our opinion were those that were considered generally accepted within the industry and are consistent with all applicable ASOPs.

If you have any questions, do not hesitate to call Donna at 520-908-7246 or Al at 770-365-6594.

Sincerely,

Donna C. Novak, FCA, ASA, MAAA, MBA

Alfred A Bingham, Jr, FSA, MAAA



## Appendix A – Trend Assumptions

### National Health Expenditure Projection Rates

The NHE Projection data splits out spending for Private Insurance into Employer-Sponsored Insurance (ESI) and Direct Purchase.<sup>35</sup> Direct Purchase includes coverage purchased through the Marketplace along with other plans such as Medicare supplemental coverage and individually purchased plans. This category seems to be the best fit for projecting individual spending among the NHE data. It has been used for other 1332 Waiver applications such as Wisconsin and Oregon (which were approved by CMS). The current NHE Projection uses 2017 for the claim distribution as the latest year with actual data. We noticed carrier projected trends were higher than NHE trends from 2017-2020, although we recognize this data included the New Hampshire Medicaid Expansion population in the experience which may skew results. Therefore, we decided to trend the claim distribution from 2017-2020 using an annual 5.6% trend, which was the highest annual NHE trend over this period. We then reverted to the NHE trends for 2021 and beyond. The NHE trends, compared with the trends used are provided in Table 12.

Year	National Health Expenditure Trends (NHE Table 17 Health Spending by Source of Insurance Coverage Spending Direct Purchase)	Trends Used in Analysis
2018	5.6%	5.6%
2019	5.3%	5.6%
2020	3.2%	5.6%
2021	5.2%	5.2%
2022	4.7%	4.7%
2023	4.7%	4.7%
2024	4.7%	4.7%
2025	4.8%	4.8%
2026	5.0%	5.0%
2027+	4.6%	4.6%

Our model currently uses 2019 actual premiums and membership. For 2019 to 2020, premiums PMPM are trending using actual issuer average premium increases from the rate filings, which are shown by metal tier in Table13.

<sup>35</sup> Projected National Health Expenditure Data. Table 17. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html> 2/26/19.



<b>Table 13</b>	
2019-2020 Average Metal Rate Increases	
Gold	1%
Silver	4%
Bronze	-7%
Catastrophic	1%

For 2020 and beyond, premium and claims PMPM amounts are projected forward using the NHE trends.



## Appendix B – Definitions and Abbreviations

**Allowed Claims** - The maximum amount a plan will pay for a covered health care service.

**Advance Premium Tax Credit “APTC” or Premium Tax Credit “PTC”** – A tax credit taken by enrollee to lower monthly health insurance payment. The enrollee will estimate yearly income when they apply for coverage in the Health Insurance marketplace. The APTC will be based on the estimate of the income entered.

**Centers for Medicare & Medicaid Services “CMS”** - The Centers for Medicare & Medicaid Services, CMS, is part of the Department of Health and Human Services (HHS). CMS oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR).

**Cost Sharing Reduction “CSR”** - A discount that lowers the amount an enrollee will have to pay for deductibles, copayments, and coinsurance. In the Health Insurance Marketplace, cost-sharing reductions are often called “extra savings.”

**Essential Health Benefits “EHB”** - A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors’ services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more.

**Federal Poverty Level “FPL”** - A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage.

**Health Insurance Marketplace “Marketplace” or “exchange”** <http://www.healthcare.gov> - A shopping and enrollment service for medical insurance created by the Affordable Care Act in 2010. In most states, the federal government runs the Marketplace (sometimes known as the "exchange") for individuals and families.

**Metal Level, Metal Plans, or Metal Categories** - Plans in the Health Insurance Marketplace are presented in 4 “metal” categories: Bronze, Silver, Gold, and Platinum.

**Patient Protection and Affordable Care Act “ACA” or “Affordable Care Act”** - United States federal statute enacted by the 111th United States Congress and signed into law by President Barack Obama on March 23, 2010.

**Per Member Per Month “PMPM”** - Per Member Per Month, or the average cost of services per individual per month.

**Premium** - A health insurance premium is a monthly fee paid to an insurance company or health plan to provide health coverage.



## Appendix C – Actuarial Certifications

The Actuarial Certification must include:

1. *Actuarial analyses and actuarial certifications.* Actuarial analyses and actuarial certifications to support New Hampshire’s estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement.
2. *Economic analyses.* Economic analyses to support New Hampshire’s estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the Federal deficit requirement, including:
  - i. A detailed 10-year budget plan that is deficit neutral to the Federal government, as prescribed by section 1332 (a) (1) (B) (ii) of the Affordable Care Act, and includes all costs under the waiver, including administrative costs and other costs to the Federal government, if applicable; and
  - ii. A detailed analysis regarding the estimated impact of the waiver on health insurance coverage in New Hampshire.
3. *Data and assumptions.* The data and assumptions used to demonstrate that New Hampshire’s proposed waiver is in compliance with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the Federal deficit requirement, including:
  - i. Information on the age, income, health expenses and current health insurance status of the relevant State population; the number of employers by number of employees and whether the employer offers insurance; cross tabulations of these variables; and an explanation of data sources and quality; and
  - ii. An explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the Federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects, and other relevant factors.
4. *Implementation timeline.* A detailed draft timeline for New Hampshire’s implementation of the proposed waiver.
5. *Additional information.* Additional information supporting New Hampshire’s proposed waiver, including:
  - i. An explanation as to whether the waiver increases or decreases the administrative burden on individuals, insurers, and employers, and if so, how and why;
  - ii. An explanation of how the waiver will affect the implementation of the provisions of the Affordable Care Act, which New Hampshire is not requesting to waive in the State or at the Federal level;
  - iii. An explanation of how the waiver will affect residents who need to obtain health care services out-of-State, as well as the State in which such residents may seek such services;



- iv. If applicable, an explanation as to how New Hampshire will provide the Federal government with all information necessary to administer the waiver at the Federal level; and
      - v. An explanation of how New Hampshire's proposal will address potential individual, employer, insurer, or provider compliance, waste, fraud and abuse within New Hampshire or in other States.
  - 6. *Reporting targets.* Quarterly, annually, and cumulative targets for the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement, and the Federal deficit requirement.
  - 7. *Other information.* Other information consistent with guidance provided by the Secretary of the Treasury and the Secretary of Health and Human Services.

*Additional supporting information.*

- (1) During the Federal review process, the Secretary may request additional supporting information from New Hampshire via the Secretary of Health and Human Services as needed to address public comments or to address issues that arise in reviewing the application.
- (2) Requests for additional information, and responses to such requests, will be made available to the public in the same manner as information described in § 33.116 (b).



## Appendix D – Qualifications

### *About the Model Team*

NovaRest was hired by the New Hampshire Insurance Services to perform a study of the New Hampshire individual health insurance market. The goal was to model the individual health insurance market and to study options to enhance that stability of the current marketplace. Ultimately, the study pointed to the creation of a reinsurance plan and the request for a Section 1332 Waiver. Public Consulting Group (PCG) was hired to write the Section 1332 Waiver application. NovaRest coordinated the application efforts with PCG. NovaRest has been helping state insurance regulators meet their regulatory responsibilities since 2002. The 1332 project included three accredited actuaries, an actuarial student, and two research assistants. The core team members have worked on healthcare actuarial and economic analyses and section 1332 waiver projects. In addition to our unique section 1332 experience, we have performed studies to analyze the cost drivers of health insurance and have analyzed the impact of proposed legislation. NovaRest employs some of the most experienced senior actuaries in the industry. The NovaRest actuaries are experts in the Affordable Care Act (ACA), modeling and project management. In addition, NovaRest has experience working on Section 1332 Waiver and reinsurance projects.