STATE OF IOWA

KIM REYNOLDS
GOVERNOR

ADAM GREGG
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DOUG OMMEN
COMMISSIONER OF INSURANCE

January 4, 2018

Governor Kim Reynolds
1007 East Grand Avenue
Des Moines, Iowa 50319

Governor Reynolds,

Enclosed please find the Iowa Insurance Division's Annual Health Costs report, which examines health care costs in the State of Iowa for 2016 as required by Iowa Code §505.18. While this report provides information regarding the costs of all health care insurance across the state in 2016, it seems appropriate to provide additional information on the current status of Iowa's individual health insurance market as well.

The structural problems of the ACA caused a collapse of Iowa's individual health insurance market. It is important to recognize that this failure did not occur overnight, and a number of factors contributed to the skyrocketing premium costs and marketed increase in the number of uninsured individuals. This letter is intended to serve as a brief overview of the history of the market and its current status, and a discussion of what changes need to be made to restore stability to Iowa's individual health insurance market.

Iowa's Pre-ACA Individual Market

Prior to the ACA, Iowa had a stable individual market with some of the lowest premium levels in the nation and many health insurance options to choose from. Iowa had one of the highest health insurance coverage rates in the nation with less than 9.7 percent of its residents being uninsured.[1] The majority of Iowa residents, approximately 65%, received health insurance through their employer.

However, while Iowa had one of the lowest uninsured rates in the country due to the large segment of the population receiving employer sponsored coverage, comprehensive health insurance was unaffordable for many lower to moderate income earners. There were challenges in the individual market, with consumers still being subject to rate increases, condition exclusions, and coverage denials.

The Iowa Comprehensive Health Association (HIPIOWA) was available to provide access to health insurance coverage to residents of the state who are unable to obtain individual health insurance, many of whom were rejected for coverage due to medical reasons.[2] At its peak, there were approximately

[1] Iowa Insurance Division 2013 calculation.
[2] https://www.hipiowa.com/

3,000 members who purchased this coverage. These plans are still offered to those today to those who qualify, and fewer than 400 members remained in the plans in 2017.

The ACA in Iowa

While the ACA resulted in a decreased number of uninsured Iowa consumers, the number of Iowans purchasing policies in the individual market has also decreased.[3] This reduction in the number of uninsured is, in large part, due to the bipartisan, tailored version of the Medicaid expansion implemented by Iowa. The program, known as the Iowa Health and Wellness Plan, provides coverage to nearly 150,000 low-income, childless adults.[4]

Those remaining in Iowa's individual commercial health insurance market segmented into three distinct sections – consumers in grandfathered plans, consumers in transition plans, and consumers who purchased ACA-compliant plans.

1. *Grandfathered Plans*
    - Plans in which an individual was enrolled as of March 23, 2010, are exempt from many requirements of the ACA. These are closed blocks, and cannot accept new individuals or groups.
    - In 2014, there were 59,213 Iowans in these plans.
    - As of October 2017, there are 37,088.

2. *Transitional Plans (aka Grandmothered plans)*
    - These plans have not been statutorily excluded from the ACA, and were allowed in response to recommendations from the Center for Consumer Information and Insurance Oversight (CCIIO) and President Obama's statements that "if you like your health plan you can keep it."[5] These plans have been "allowed" by the Obama and Trump Administrations on a yearly basis.
    - No decision as to the availability of these plans for 2019 has been announced.
    - In 2014, there were approximately 75,577 Iowans in these plans.
    - As of October 2017, this pool is down to 37,914.

3. *ACA-Complaint Plans*
    - Consumers can buy plans "on-Exchange" via healthcare.gov.
    - Consumers can buy plans directly with carriers "off-Exchange." A consumer who purchases an "off-Exchange" plan is not eligible for federal subsidies.

[3] See page 1 of Commissioner Gerhart's testimony before the U.S. Senate Committee on Homeland Security and Government Affairs Committee at <http://www.hsgac.senate.gov/download/gerhart-testimony>.

[4] Iowa Department of Human Services, Improve Iowan's Health Status, p. 3-28 available at: <http://dhs.iowa.gov/sites/default/files/15-6_Improve_Health_Status.pdf>.

[5] <https://iid.iowa.gov/documents/cciio-transitional-plans-letter>.

- Beginning in 2015, the age band restriction and subsidy structure disadvantaged healthy young moderate-income individuals, attracting significantly fewer healthy young participants into the market than expected.
- Enrollment in these ACA plans peaked in 2016 with nearly 75,000 enrolled. However the subsidy structure attracted a significantly larger proportion of 55-64 year-old individuals than expected, causing substantial market losses, due to the higher costs for healthcare utilization of this population.
- Due to increasing premium rates in 2016 and 2017, adverse selection reached across all age segments from age 0 to 55, with ACA enrollment down to 60,758 as of October 2017.
- Given the rates filed by Medica for 2018, we anticipate that only 50,000 Iowans will purchase these plans through 2018.
- We anticipate that many of those who are not eligible for subsidies will not purchase coverage in 2018.

Of the individuals who purchased individual health insurance coverage prior to the ACA, nearly 78% purchased through a single company – Wellmark Blue Cross Blue Shield of Iowa. When the Marketplace Exchange was established, Wellmark chose not to sell ACA-compliant plans on the Marketplace and offered only off-Exchange plans in addition to their grandfathered and transitional plans. Thus, any individual who was eligible for and sought federal subsidies to assist with purchasing insurance could not purchase a Wellmark plan. While Wellmark offered ACA-compliant plans for one year – 2017 – Wellmark has another 73,000 individuals in grandfathered and transitional plans and is not offering coverage on the Marketplace in 2018.

Rates Rise and the Market Falls

The individuals who initially enrolled in the ACA-compliant individual market were generally older on average than expected and had a higher utilization rate which resulted in a more concentrated risk for carriers. Initial premium prices did not adequately reflect this utilization rate, and rates started to climb. For calendar years 2016 and 2017, Wellmark received rate increases of 26.5 and 42.6 percent respectively for its ACA-compliant, off Marketplace plans.[6] Aetna (formerly Coventry Health Care of Iowa, Inc.) received rate increases of 19.8 and 22.58 percent for the years 2016 and 2017 for its ACA-compliant plans on and off the Marketplace.[7] The carriers suffered substantial losses even with the continued rise in premium rates.

The liquidation of CoOportunity Health in February 2015 was the first very notable indication of the severe instability of the Iowa individual ACA-compliant market. The effects of that liquidation are still impacting the stability of the market in Iowa today and continue to compound the problems. Prior to its liquidation, CoOportunity Health participated in the federal reinsurance, risk corridor, and risk

[6] Available at: <https://iid.iowa.gov/press-releases/2016-wellmark-iowa-rate-proposal-review-decision> and <https://iid.iowa.gov/press-releases/2017-wellmark-inc-rate-proposal-review-decision>.

[7] Available at: <https://iid.iowa.gov/press-releases/2016-coventry-health-care-of-iowa-rate-proposal-review-decision> and <https://iid.iowa.gov/press-releases/2017-aetna-health-of-iowa-rate-proposal-review-decision>.

adjustment programs pursuant to the federally mandated guidelines under the ACA. Despite assurances to the Insurance Commissioner, HHS and CMS specifically did not fully fund the risk corridor program for calendar year 2014, resulting in a debt to CoOportunity Health of approximately $130 million, contributing to the failure of CoOportunity. As of the date of this letter, these funds have not yet been paid by the federal government and the Commissioner, as liquidator for CoOportunity Health, continues his pursuit of the claim against the federal government in federal claims court.

Iowa's individual ACA-compliant market continued to deteriorate as claim and costs exceeded premiums. On April 25, 2016, UnitedHealthcare notified the Iowa Insurance Division that they would not offer individual ACA-compliant plans in 2017.[8] Without federal action, the concentration of individuals with persistent, high cost conditions; the significant disadvantage for subsidized 25 year-old adults seeing increasing rates, while subsidized 62 year-old adults did not experience any increases; and ultimately the threat of skyrocketing rates triggered a near complete exodus departure of insurance carriers from Iowa. On March 30, 2017, Wellmark, Inc. and Wellmark Health Plan of Iowa, Inc. notified the Iowa Insurance Division that they would not offer individual ACA-compliant plans in 2018.[9] On April 6, 2017, Aetna, Inc. notified the Iowa Insurance Division that it would not offer individual ACA-compliant plans in 2018.[10] Finally, before Iowa's rate filing deadline, June 19, 2017, Wellmark Value Health Plan, Inc., Wellmark Synergy Health, Inc., and Gundersen Health Plan, Inc. informed the Iowa Insurance Division that they will not offer individual ACA-compliant plans in 2018. Medica publicly released a statement that it too would be departing if no actions were taken to protect it from the anticipated losses in 2018.

Despite no federal assurances for relief, Medica is offering plans in all of Iowa's 99 counties in 2018 as the sole insurer offering ACA-compliant plans. However, the rates have an average premium increase for the standard silver plans of 56 percent over Medica's 2017 ACA rates. As 58,317 consumers on the 2017 ACA market in Iowa utilized other carriers, the majority of Iowans remaining in the ACA market, but for the insulation under the federal subsidy structure, would see actual rate increases of much more, up to 100 percent for 2018.

These premium rates under the ACA are expected to price out nearly all individuals currently on the individual health insurance market except for those who are federally subsidized or those who must incur these steep costs to ensure health insurance coverage for their serious illnesses or medical conditions.

The loss of these consumers further drives the market into collapse as then only fully subsidized individuals or consumers experiencing severe medical conditions remain. This will cause premium rates to increase again in 2019, and result in a market comprised only of subsidized individuals.

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8 <https://iid.iowa.gov/press-releases/unitedhealthcare-to-leave-certain-iowa-health-insurance-markets-in-2017>.

9 <https://iid.iowa.gov/press-releases/wellmark-to-leave-iowa%E2%80%99s-aca-health-insurance-market-in-2018>.

10 <https://iid.iowa.gov/press-releases/commissioner-ommen-statement-regarding-aetna-leaving-iowas-individual-market-in-2018>.

Market Restructuring is Needed

The steady increase in premium costs had resulted in a decline in market participation, which in turn causes higher prices. This cyclical nature makes it very difficult to salvage the existing market. There are several key areas that need to be considered in a solution, including the market impact of Iowa's high risk population, rate increases resulting in adverse selection, and the viability of the existing risk pool.

High Risk Population

When the ACA was implemented, individuals with pre-existing and persistent health conditions entered the individual market in large numbers. Many of these individuals likely had difficulty obtaining comprehensive coverage at affordable rates prior to the ACA, as many insurance companies performed underwriting and either denied individuals with serious health conditions or charged high premium rates.

Carriers did not fully understand the health status of the population when the ACA markets first opened, in part due to the lack of claims history on the uninsured, pent-up demand, and lack of movement from the grandfathered and transitional policies. Thus, premium rates were set too low to adequately account for the risk. Carriers found that these individuals were, on average, less healthy than those who receive coverage through their employer sponsored plans and had a high level of healthcare utilization.

This trend continues and in 2016, 5% of the population in the individual health insurance market accounted for 70% of the claims experience.[11] As prices continue to rise to compensate for these catastrophic claims, healthy individuals have departed the market. At this juncture, there is no fall back mechanism for the insurance carrier to shield the rest of its risk pool from these catastrophic claims. There is inadequate sharing of the risks amongst carriers as the number of carriers declined in the market.

Rate Increases Resulting in Adverse Selection and Income Management

When the ACA was implemented, the price of insurance – because of the 3:1 age based risk band restrictions coupled with an income based subsidy structure – has always been unappealing to healthy lower and moderate income earning young adults. The premium amount that subsidized consumers are responsible for contributing is capped at a percentage of their income, and remains capped at this federally established level regardless of their age or how high the premiums increase. With some variation in price dependent on deductibles and copays, essentially, the most an individual will pay for premium costs for a silver plan is 9.69% of their income. This amount is the same whether an individual is 28 or 62. The most any single individual who receives subsidies will pay is $390 per month for a silver plan. As premiums have skyrocketed, these individuals have seen no increase in their monthly premiums. The federal taxpayers have picked up the balance between the income capped premium payment and the ever increasing premium costs.

Given the structure of the subsidies under the ACA, there is currently no incentive for carriers to lower premium costs. As the majority of Iowa consumers are subsidized and will feel no impact from

[11] Figures based on Iowa Insurance Division data.

premium rate increases, insurance carriers can build all of these claims cost into their premium rates, with the federal government paying the difference. However, this dramatic increase in claims cost is acutely felt by those consumers who do not receive federal subsidies and will be forced to pay these substantial premium rates.

Younger individuals are choosing to not participate because their premium rates are not correlated to their risk – rather, they are capped based on their income at a percentage amount determined and applied across all individuals. The risk associated with insuring a 60 year-old is higher than that for insuring a 28 year-old, and the subsidy structure has destroyed this correlation.

The subsidy structure has also lead to the development of a dramatic rate cliff for individuals near the eligibility line. There is a drastic difference in rates for individuals based on a few hundred dollars of annual income. As an example, the premiums for Medica in 2018 for a couple living in Iowa City who are both 55 years and earn just *under* 400% FPL (approximately $64,800) are capped at 9.69% or $6,278 annually. On the other hand, the premiums for Medica in 2018 for a couple living in Iowa City who are both 55 years and earn just *over* 400% FPL (approximately $65,000) are over $32,000 annually. There is a nearly $24,000 increase in premiums for a $200 difference in income.

Families may have found it necessary to restructure their income to become eligible for subsidies or qualify for small group coverage. Some may have simply put their own business on hold. The Iowa Insurance Division has anecdotal evidence of couples divorcing in order to lower their income and receive subsidies, or members of the family quitting a job or cutting hours to reduce income and qualify for subsidies. Some have sought refuge in health sharing ministries and others have sought small group coverage.

Non-Viable Risk Pool

Individuals wanting to purchase ACA-compliant plans via the Marketplace Exchange are subject to an open enrollment period at the end of the calendar year wherein consumers can purchase coverage for the following year. However, the statute provides for a number of "special enrollment periods" that are also available to consumers. The special enrollment periods were designed to allow consumers to purchase coverage if they have a change in employment status and lose their coverage, add or lose a dependent, or other defined reasons.

The federal government has been unable to effectively regulate these special enrollment periods, resulting in part from the inability to adequately verify the qualifying event for the special enrollment. Accordingly, consumers have found it easy to "game" the available special enrollment periods and enter and leave the market when care is needed.

Additionally, enrollment data shows that many individuals enroll at the beginning of the year, get the coverage and treatment they need, then drop off. As noted above, the ease at which consumers are able to re-enter the market allows them to simply back-enroll when they need more treatment. This structure does not allow these consumers' risk to be spread throughout the year, negatively impacting costs to the carrier as no premium dollars are collected to "off-set" the claims. The costs of individuals

who enroll during special enrollment periods have been found, both by local and national carriers, to be nearly double those incurred by individuals who enter during open enrollment.

It is important to have stronger coverage incentives, specifically to encourage and require continuous coverage. Such a continuous coverage requirement would keep consumers in the market throughout the year, when they need care and when they do not. The individual mandate was designed to ensure that risk is spread across the market; however, given disproportionate impact of rate increases on young and healthy individuals, the limited cost associated with failure to pay at implementation and now the high rates providing an exemption from the penalty for many, the mandate has been proven as ineffective in Iowa.

Iowa Stopgap Measure

The Iowa Insurance Division filed a waiver under Section 1332 of the ACA seeking permission to implement the Iowa Stopgap Measure. The Iowa Stopgap Measure proposed to redistribute the estimated advanced premium tax credit subsidies expected by Iowa in 2018 between a reinsurance program and per-member per-month premium credits adjusted based on age and income. Any carrier that participated in the commercial individual health insurance market would only be able to sell the standard plan developed as part of the Iowa Stopgap Measure. As designed, the Iowa Stopgap Measure would have lowered monthly premium costs by 70% for Iowans and the state had commitments from multiple carriers to participate.

In October 2017, Iowa withdrew its waiver request when it became clear that the waiver would not have been granted on terms acceptable to Iowa, nor in time for open enrollment. The Affordable Care Act, the Centers for Medicare and Medicaid Services and the Department of Treasury proved unworkable and inflexible.

A full copy of the Iowa Stopgap Measure application can be found here: https://iid.iowa.gov/documents/state-of-iowa-1332-waiver-submission.

Federal Law Requires Federal Action

Regulatory Changes

The breadth and scope of the regulatory requirements of the ACA pre-empts states' ability to develop solutions to address the nuances and complexities of their individual markets. The inability of federal legislators to pass legislation to address the structural flaws of the ACA continues to impede meaningful change. The instability and inaction creates confusion not only for consumers but for carriers and regulators as well.

President Trump issued an Executive Order on October 12, 2017 that aims to provide more flexibility into the non-ACA-compliant market. Specifically, the Order directed federal agencies to promulgate rules to expand access to association health plans. Today, the Department of Labor released a

proposed regulation which seeks to expand access to Association Health Plans. Our office is reviewing the proposed rulemaking against current state law and regulations.

The Order also directed HHS to draft new rules regarding short-term limited duration insurance plans. The Obama Administration required these plans to be issued for periods not exceeding 3 months, when these plans had previously been available in 12 month increments. It is anticipated that the new rules will remove the 3 month time limit and allow these plans to be issued for a period of 12 months.

Both of these measures are likely to provide relief to consumers who are priced out of the market, but they will further segment the individual market risk pool as young and healthy consumers may choose to purchase plans through these vehicles rather than continue to participate in the ACA-compliant market.

Reinsurance

As described above, there are significant claims costs associated with Iowa's individual health insurance market. Supporting these costs to carriers with some kind of reinsurance mechanism to share catastrophic events will be critical to not only bring carriers back into the market, but lower premium rates for all Iowans.

There has been discussion about the potential for submitting a new Section 1332 waiver focusing solely on reinsurance. Several states, including Alaska, Minnesota, and Oregon, have successfully applied for such a waiver and are implementing reinsurance programs in 2018. These states will utilize significant state funds, whether they come through an assessment or other funding mechanism, to provide to carriers reinsurance for high cost claims. These funds will drive down premium costs, creating savings in the amount of federal subsidies needed to support these premiums. This "savings" in the subsidies will be passed back to the state to repay itself for the reinsurance. However, there is no guarantee that the resulting savings will equal, or come close to equal, the amount of reinsurance funds needed to drive down premium rates.

In addition to the funds needed to provide the initial reinsurance, significant state resources are required to draft, implement, and manage such a reinsurance program. At this juncture, the impact of a reinsurance program alone is unlikely to provide the stabilization needed in Iowa's market. Although reinsurance for high cost claimants is a necessary part of the solution, reinsurance alone cannot be the solution.

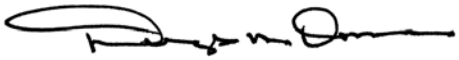
Restructuring of Subsidy Structure

As evidenced in our Stopgap Measure proposal, we believe that a Congressional change or broad state waiver authority is required in the subsidy structure. For example, subsidies could be adjusted to account for the consumer's age and income, as opposed to just income. That subsidy structure would attract young and healthy individuals into the market by adjusting premium costs to better and more accurately reflect the consumer's health risk and costs. A 25-year-old will have different health risk and benefit utilization than a 60-year-old, and this difference is not only muted, but reversed to the disadvantage of the young by the age band restrictions and the income only based subsidy structure.

Conclusion

Our office remains committed in its goals to ensure that Iowa consumers have access to affordable and meaningful health insurance. The Iowa Insurance Division is open to ideas, and is willing to engage with legislators, business leaders, and consumers alike to develop a solution that works for Iowa. However, without meaningful federal legislative movement, it will be difficult to overcome the failure of the ACA in our state.

Respectfully,



Doug Ommen
Iowa Insurance Commissioner

cc: Members of the Iowa Legislature

NovaRest
ACTUARIAL CONSULTING

NovaRest Report for the Iowa Insurance Division

In support of the

Annual Report to the Iowa Governor and to the Iowa Legislature

January 2018

NovaRest
ACTUARIAL CONSULTING

Table of Contents

Introduction

This report was prepared by NovaRest Consulting for the Iowa Insurance Division (Division). We understand that the Division will use the information in this report as the basis of the annual report for the governor of Iowa and for the Iowa legislature. The annual report, required by statute (Iowa Code §505.18), provides findings regarding health spending costs for health insurance plans in Iowa for the previous calendar year.

The purpose of the annual report is to increase health care insurance transparency and provide consumers with the information necessary, and the incentive, to choose health plans based on cost and quality. Reliable cost and quality information about health care insurance empowers consumer choice, which incentivizes and motivates the entire health care delivery system to provide better care and benefits at a lower cost. It is the purpose of this report to aid in making information regarding the costs of health care insurance readily available to consumers.

This report is intended to provide information in a form that can be used in the annual report to the governor of Iowa and the Iowa legislature.

This report uses information gathered from the top 95% of health insurers by premium in Iowa through a data request from the Iowa Insurance Division. Our goal is to ensure that we have the most accurate and complete information possible. We have noted all situations when the data request information was not complete. Additional information was extracted from statutory annual financial statement information filed with the National Association of Insurance Commissioners (NAIC), the Unified Rate Review Templates (URRTs) filed by the companies, and other public sources that we believe are credible.

Since the carriers that fall in the top 95% can change every year, some carriers surveyed in the 2017 data call do not have data prior to 2016 and some carriers surveyed in earlier years do not have 2016 data. Medica Insurance Company was new to the Iowa individual market in 2016 and has been added to the list of carriers that were surveyed. The other carriers surveyed are consistent with the 2016 Annual Report to the Iowa Governor and to the Iowa Legislature.

The following companies were included in the 2017 data call (survey) based on their health care premium market share in Iowa in 2016:

- Aetna Health of Iowa, Inc.
- Coventry Health & Life Insurance Co.
- Federated Mutual Insurance Co.
- Golden Rule Insurance Co.
- Medica Insurance Co.[1]
- Medical Associates Health Plan, Inc.
- United Healthcare Insurance Co.
- United Healthcare Plan of the River Valley
- Wellmark Health Plan of Iowa, Inc.
- Wellmark, Inc.

This report is structured to follow the requirements of the annual report required by Iowa Code §505.18. The summary of the results is first presented, followed by a section with more detail for each requirement, and finally the appendices containing all of the raw data in tabular format.

Summary

- The percentage of the Iowa population that is uninsured in 2016 is consistent with the 2015 numbers and is among the lowest in the nation according to the Kaiser Family Foundation.[2]

- In 2016, Wellmark, Inc. continued to hold a significant market share in the individual, small group, and large group markets, consistent with prior year's reports. Wellmark, Inc's market share among those carriers surveyed increased from 44% to 51% in the individual market using 2015 and 2016 member months calculated from the survey.[3] This market share increased from 64% to 66% in the small group market and decreased from 69% to 68% in the large group market over the same period.

- Medica was new to the Iowa individual market in 2016 and while they had the lowest market share among those carriers surveyed in 2017, they will be the only carrier participating in the Iowa individual market offering ACA policies in 2018 following the withdrawal of UnitedHeathcare (United) (Golden Rule's parent company) from the Iowa individual market

[1] Medica Insurance Company entered the Iowa individual market in 2016. They did not participate in any Iowa health insurance market prior to 2016 and were not included in prior surveys.
[2] KFF.org. "Health Insurance Coverage of the Total Population." Updated 2017. https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=3&selectedDistributions=uninsured&sortModel=%7B%22colId%22:%222016__Uninsured%22,%22sort%22:%22desc%22%7D. Accessed November 28, 2017.
[3] Although we do not request member months directly from the carriers, they do provide the total incurred claims and the incurred claims PMPM. We then use this information to calculate the member months and we verify the numbers are accurate using the NAIC Statements and Supplemental Health Care Exhibits.

for the 2017 plan year and the withdrawal of the subsidiary companies of Wellmark Blue Cross and Blue Shield (Wellmark) and Aetna from the Iowa individual market for the 2018 plan year.[4]

- Loss ratios in the individual market continue to run very high, 99% on a non-weighted straight average basis and 95% when weighted by member months. Although the average weighted loss ratio decreased from the 2016 data call, carriers in this market are likely continuing to operate at a loss. The loss ratios in the small group and large group markets are closer to the federal minimum loss ratio requirements and are relatively consistent with the amounts provided in the 2016 data call with only a slight increase and decrease in each market respectively.

- Average rate increases in the individual market continue to increase as they have since the implementation of the ACA in 2014, to 24% in 2016 on a weighted average basis. Although one carrier in the individual market reported a 5% rate increase, the other three companies who had an increase in 2016 reported increases ranging from 19% to 33%. The rate increases in the small group and large group market also increased, but were much more modest averaging 9% and 7% respectively on a weighted average basis.

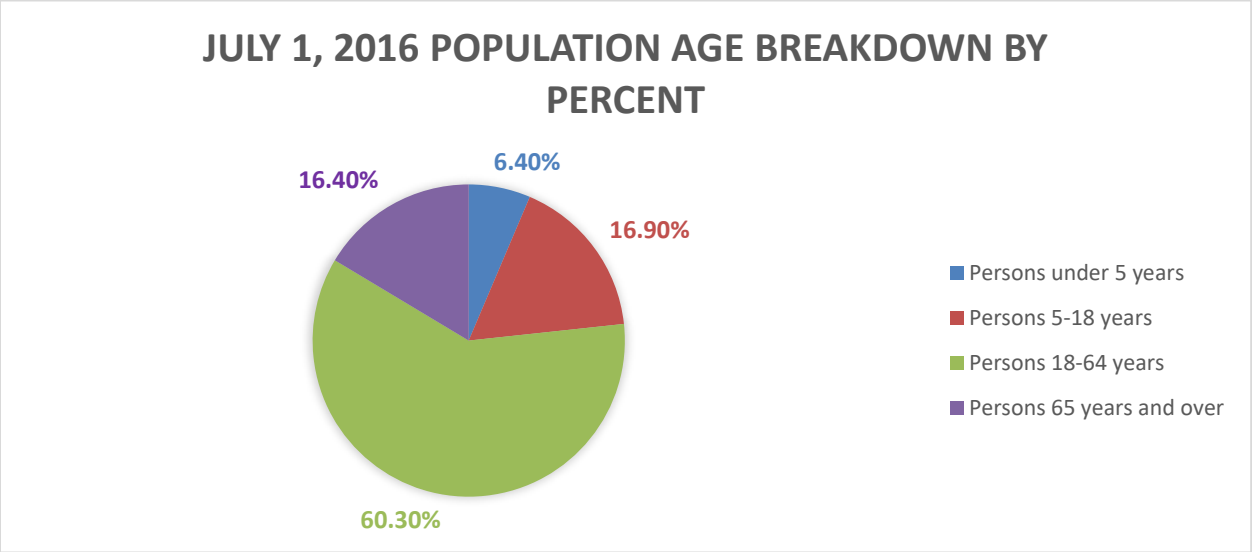
- Health care expenditures in Iowa continued to trend upward according to a CMS report of health care expenditures by state from 1980 to 2014.[5] Even with increases in the health care expenditures, Iowa is below the median per capita health care expenditure in the nation. [6] We also reviewed carrier submitted information from 2014 to 2016 which also showed that the individual market health care costs per-member-per-month (PMPM) are increasing at a much faster rate than the small group market.

- Cost drivers increased and decreased at a more uniform rate in 2016 as compared to 2015 with the top five drivers consuming a lower percentage of the total increase cost factors. Carriers also reported lower cost drivers and cost reduction drivers than in past reports.

[4] Pitt, David. "Iowa May Be First State With No Health Insurers on Exchange." U.S. News. June 12, 2017. https://www.usnews.com/news/best-states/iowa/articles/2017-06-12/iowa-official-pitches-stopgap-health-insurance-solution. Accessed December 4, 2017.
[5] CMS.gov. "State (Provider) Health Expenditures by State of Provider, 1980-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html
[6] CMS.gov. "Health Expenditures by State of Residence, 1991-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html.

Background

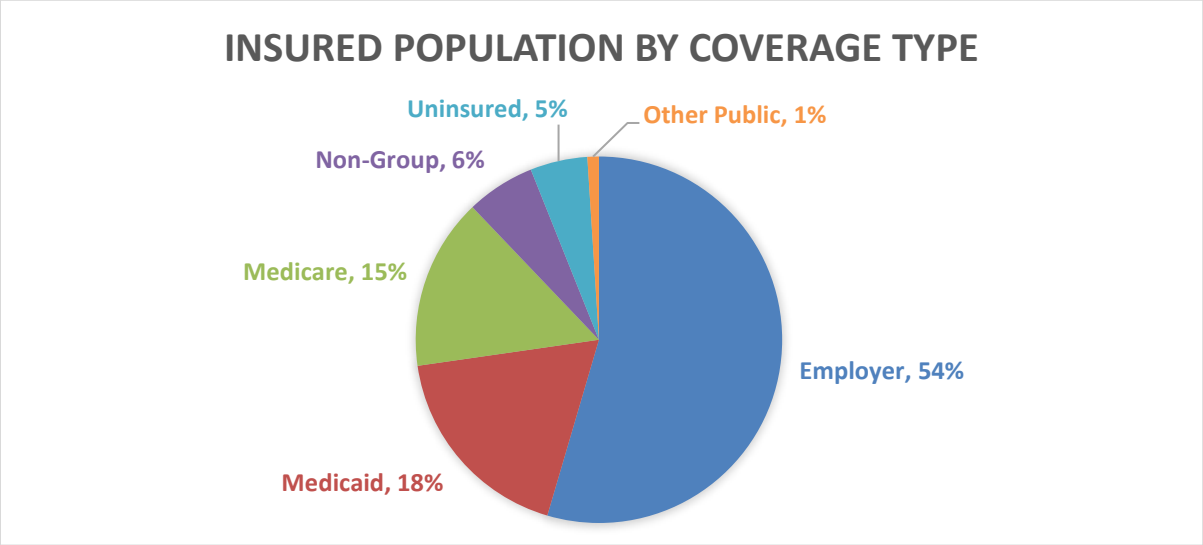
Iowa's total population as of July 1, 2016 is 3,134,693.[7] A breakdown of the major age groups is below.



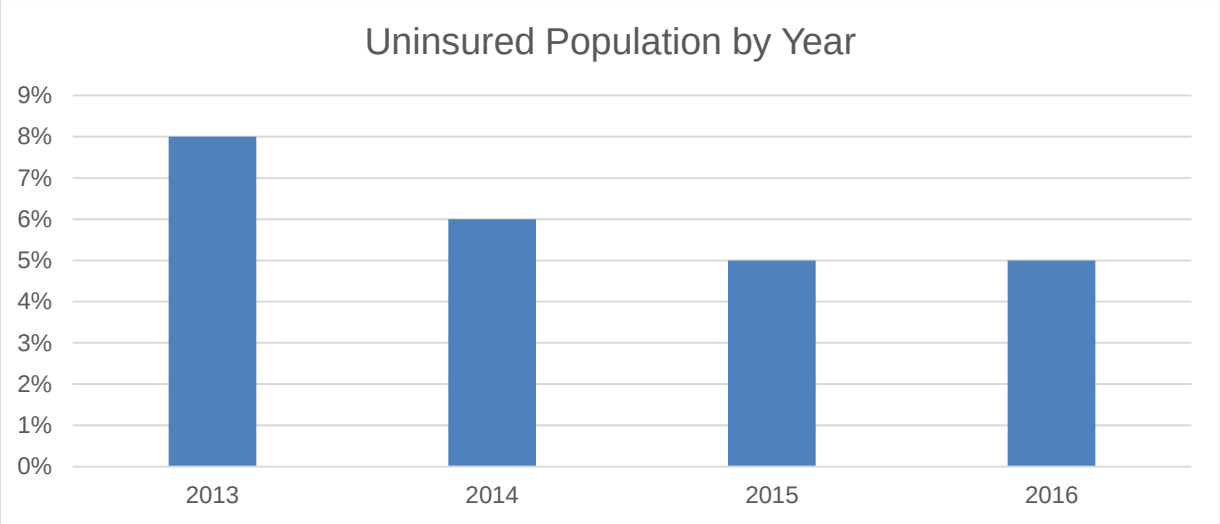
The median household income (in 2016 dollars) from 2012 to 2016 for the Iowa population was reported by the U.S. Census Bureau as $54,570.[8] This is only slightly below the U.S. median household income of $59,039.[9] The American Community Services (ACS) estimated 11.8% of the Iowa population in 2016 was considered below the poverty level.[10]

In 2016, 60% of the population were enrolled in the commercial non-public insurance market, with 54% receiving coverage from an employer and 6% receiving coverage from the non-group non-public market.[11] Another 34% of the population were receiving coverage from public programs such as Medicaid and Medicare. The insured population by coverage type can be seen in the following chart.

[7] U.S. Census Bureau. QuickFacts: Iowa. https://www.census.gov/quickfacts/IA. Accessed December 11, 2017.
[8] U.S. Census Bureau. QuickFacts: Iowa. https://www.census.gov/quickfacts/IA. Accessed December 11, 2017.
[9] U.S. Census Bureau. Income, Poverty and Health Insurance Coverage in the United States: 2016. https://www.census.gov/newsroom/press-releases/2017/income-povery.html. Accessed December 11, 2017.
[10] U.S. Census Bureau. QuickFacts: Iowa. https://www.census.gov/quickfacts/IA. Accessed December 11, 2017.
[11] KFF.org. "Health Insurance Coverage of the Total Population." Updated 2017. https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=3&selectedDistributions=uninsured&sortModel=%7B%22colId%22:%222016__Uninsured%22,%22sort%22:%22desc%22%7D. Accessed November 28, 2017.



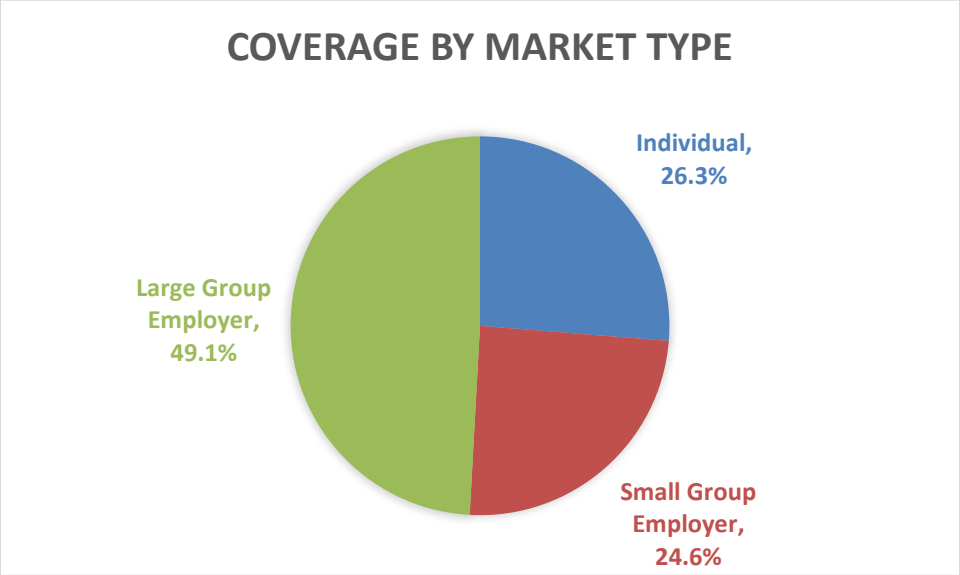
According to the Henry J. Kaiser Family Foundation, Iowa was tied with Hawaii, Oregon, Pennsylvania, Rhode Island, and Vermont for the lowest uninsured population in the U.S. with 5% of the population uninsured in 2016.[12] This percentage has been trending downward from 2013 to 2016 as can be seen in the following chart.[13] The large drop in 2014 was the result of Medicaid expansion in Iowa.



[12] KFF.org. "Health Insurance Coverage of the Total Population." Updated 2017. https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=3&selectedDistributions=uninsured&sortModel=%7B%22colId%22:%222016__Uninsured%22,%22sort%22:%22desc%22%7D. Accessed November 28, 2017.

[13] KFF.org. "Health Insurance Coverage of the Total Population." Updated 2017. https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=3&selectedDistributions=uninsured&sortModel=%7B%22colId%22:%222016__Uninsured%22,%22sort%22:%22desc%22%7D. Accessed November 28, 2017.

Although a significant portion of the Iowa market is enrolled in public programs or are uninsured, the focus of this report is on the commercial non-public individual, small group, and large group markets. For those enrolled in these markets, the percentage covered are shown in the chart below.[14]



Enrollment

A complete set of data can be found in ***Appendix A.***

The 2016 health insurance market in Iowa was dominated by Wellmark, Inc. (51% to 69% of the three markets – individual, small group and large group). Therefore, the weighted averages for loss ratios[15] and rate increases provided in this report will fall very close to the Wellmark, Inc. values, even though there are significant differences between companies. These weighted averages were weighted by member months[16], which results in an average closer to what most members are experiencing as rate increases in their premiums. Taking the rate increases as an example, the weighted average will result in the same value as if a surveyor totaled and averaged the rate increases across all members in Iowa. By averaging across members rather than carriers we will attain a better estimate of the rate increases experienced by the population in Iowa.

While Wellmark, Inc. insured a majority of the 2016 Iowa individual market in 2016, it is important to note that United, Aetna, and Wellmark have all recently withdrawn their subsidiary companies from the individual market for 2018, leaving Medica Insurance Co. as the only carrier

[14] 2016 NAIC Supplemental Health Care Exhibit, All Carriers in Iowa.
[15] Note that in this report loss ratios are calculated as incurred claims over earned premium and not using the federal rebate formula definition for medical loss ratio.
[16] Member months are the number of total months covered for all individuals insured by a carrier in a market.

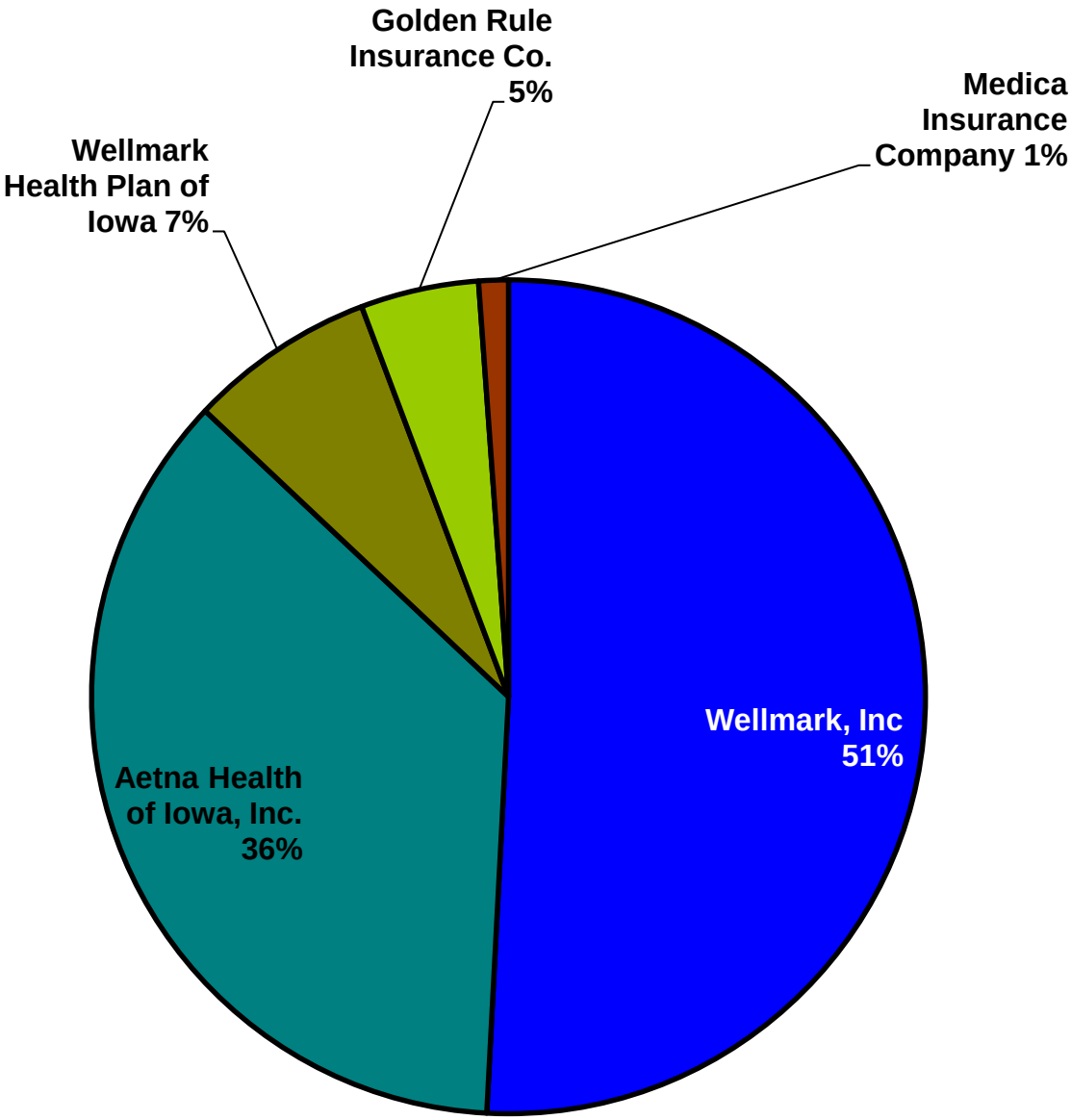
participating in the individual market to Iowa in 2018. [17] Therefore, the 2018 individual market will reflect only Medica's population. However, for the purposes of this report, Medica Insurance Co. only covered 15,036 member months in 2016 which we do not consider fully credible. Therefore, the values experienced by Wellmark, Inc. are more consistent with what the members experienced. We note that 2016 is the most recent data available as 2017 is not yet complete.

While Aetna, United, and Wellmark have withdrawn their subsidiary companies from the individual market, it is our understanding that they have not withdrawn from the small group or large group markets. We would therefore expect Wellmark, Inc. to continue to hold a significant group market share in the future.

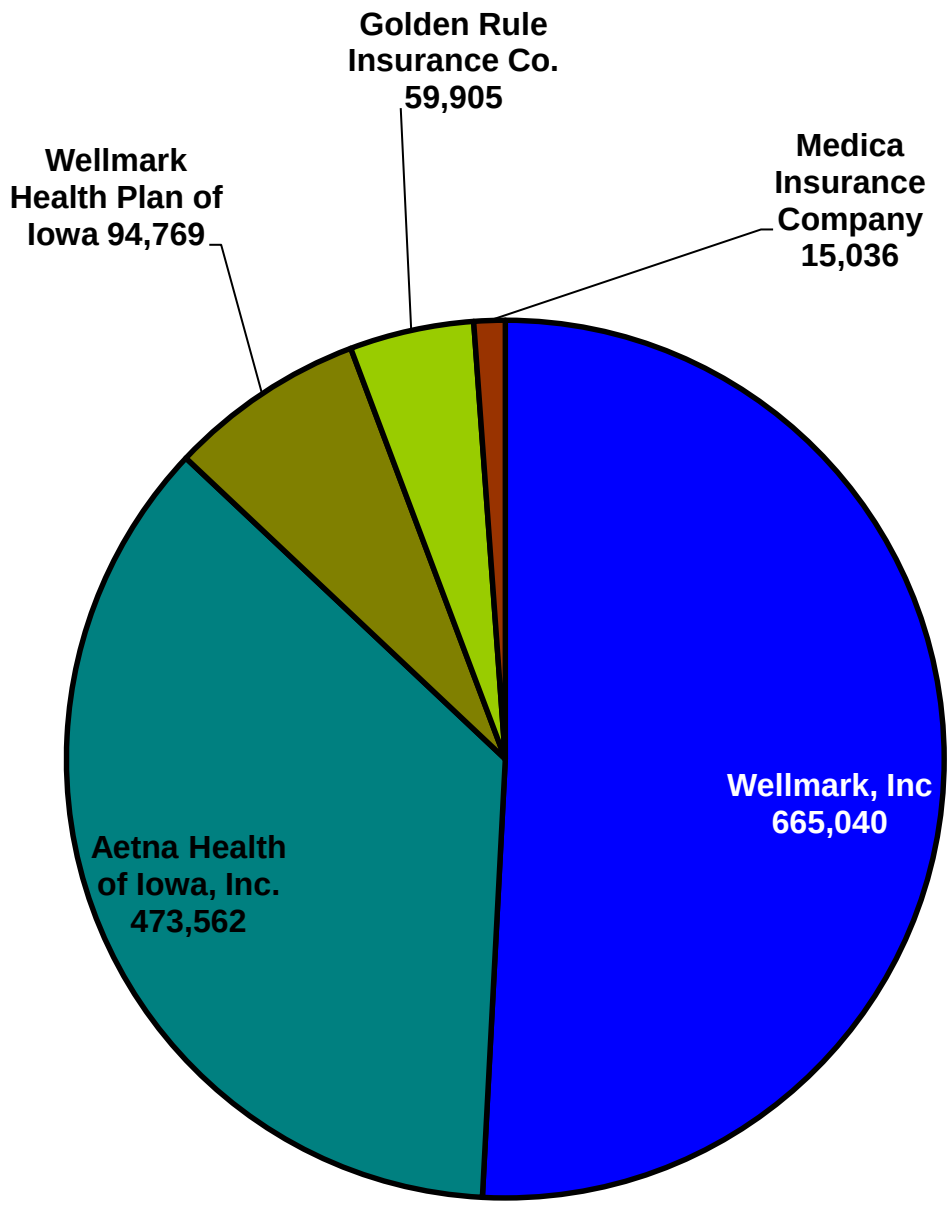
We have provided pie charts of member months to demonstrate the large variance in members per carrier in Iowa. The key for each chart is in descending order of total member months. A complete set of data can be found in ***Appendix A.***

[17] Pitt, David. "Iowa May Be First State With No Health Insurers on Exchange." U.S. News. June 12, 2017. https://www.usnews.com/news/best-states/iowa/articles/2017-06-12/iowa-official-pitches-stopgap-health-insurance-solution. Accessed December 4, 2017.

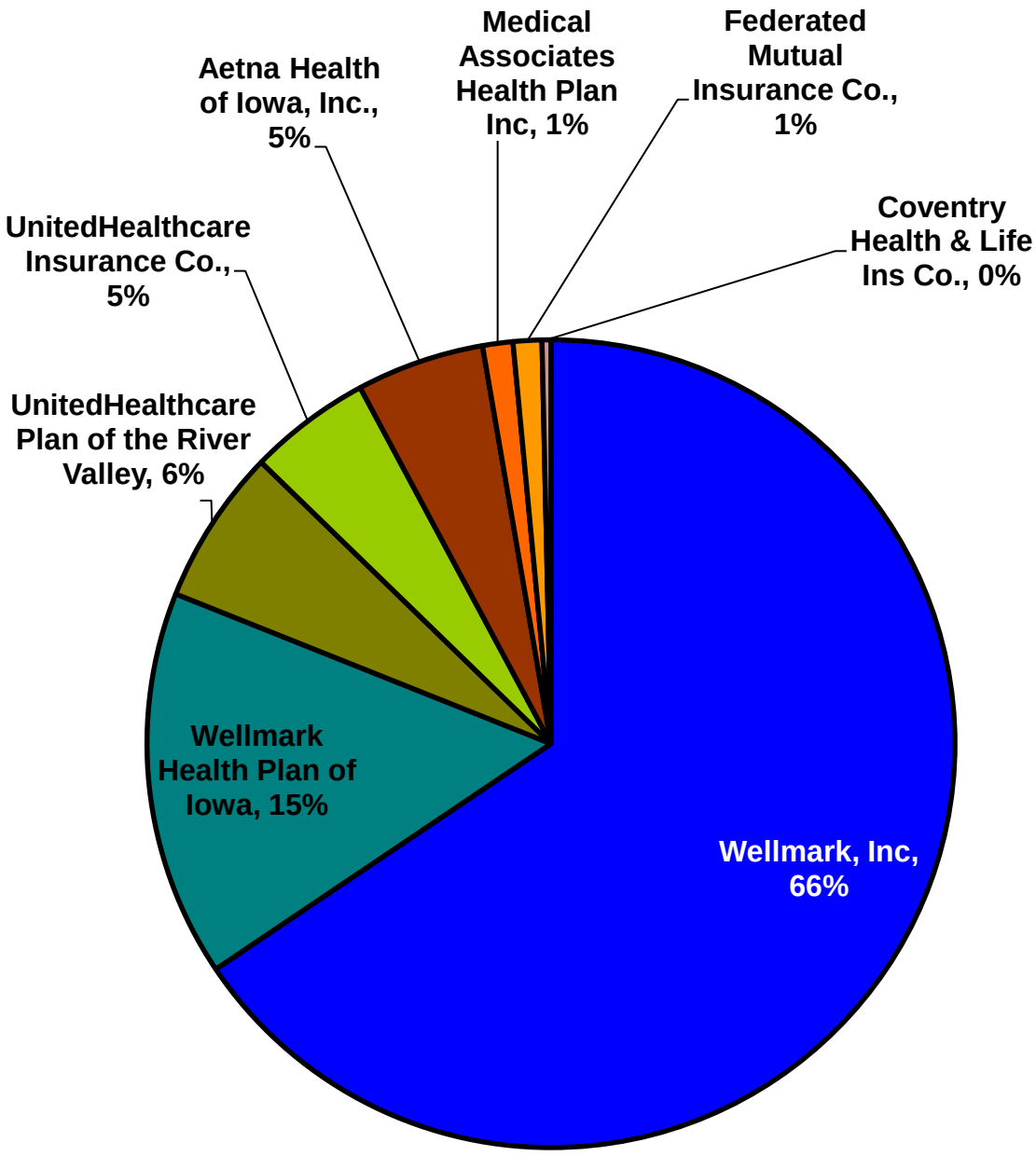
2016 Individual Comprehensive Major Medical (ICMM) Member Months by Percent



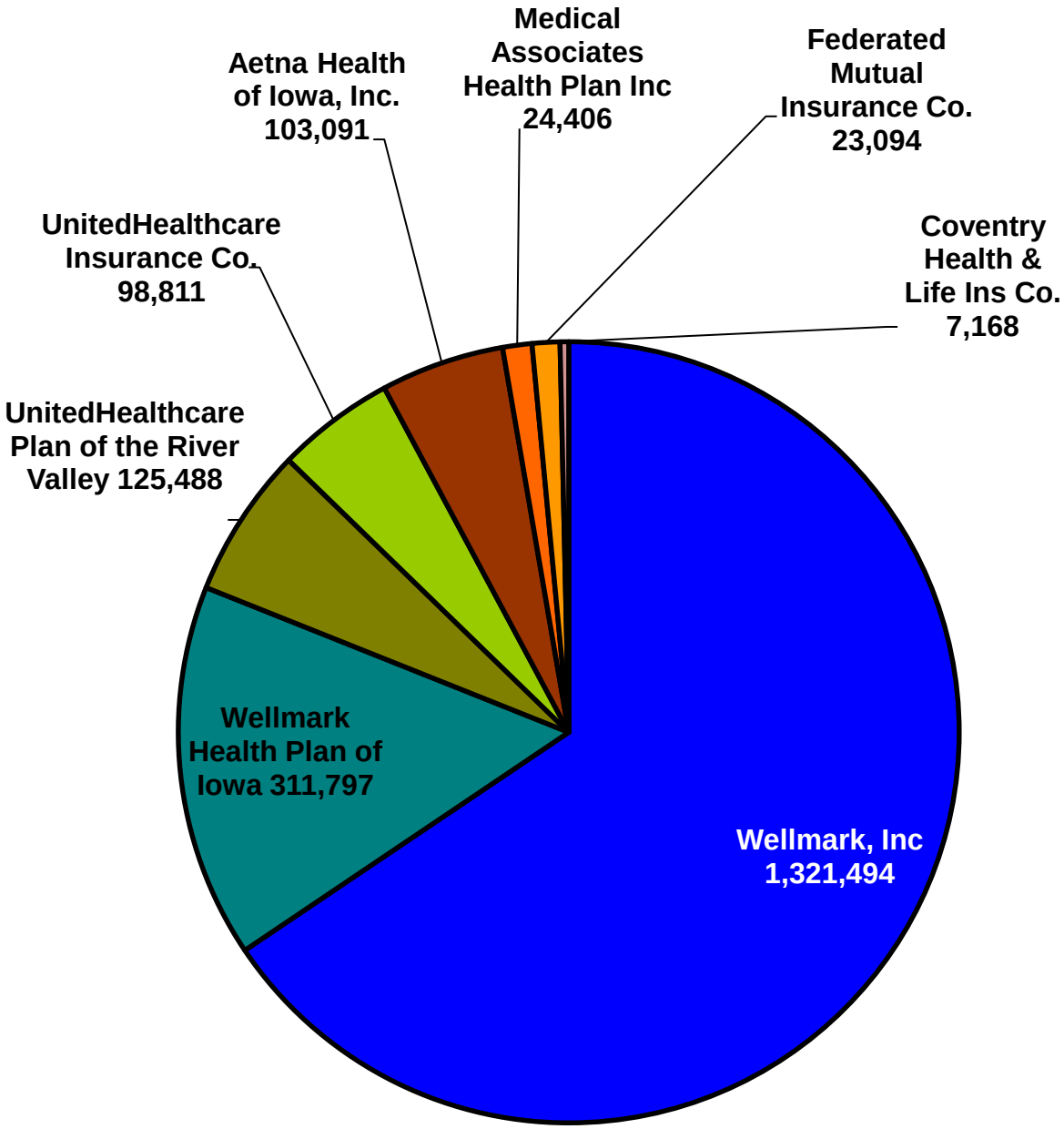
2016 ICMM Member Months



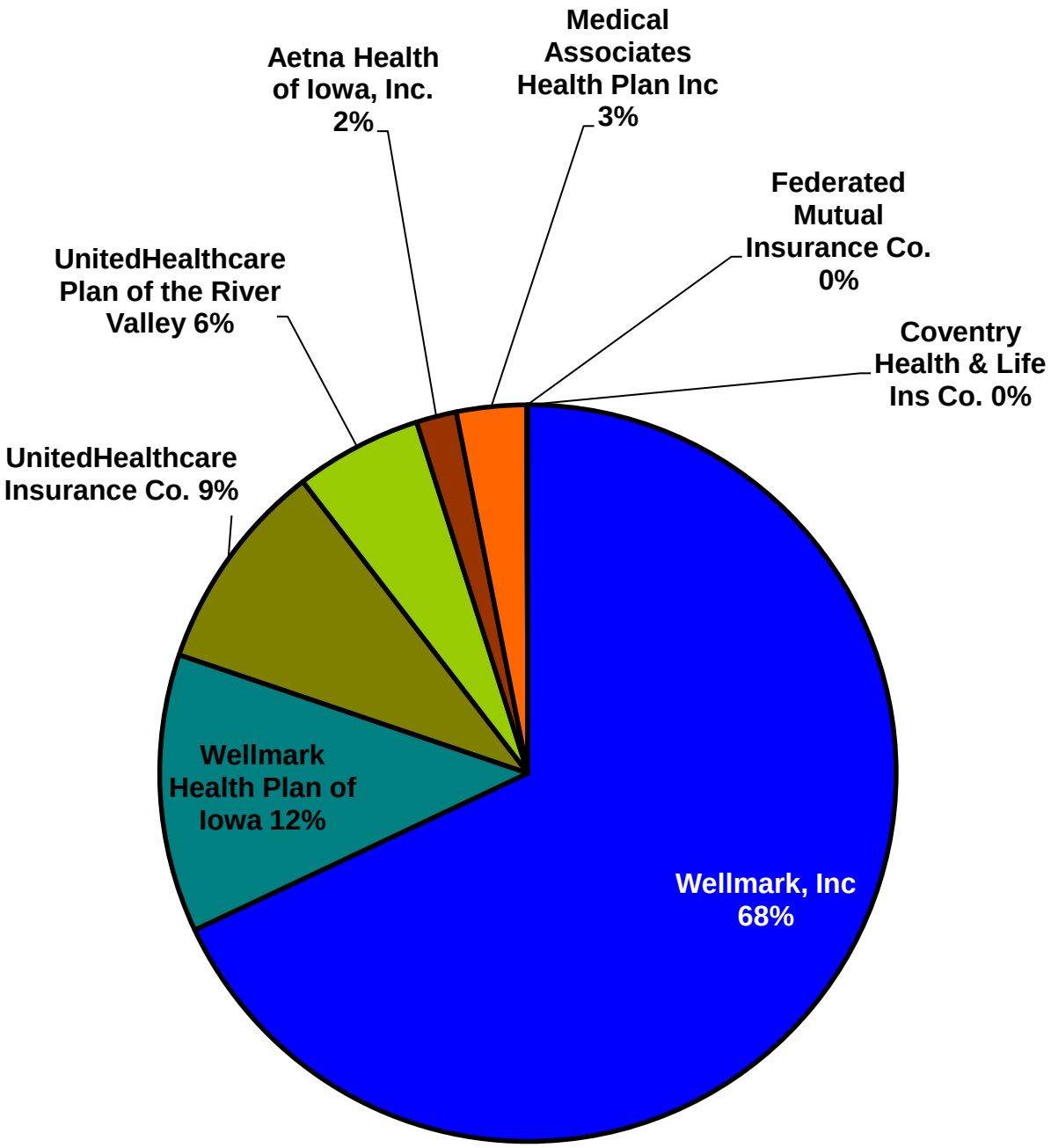
2016 Small Group Member Months by Percent



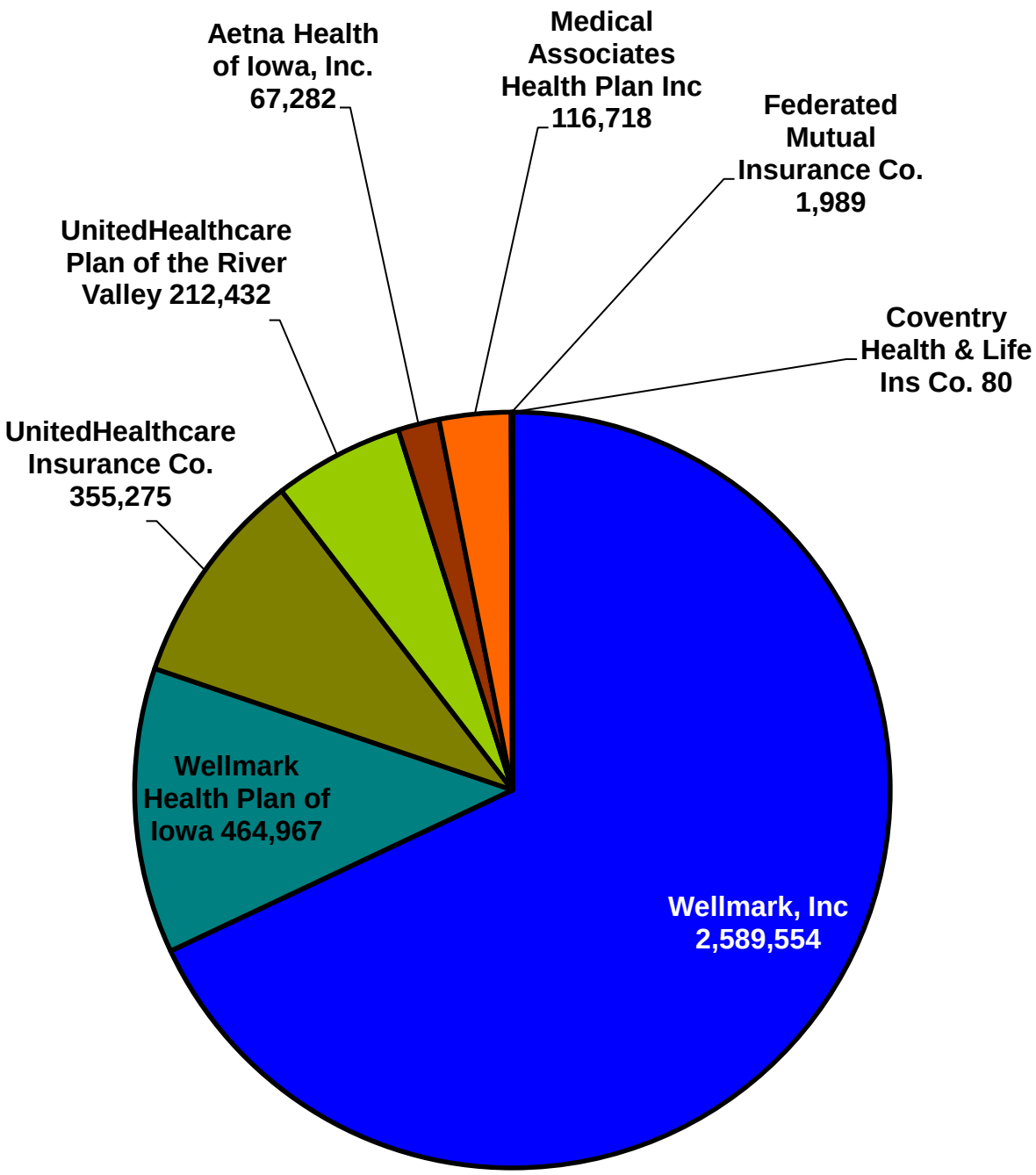
2016 Small Group Member Months



2016 Large Group Member Months by Percent



2016 Large Group Member Months



Loss Ratios

a. Aggregate health insurance data concerning loss ratios of health insurance carriers licensed to do business in the state.

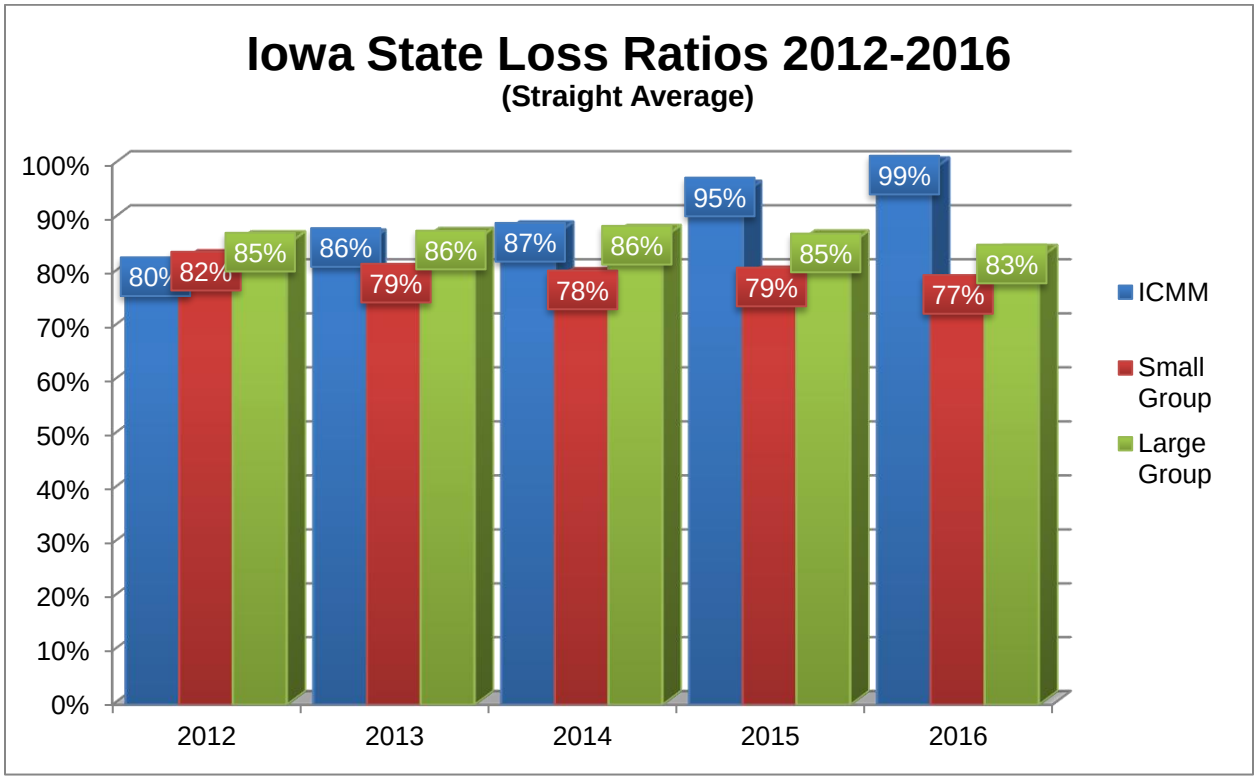
A complete set of data can be found in ***Appendix B.***

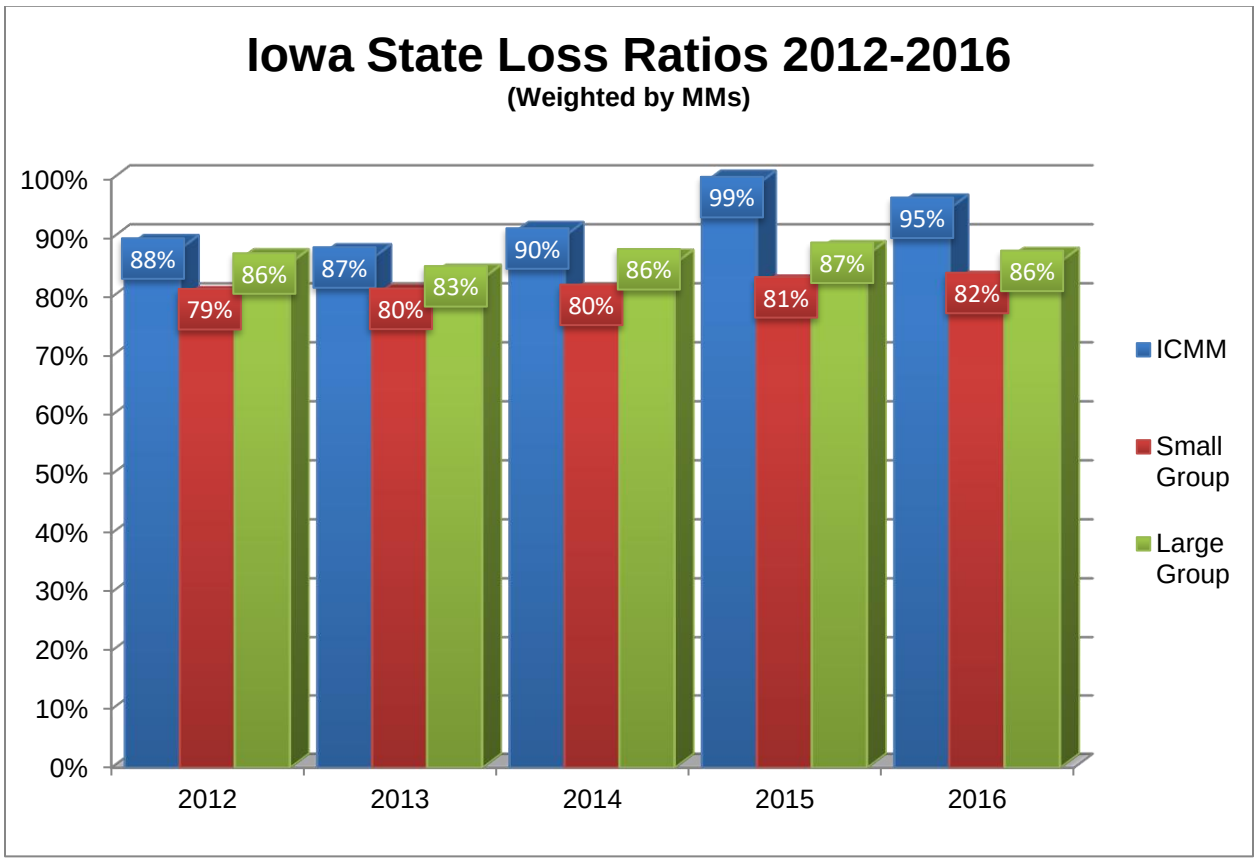
A loss ratio is the ratio of claims to premiums. In addition to direct claims payments for medical services, the claims used in the loss ratio may include case management services, the cost of quality improvement efforts and other costs related to health care services not directly delivered to members. No specific definition of claims was provided to carriers. The federal health insurance reform requires carriers in a state to provide a rebate to policyholders if the carrier's loss ratio, with certain adjustments, is less than 80% for the individual or small group markets and 85% for the large group market.[18] Note: the loss ratios provided by the carriers do not include the adjustments that are allowed under the federal loss ratio definition, therefore we cannot definitively say if a carrier will be required to pay a rebate based on the information that was provided. The federal loss ratios for rebate purposes are also adjusted for credibility. If a carrier has less than 75,000 life years in a market, an amount is added to the calculated MLR. The result of the credibility adjustment is that carriers can have a loss ratio lower than the federal standard and still not be required to pay a rebate.[19] The remaining 20% or 15% is the amount of premium that is available for the cost of administering the insurance (commissions, paying claims, tracking enrollment changes, etc.) and for company profits.

According to the information filed in the 2016 Supplemental Health Care Exhibit (SHCEs) for all carriers in the Iowa market, $0 in rebates were paid in the individual market, $563,907 were paid in the small group market, and $948,563 were paid in the large group market in 2016 for the 2015 plan year. [20] Further investigation revealed that the entirety of these rebates was paid by Aetna Health of Iowa, Inc and no other carriers paid rebates in 2016 for the 2015 plan year.

The 2016 average loss ratios are 99%, 77% and 83% for individual, small group, and large group respectively on a non-weighted basis. When loss ratios are weighted by membership in the ten companies, the averages are 95%, 82% and 86% for individual, small group, and large group respectively. The following graphs detail the average (not-weighted and weighted) loss ratios for the past 5 years.

[18] Not enough information was accessible to calculate the federal loss ratios. All loss ratios in this report are the ratio of claims to premiums.
[19] In Iowa, Wellmark is the only carrier that is fully credible according to the federal formula and therefore the only carrier required to meet the full 80% or 85% loss ratio requirement.
[20] Per NAIC Supplemental Exhibit. Information related to MLR rebates paid in 2017 for 2016 are not available at this time.


Iowa State Loss Ratios 2012-2016
(Straight Average)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
80%
82%
85%
86%
79%
86%
87%
78%
86%
95%
79%
85%
99%
77%
83%
2012
2013
2014
2015
2016
ICMM
Small Group
Large Group


Iowa State Loss Ratios 2012-2016
(Weighted by MMs)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
88%
79%
86%
87%
80%
83%
90%
80%
86%
99%
81%
87%
95%
82%
86%
2012
2013
2014
2015
2016
ICMM
Small Group
Large Group

Using the straight averages, it seems the loss ratios in the individual market have been increasing over the past five years, to 99% in 2016. This means that carriers on average pay out essentially all of the premiums they receive as claims, leaving only 1% of premiums available for non-benefit expenses such as administrative costs, taxes, and profit. When weighted by membership, the average loss ratio in the individual market still shows an increase in loss ratios over the past few years, to 95% in 2016 which, although lower than the straight average, is still high. The federal minimum loss ratio requirement in the individual market is 80%.

The small group and large group average loss ratios (weighted and unweighted) seem much less volatile over the past 5 years. The small group loss ratios in 2016 were 77% using a straight average and 82% using a weighted average. These are very close to the ACA minimum MLR requirement of 80% for the small group market. The large group loss ratios in 2016 were 83% using a straight average and 86% using a weighted average which is also close to the ACA minimum MLR requirement of 85% for the large group market.

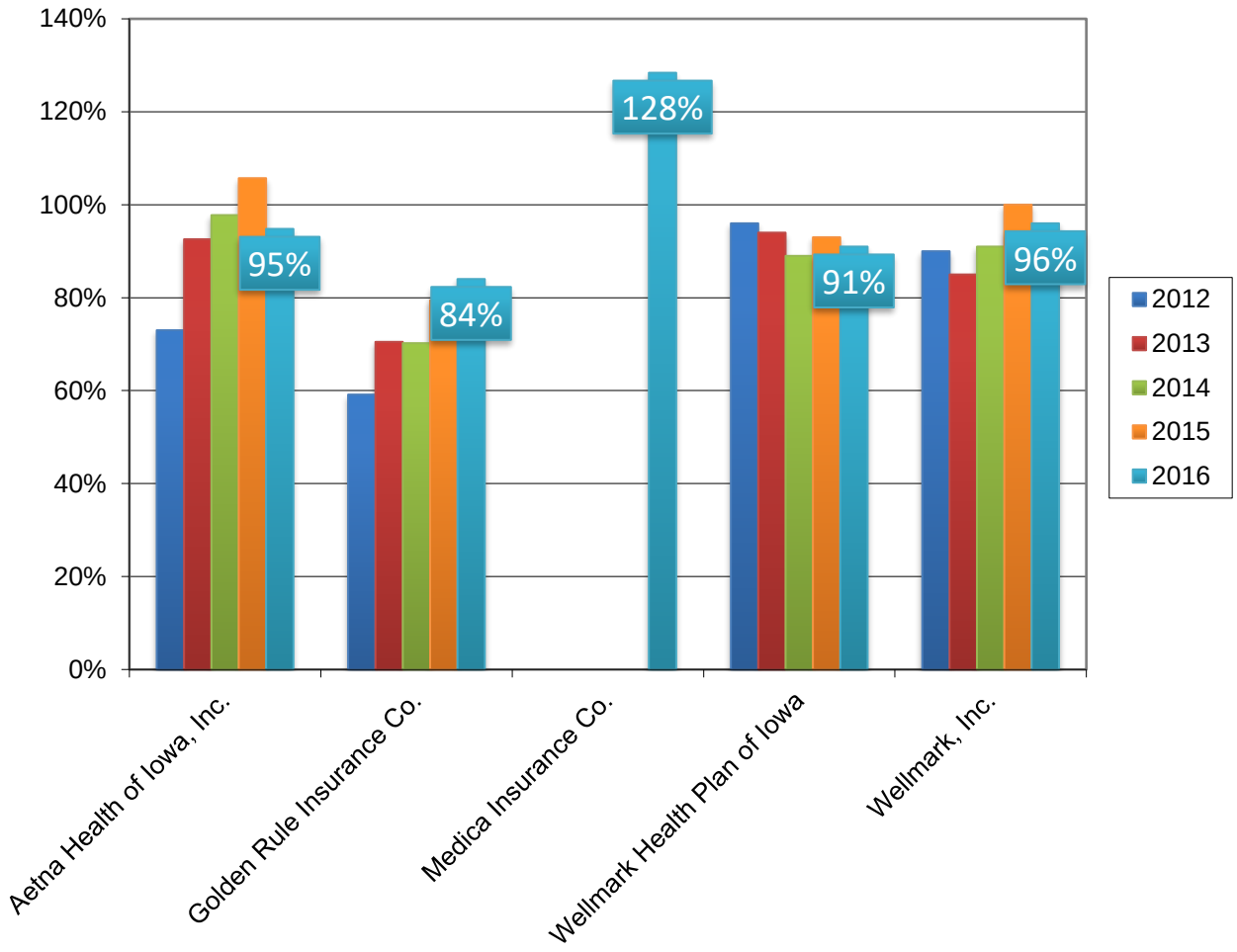
As discussed above, the federal rules allow additional adjustments to the numerator (claims) and denominator (premium) of the loss ratio to determine if a carrier has to pay rebates, so the information provided by the carriers and presented in the previous tables is not on the same basis as the 80% requirement, though it does provide a good estimate of the percentage of premium that carriers are paying in health care claims.

Under the federal health insurance reform rebate regulations from CMS, carriers with less than 75,000 life years are allowed to take an adjustment to the medical loss ratio used in the rebate formula. The adjustment is intended to compensate for the larger statistical fluctuations found in smaller less credible blocks of business. This credibility adjustment increases the actual loss ratio used for rebate calculation purposes based on the size of the carrier with smaller carriers receiving larger adjustments. As was the situation for 2016 rebates, all carriers in Iowa except for Wellmark, Inc. (in the Small Group and Large Group market), will receive a credibility adjustment for 2017 rebates.

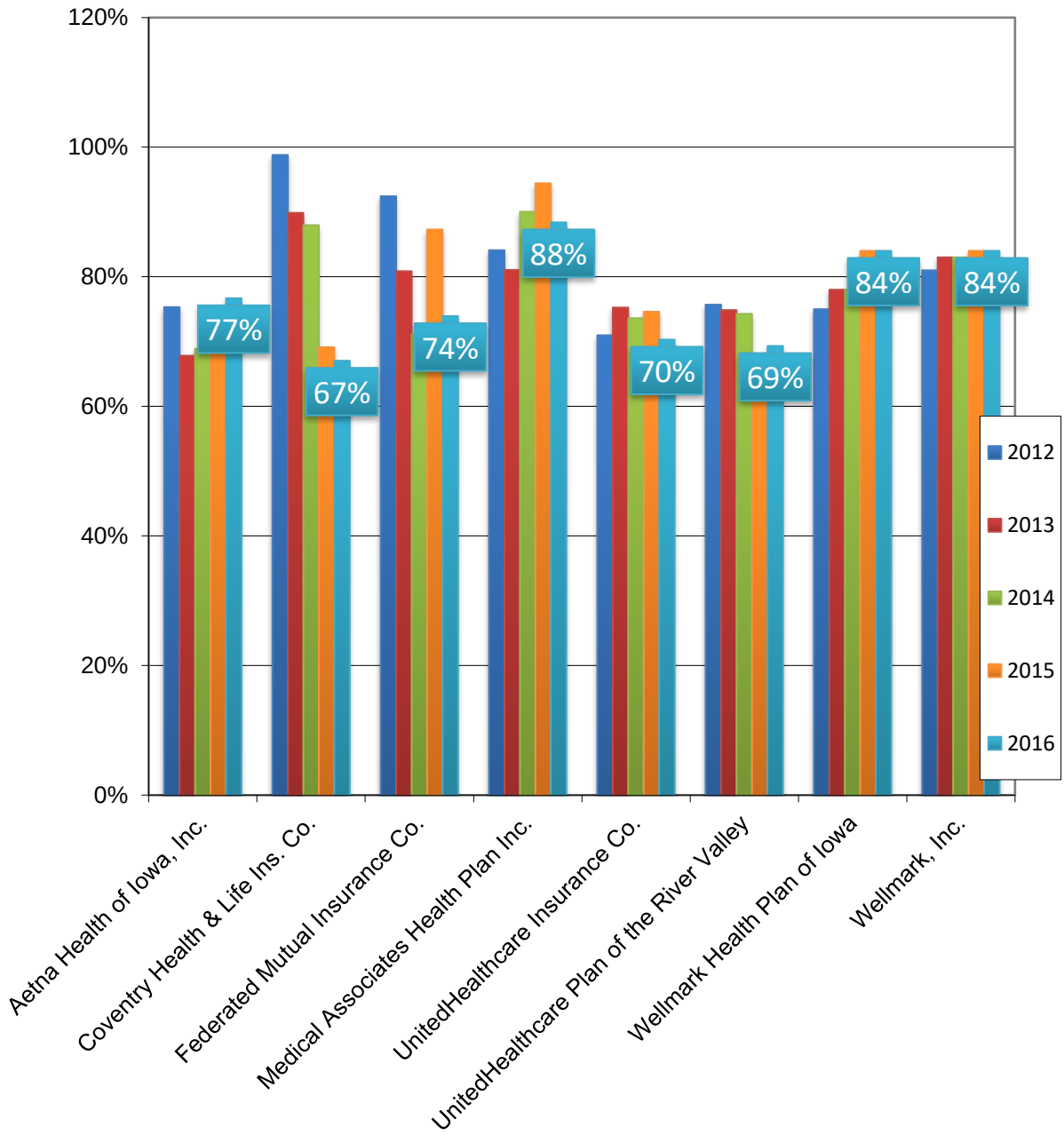
There is wide variation in loss ratios from company to company. Individual loss ratios varied from 84% to 128% in 2016 before credibility adjustment. Small and large group varied from 67% to 88% and 66% to 93% respectively before credibility adjustment. The following charts are loss ratios using straight averages and loss ratios weighted by membership. The weighting results in loss ratios closer to those of Wellmark, Inc. and is more representative of the actual loss ratio average in Iowa. The loss ratios displayed here do not use the federal medical loss ratio (MLR) formula used for the federal MLR rebate calculation. The rebate MLR is typically higher than the traditional loss ratio displayed here.

The following charts compare companies for each market segment for 2012-2016. Note that companies that do not offer coverage in a market segment are not included.

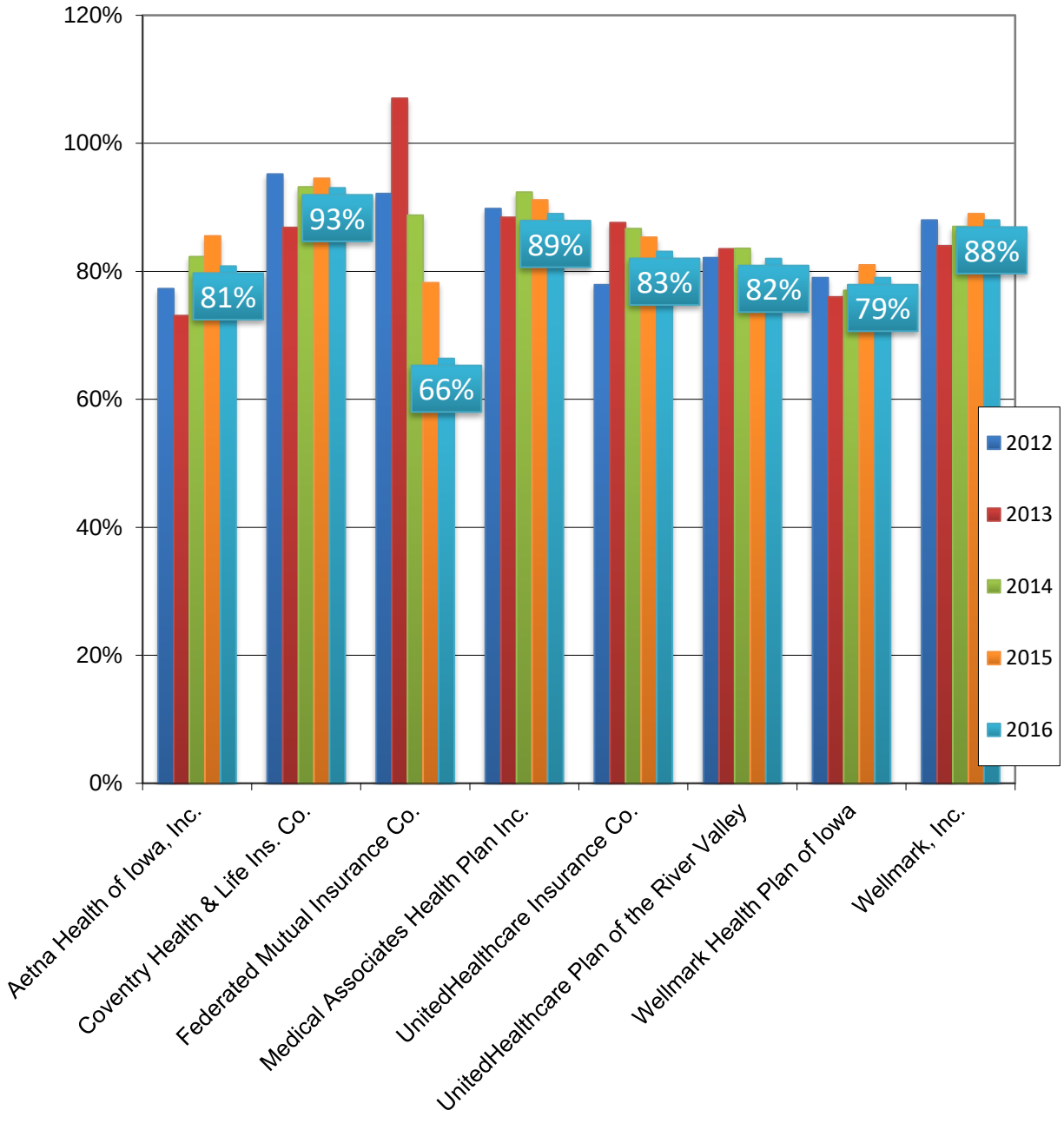
ICMM Loss Ratios 2012-2016



Small Group Loss Ratios 2012-2016



Large Group Loss Ratios 2012-2016



The following three tables show each company's loss ratio by market for 2016:

2016 ICMM Loss Ratios	
Aetna Health of Iowa, Inc.	95%
Golden Rule Insurance Co.	84%
Medica Insurance Co.	128%
Wellmark Health Plan of Iowa, Inc.	91%
Wellmark, Inc.	96%

2016 Small Group Loss Ratios	
Aetna Health of Iowa, Inc.	77%
Coventry Health & Life Ins. Co.	67%
Federated Mutual Insurance Co.	74%
Medical Associates Health Plan, Inc.	88%
UnitedHealthcare Insurance Co.	70%
UnitedHealthcare Plan of the River Valley	69%
Wellmark Health Plan of Iowa, Inc.	84%
Wellmark, Inc.	84%

2016 Large Group Loss Ratios	
Aetna Health of Iowa, Inc.	81%
Coventry Health & Life Ins. Co.	93%
Federated Mutual Insurance Co.	66%
Medical Associates Health Plan, Inc.	89%
UnitedHealthcare Insurance Co.	83%
UnitedHealthcare Plan of the River Valley	82%
Wellmark Health Plan of Iowa, Inc.	79%
Wellmark, Inc.	88%

The part of the premium not used for claims is used for other expenses and profits. Companies surveyed reported a wide range of commission percentages and administrative percentages. The average commission percentage in 2016 was 1.93%, but it ranged from 1% to 4%. This is a slight decrease from the 2.00% average commission in 2015. Commissions for individual products are traditionally higher than for small group products and commissions for large group products are traditionally lower. The mix of business between individual and group may explain some of the variation between the companies because these lines of business have different levels of administrative cost. The average administrative expense percent of premium in 2016 was 12.94%, but the percentages ranged from 8.0% to 21.9%. This was also a decrease from the average administrative expense percent of premium of 13.98% in 2015. (See ***Appendix G*** for more detail on the highest percentages of other administrative costs reported by the companies).

Rate Increase History

b. Rate increase data.

A complete set of data can be found in ***Appendix C.***

The tables below detail the average rate increases among carriers included in the data call for the past 5 years, on a non-weighted basis and on a weighted basis. [21] As explained above, the weighted increases are weighted using member months and, due to Wellmark Inc.'s significant membership in all three markets, the weighted rate increases with more closely resemble Wellmark, Inc.'s rate increases.

ICMM Market Rate Increases	2012	2013	2014	2015	2016
Non-weighted	7%	5%	5%	10%	22%
Weighted	9%	9%	5%	10%	24%

Small Group Market Rate Increases	2012	2013	2014	2015	2016
Non-weighted	9%	9%	4%	5%	4%
Weighted	8%	8%	5%	7%	9%

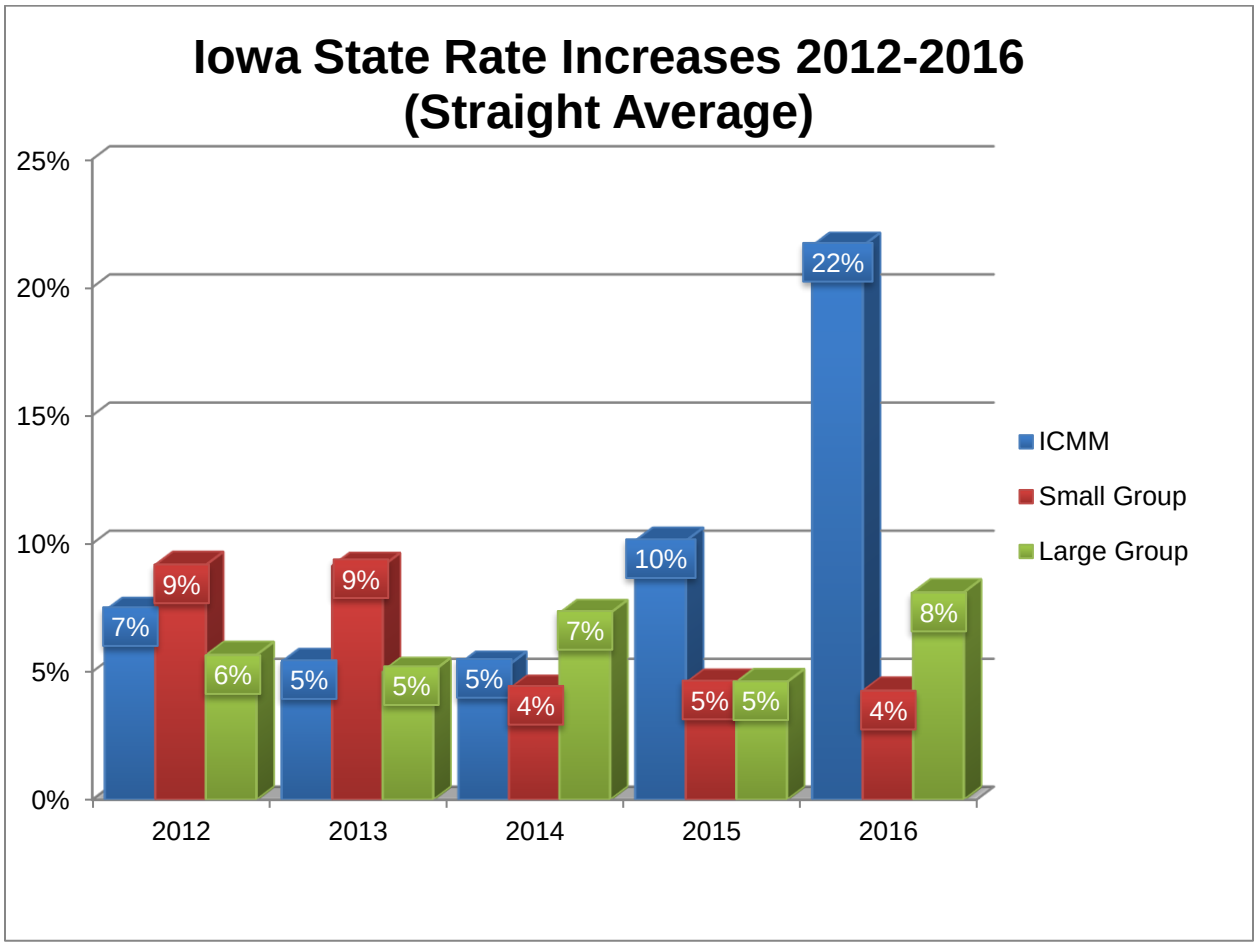
Large Group Market Rate Increases	2012	2013	2014	2015	2016
Non-weighted	6%	5%	7%	5%	8%
Weighted	6%	6%	6%	5%	7%

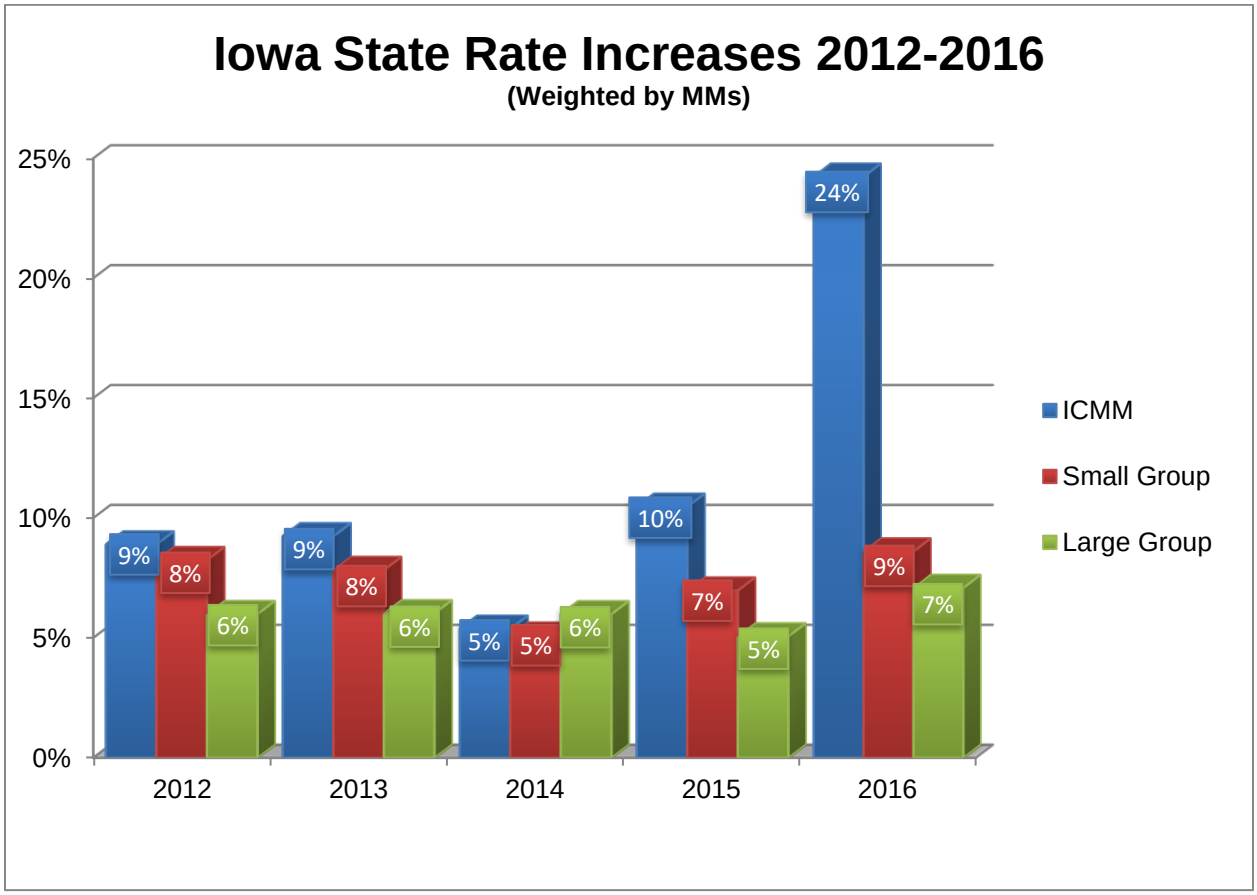
The individual market rate increases have been increasing significantly since the implementation of the ACA in 2014 on both a non-weighted (from 5% in 2014 to 22% in 2016) and weighted (from 5% in 2014 to 24% in 2016) basis. This, with the high loss ratios for the individual market presented in the prior section, show that carrier's experience was worse than projected for these years, and carriers required large rate increases to combat actual and potential losses in the market. The individual market rate increases varied from 5% to 33%[22], although disregarding Golden Rule's small increase and the rate increases ranged from 19% to 33%. For comparative purposes, the ACA required a determination of reasonableness from the State and an explanation from the carrier for any rate increases of 10 percent or more, although the Health and Human Services Department has proposed to increase this requirement to 15 percent in its proposed Benefit and Payment Parameters for 2019. The small group average rate increases have been relatively stable on a non-weighted basis, but have also been increasing on a weighted basis from

[21] This is an example of historic values that may not match previous reports due to the companies that have left the market and were removed from historic data.
[22] Medica Insurance Co. did not have a rate increase as they were new to the Iowa individual market in 2016.

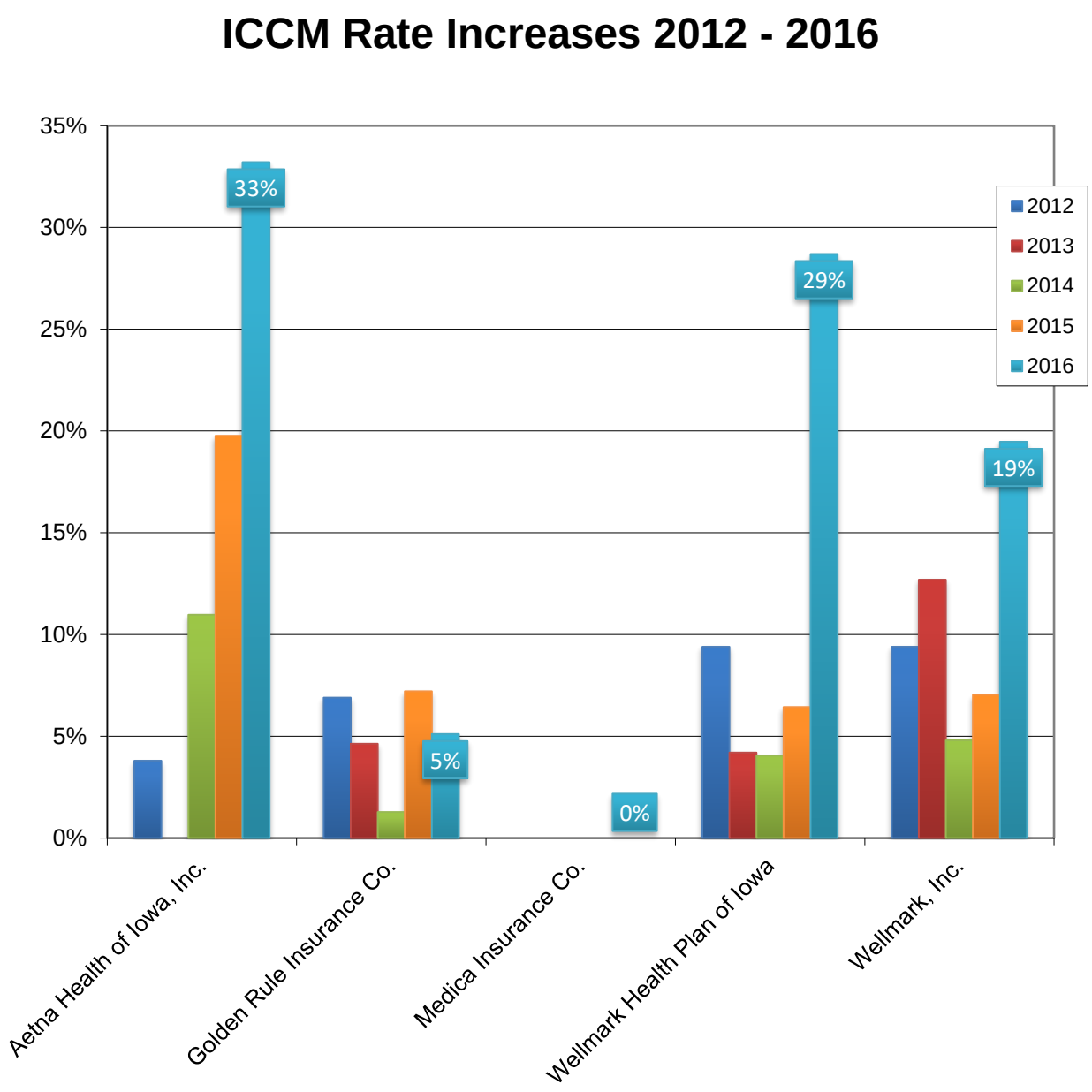
5% to 9% from 2014 to 2016. The carriers reported small group increases ranging from -8% to 11% in 2016. The large group average rate increases have also been relatively stable on both a non-weighted and weighted basis for the past five years. The large group market is much less affected by the implementation of the ACA because many of the regulations that apply to the individual and small group markets do not apply to the large group market. In 2016, carriers reported rate increases ranging from 3% to 15% for the large group market.

The following charts show rate increases using straight averages and rate increases weighted by membership.



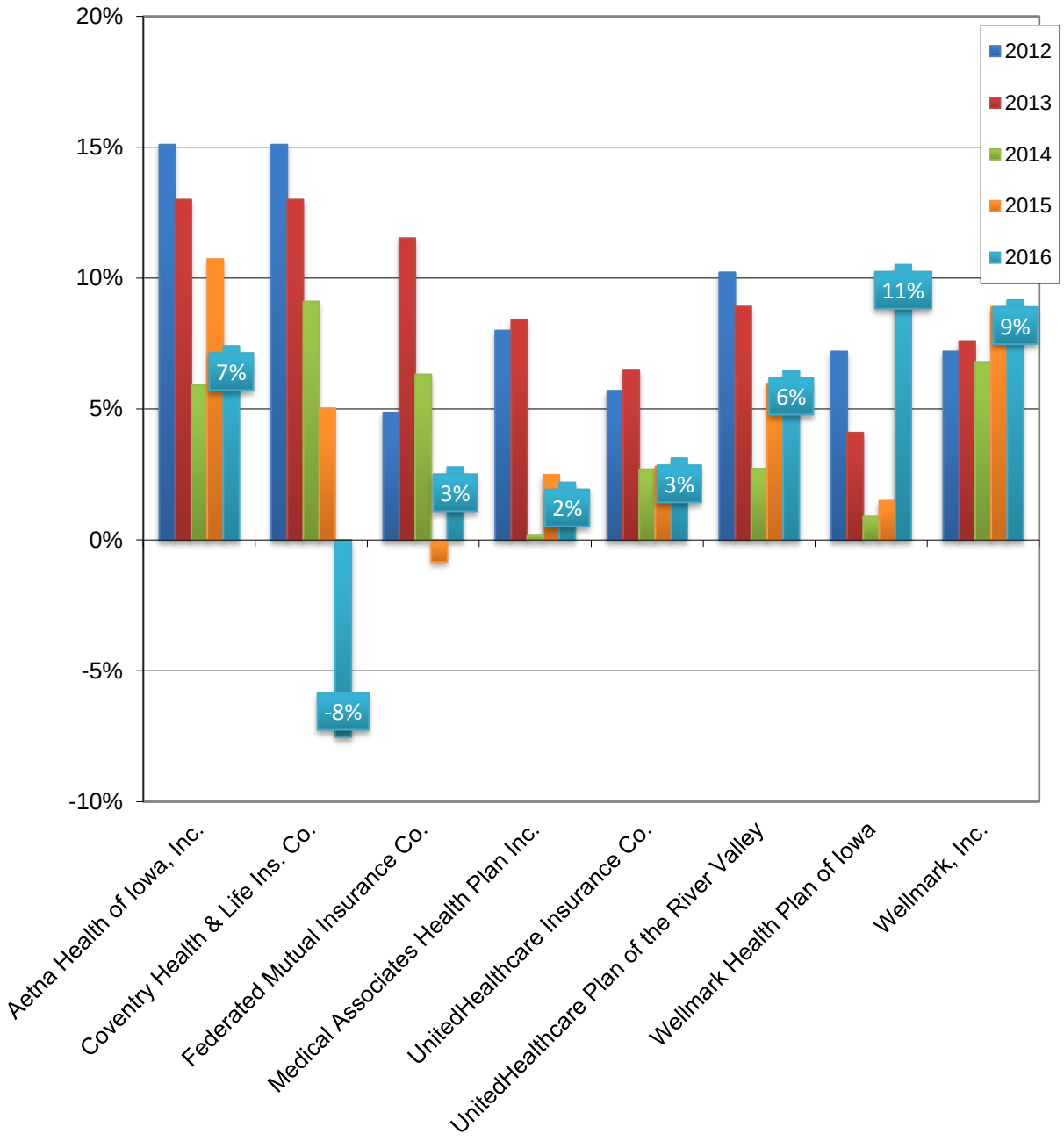

Iowa State Rate Increases 2012-2016
(Weighted by MMs)
25%
20%
15%
10%
5%
0%
9%
8%
6%
9%
8%
6%
5%
5%
6%
10%
7%
5%
24%
9%
7%
2012
2013
2014
2015
2016
ICMM
Small Group
Large Group

The following three charts show rate increases by company within each market.[23,24]

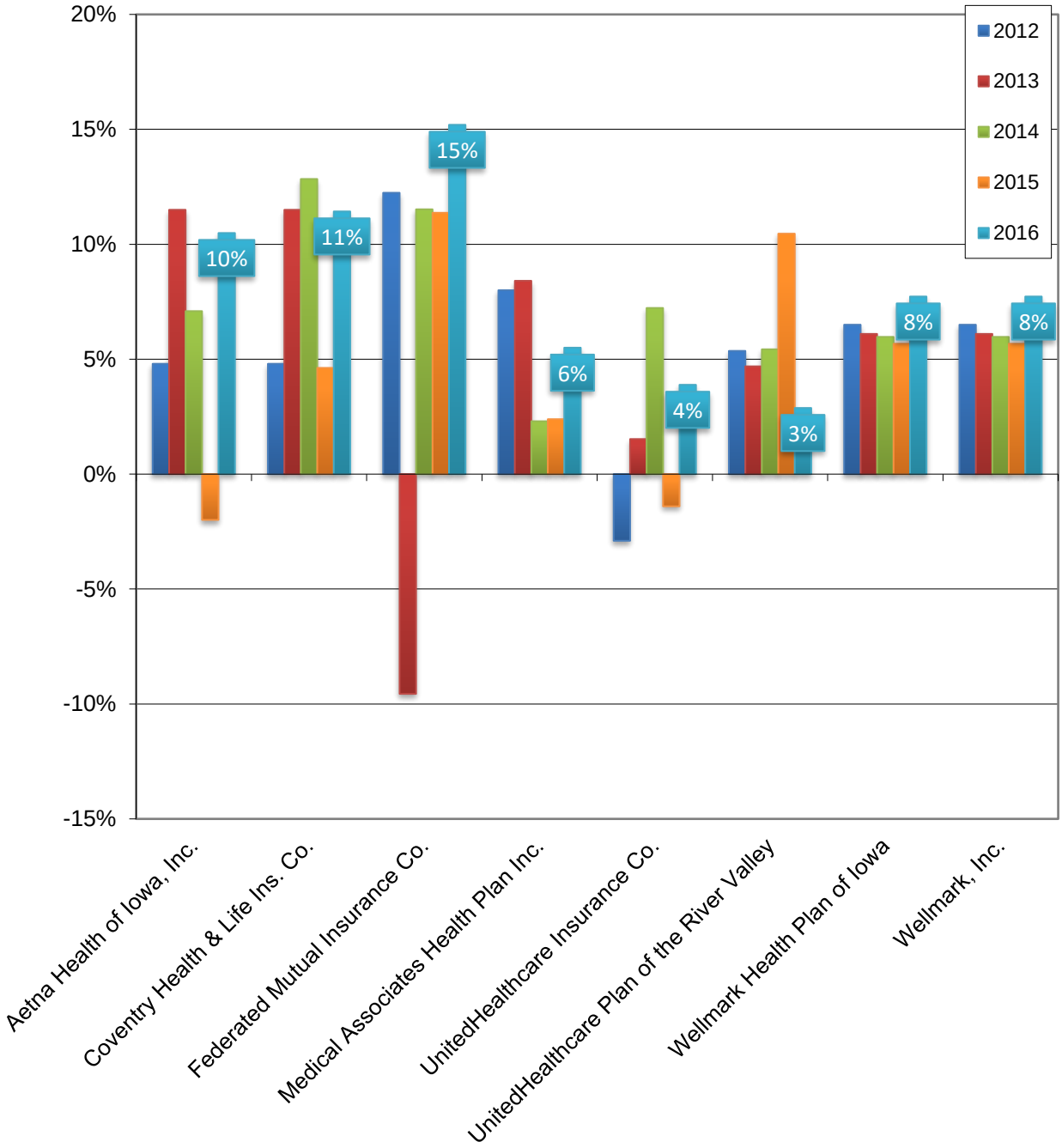


[23] The percentages in the following charts represent rate increases for 2012-2016 for each company. Only 2016 labels are included for readability.
[24] Medica Insurance Co. was new to the Iowa individual market in 2016 which is why they show a 0% increase.

Small Group Rate Increases 2012 - 2016



Large Group Rate Increases 2012 - 2016



Health Care Expenditures

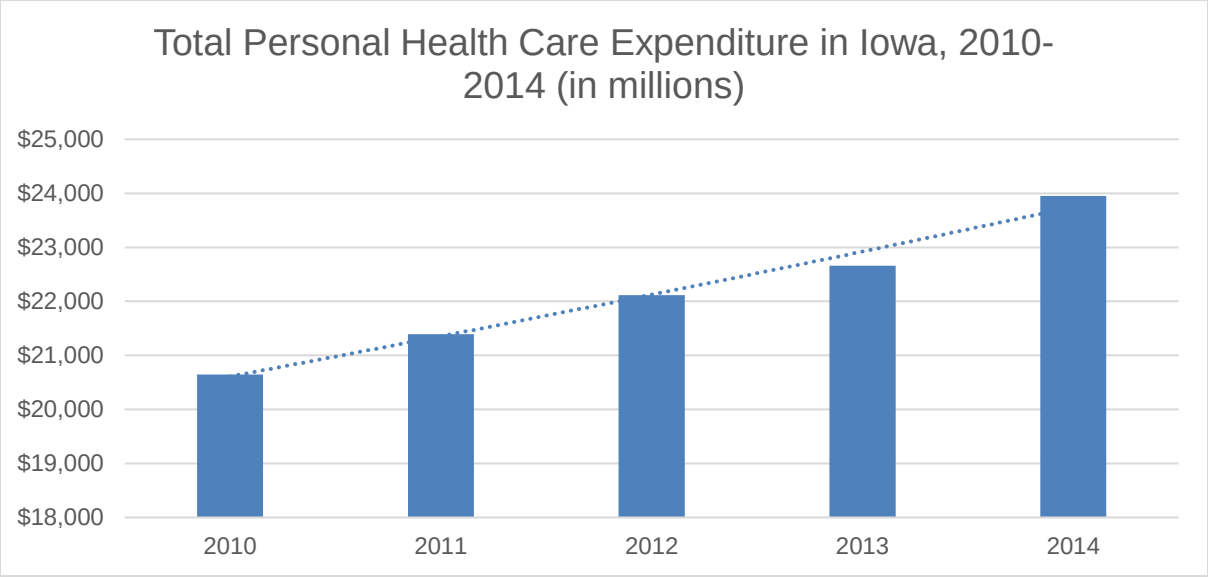
c. Health care expenditures in the state and the effect of such expenditure on health insurance premium rates.

Health care expenditures drive health insurance premiums. As the cost of health care services increase due to either the cost of the individual services or the use of the services, that cost increase is passed on to policyholders in the form of premium increases. Periodically, CMS releases a provider expenditure report which provides information on the annual health care expenditures for certain categories by state and by region. The latest report includes data from 1980 through 2014. The table below indicates shows the total expenditures in Iowa by category (in millions) for the most recent 5 years included in the report.[25]

Iowa Expenditure Category (in millions)	**2010**	**2011**	**2012**	**2013**	**2014**
Hospital Care	$8,065	$8,336	$8,704	$8,993	$9,426
Physician & Clinical Services	$3,775	$3,861	$3,985	$4,031	$4,238
Other Professional Services	$631	$654	$688	$725	$757
Dental Services	$939	$1,001	$977	$984	$1,017
Home Health Care	$422	$435	$480	$504	$549
Prescription Drugs	$2,553	$2,693	$2,748	$2,726	$3,066
Other Non-durable Medical Products	$428	$465	$478	$496	$503
Durable Medical Products	$345	$377	$387	$400	$410
Nursing Home Care	$1,837	$1,897	$1,942	$1,973	$2,077
Other Health, Residential, and Personal Care	$1,647	$1,675	$1,725	$1,827	$1,907
Total Personal Health Care	**$20,644**	**$21,394**	**$22,115**	**$22,659**	**$23,949**

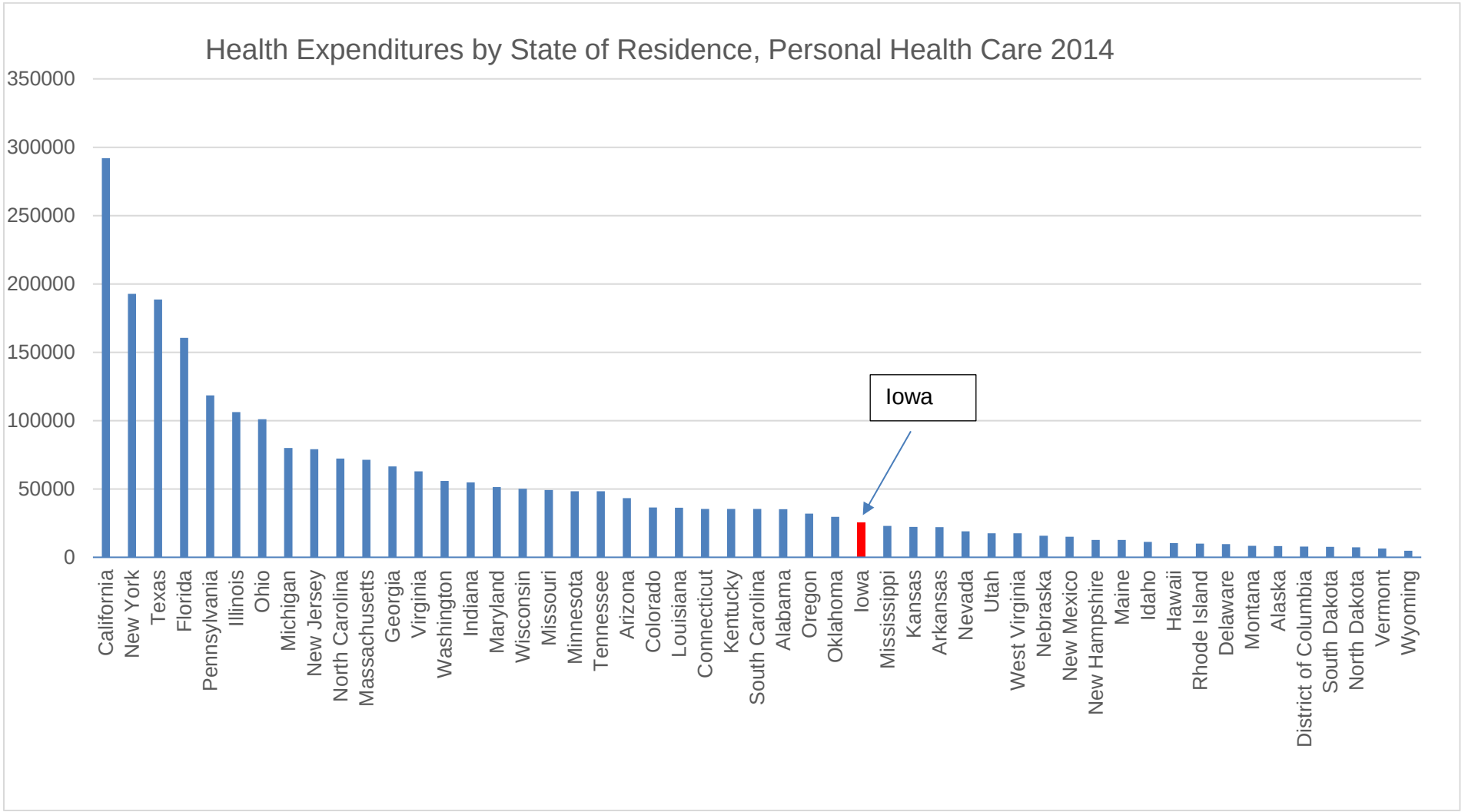
[25] CMS.gov. "State (Provider) Health Expenditures by State of Provider, 1980-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsProvider.html

The CMS report showed a consistent increase in the total personal health care expenditure over the latest five years. The graph below shows the trend in total personal health care expenditure in Iowa from 2010 to 2014.



CMS also provided a report detailing the health expenditures for personal health care by state. The chart below compares the aggregate and per capita estimates of Iowa (in red) to the other states.[26] According to the table, Iowa's per capita health expenditures rank 30 of 51 states (including the District of Columbia). Although Iowa's expenditures have been consistently increase, they continue to be significantly less than states such as California, New York, and Texas.

[26] CMS.gov. "Health Expenditures by State of Residence, 1991-2014." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsStateHealthAccountsResidence.html.


Health Expenditures by State of Residence, Personal Health Care 2014
350000
300000
250000
200000
150000
100000
50000
0
Iowa
California
New York
Texas
Florida
Pennsylvania
Illinois
Ohio
Michigan
New Jersey
North Carolina
Massachusetts
Georgia
Virginia
Washington
Indiana
Maryland
Wisconsin
Missouri
Minnesota
Tennessee
Arizona
Colorado
Louisiana
Connecticut
Kentucky
South Carolina
Alabama
Oregon
Oklahoma
Iowa
Mississippi
Kansas
Arkansas
Nevada
Utah
West Virginia
Nebraska
New Mexico
New Hampshire
Maine
Idaho
Hawaii
Rhode Island
Delaware
Montana
Alaska
District of Columbia
South Dakota
North Dakota
Vermont
Wyoming

We recognize this data, while relatively recent, is outdated due to implementation of the ACA, which was not implemented until 2014. Even after the implementation, the market has continued to evolve and adapt to continually changing regulations and guidance. In order to capture the most recent information available on expenditures and trend, we have used experience data from the URRT in the ACA-compliant filings submitted in the last 3 years. The URRT is required to be submitted by carriers in the individual and small group markets when they propose ACA-compliant plan rates in a plan year.

The URRT includes actual allowed claims in the experience period, which is defined as two years prior to the plan year, for ACA-compliant and transitional business. For example, if a carrier proposes to offer ACA-compliant plans in 2018, a URRT will include actual allowed costs from the 2016 plan year for a company's ACA-compliant and transitional business. Therefore, by reviewing the URRTs submitted by carriers for plan year 2016, 2017, and 2018[27], it allows us to capture actual allowed costs from 2014, 2015, and 2016 by benefit category for the individual and small group markets only, as large group market rate filings are not required to provide the URRT.

We also received allowed claims in total from the data call by market. Because the URRT information is only representative ACA-compliant and transitional products, and non-ACA business such as grandfathered plans will not be included. For this reason, and due to differences in accounting, the allowed claims amounts provided in the URRTs will be different from the amounts provided in the data call. The allowed amounts provided in the data call are provided in ***Appendix*** G. Currently ACA compliant products represent a large portion of the market and we expect it will continue to grow in the future as grandfathered plans are cancelled.

Because Medica Insurance Co.'s 2016 experience is not credible and because Medica Insurance Co. is the only carrier who filed rates for the 2018 plan year; URRTs for the other companies were not provided. This means we were not able to capture credible experience information from the 2016 plan year for the individual market.

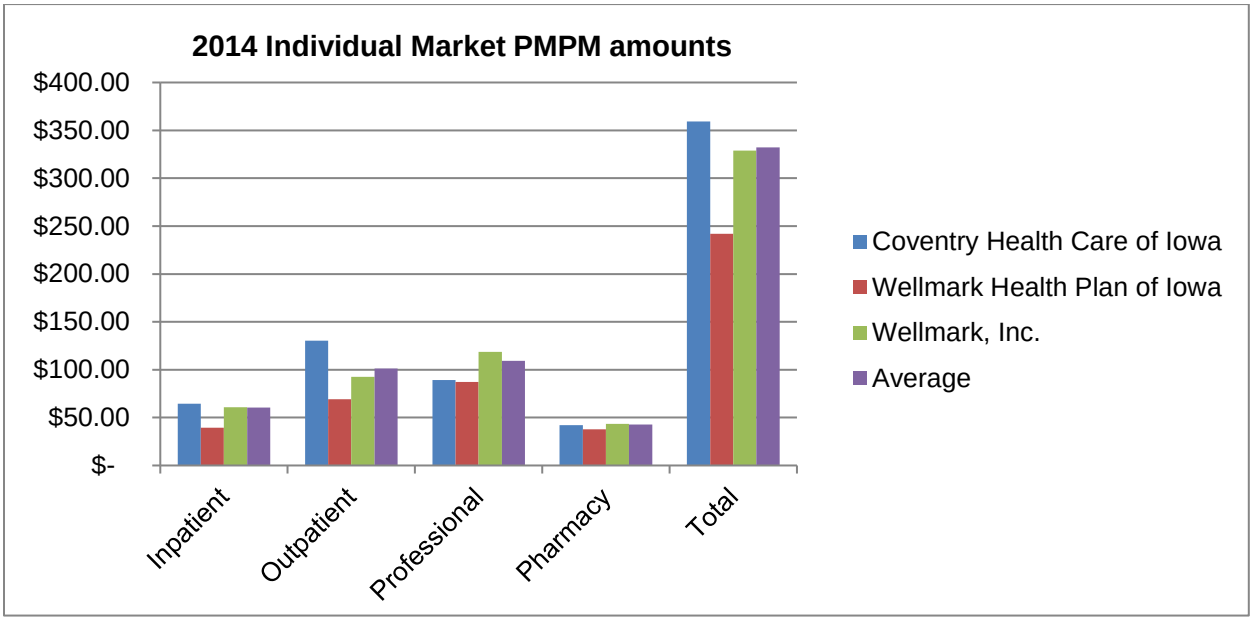
In addition, Golden Rule Insurance Co. only has experience information for 2015 in the individual market and Federated Mutual Insurance Co. has withdrawn from the Iowa market and therefore we do not have their 2016 information.

For consistency with the rest of this report, we are looking at the companies that were included as part of the data call, meaning they are within the top 95% of the health insurance market by premium. However, to show how these companies compare to the whole of the Iowa market, we have included an "average" category, which is the average of the entire ACA compliant market including companies not included in the data call.

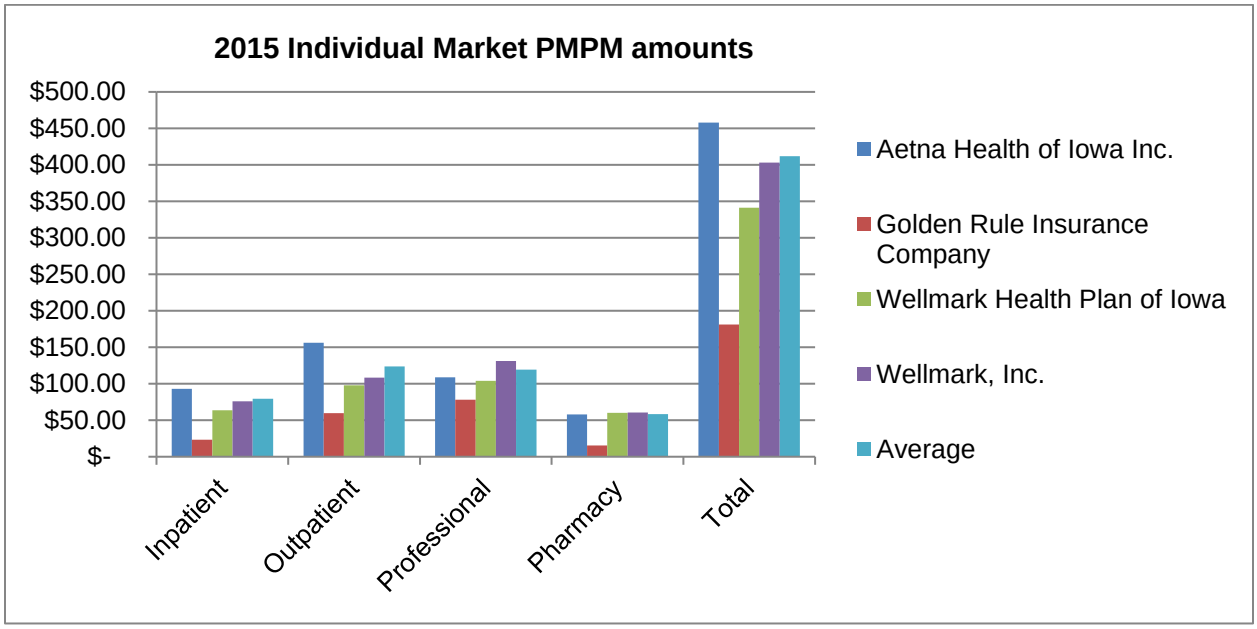
[27] URRT information can be found at https://iid.iowa.gov/sfa

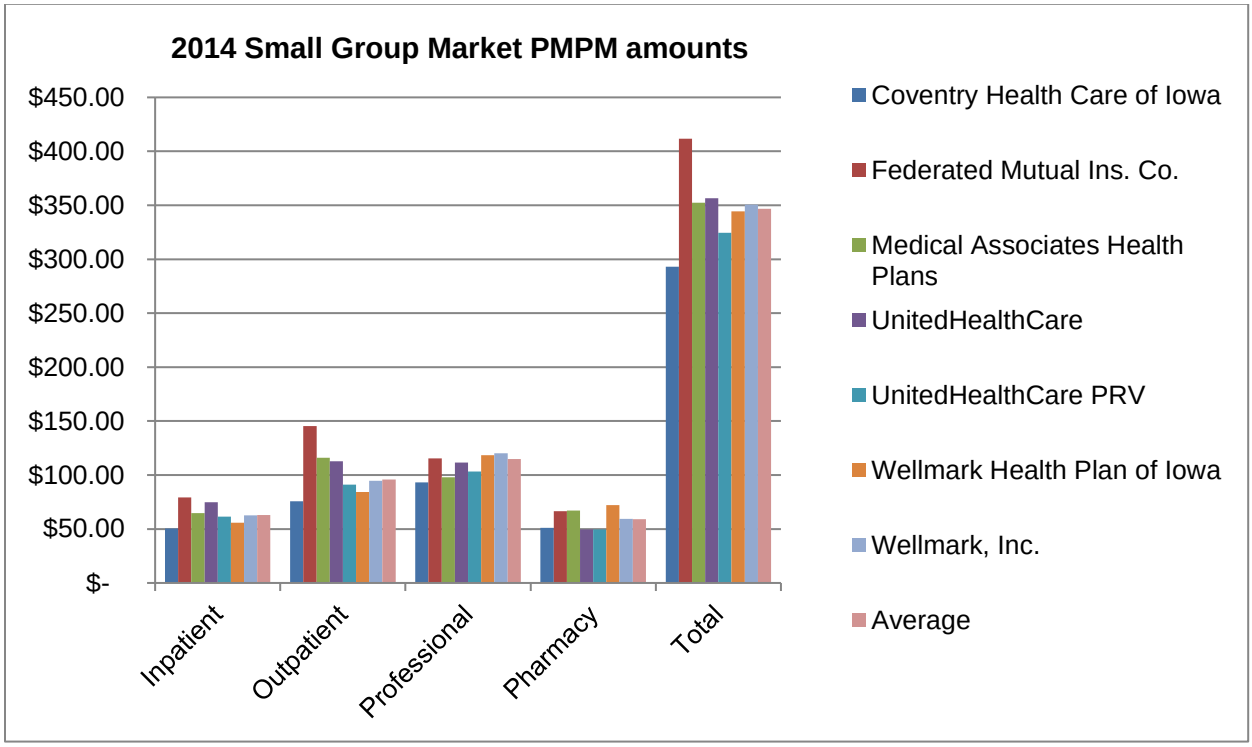
The URRT requires carriers to categorize allowed costs into Inpatient, Outpatient, Professional, Other, and Capitation. We find that carriers benefit categories are typically comparable between carriers for Inpatient, Outpatient, Professional, and Pharmacy, however, the Other and Capitation categories may be quite different. For example, carriers may define different services as "Other", making them not comparable. Also, some carriers may not include capitation and the amounts may be very small, making an analysis of increases not useful. For these reasons, we have not explicitly broken out these categories, but we recognize that they are included in the "Total" category. Note the PMPM cost can vary between carriers based on the health of the carrier's membership and therefore PMPM costs are not totally comparable.

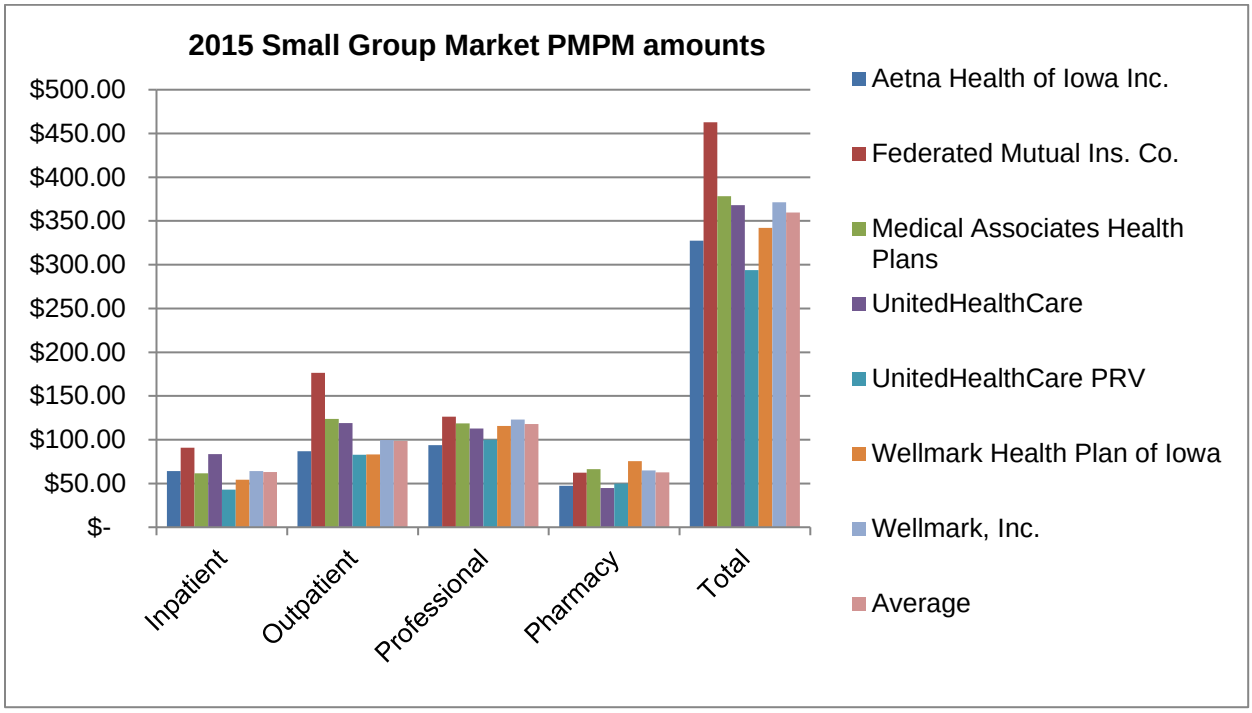
The following tables show the PMPM costs by benefit category by market for the past three years.[28,29,30]

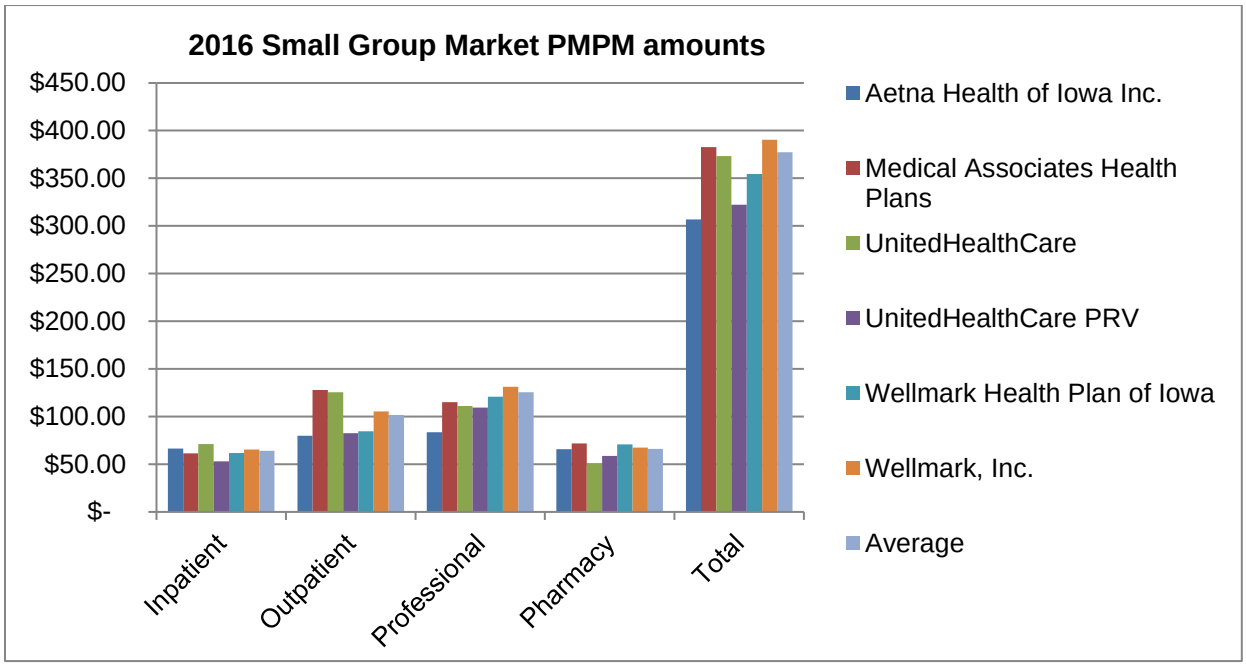


[28] The benefit categories "Other" and "Capitation" are not included due to differences in reporting between carriers.
[29] 2016 is not provided for the individual market because we were only able to capture information from Medica Insurance Co. which was not credible in 2016.
[30] The allowed amounts provided in these tables are from the carrier submitted URRTs, which represent ACA-compliant and transitional products. The carriers provided allowed amounts in the data call which differ from the allowed amounts in the URRT because of accounting differences and because they include additional business such as grandfathered plans.


2015 Individual Market PMPM amounts
$500.00
$450.00
$400.00
$350.00
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$-
Inpatient
Outpatient
Professional
Pharmacy
Total
Aetna Health of Iowa Inc.
Golden Rule Insurance Company
Wellmark Health Plan of Iowa
Wellmark, Inc.
Average

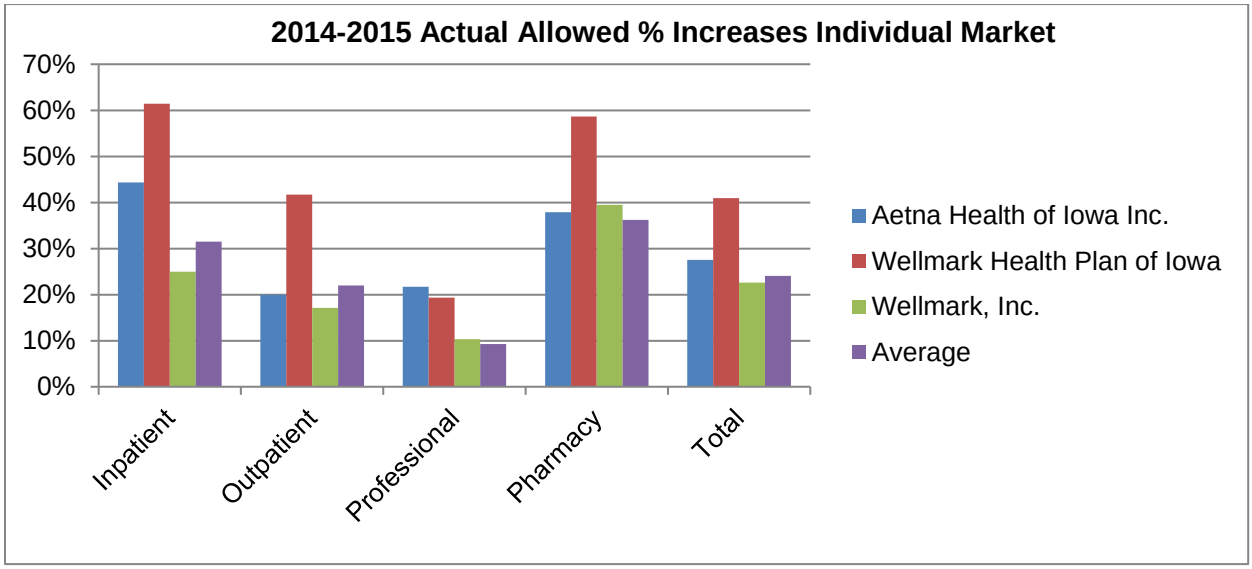

2014 Small Group Market PMPM amounts
$450.00
$400.00
$350.00
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$-
Inpatient
Outpatient
Professional
Pharmacy
Total
Coventry Health Care of Iowa
Federated Mutual Ins. Co.
Medical Associates Health Plans
UnitedHealthCare
UnitedHealthCare PRV
Wellmark Health Plan of Iowa
Wellmark, Inc.
Average

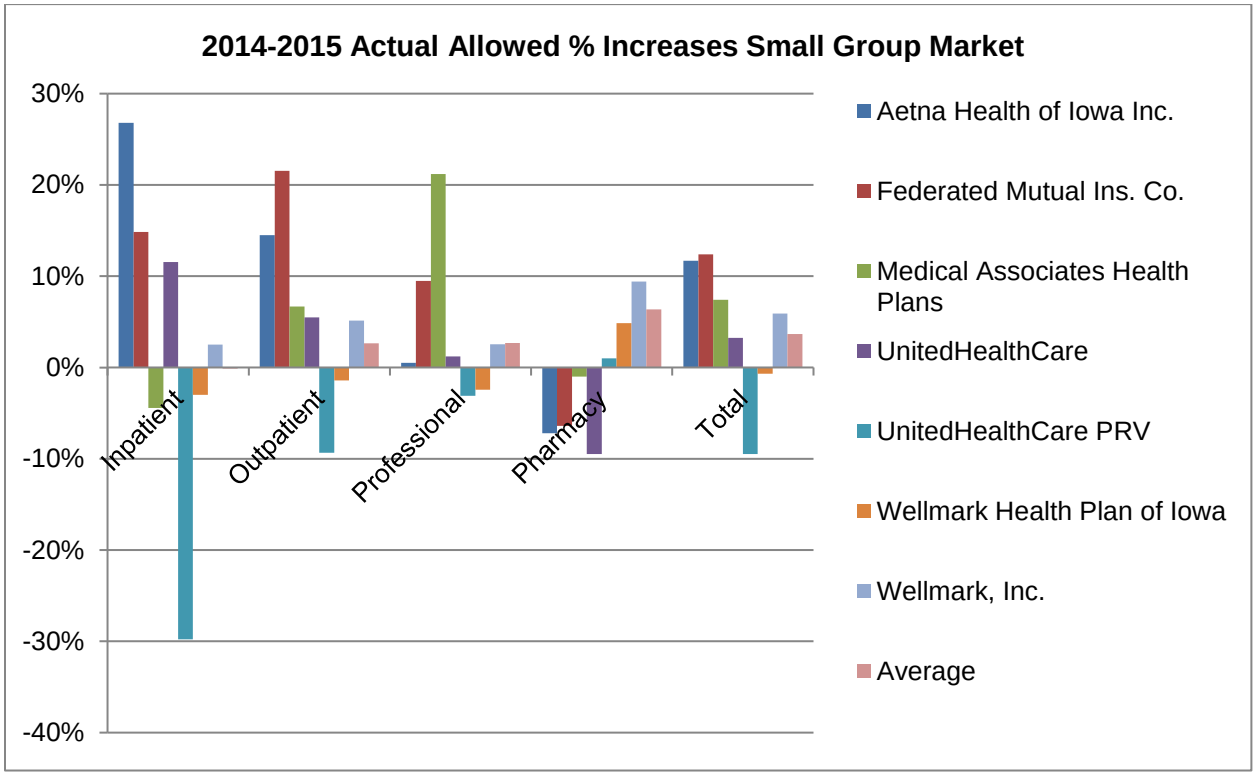




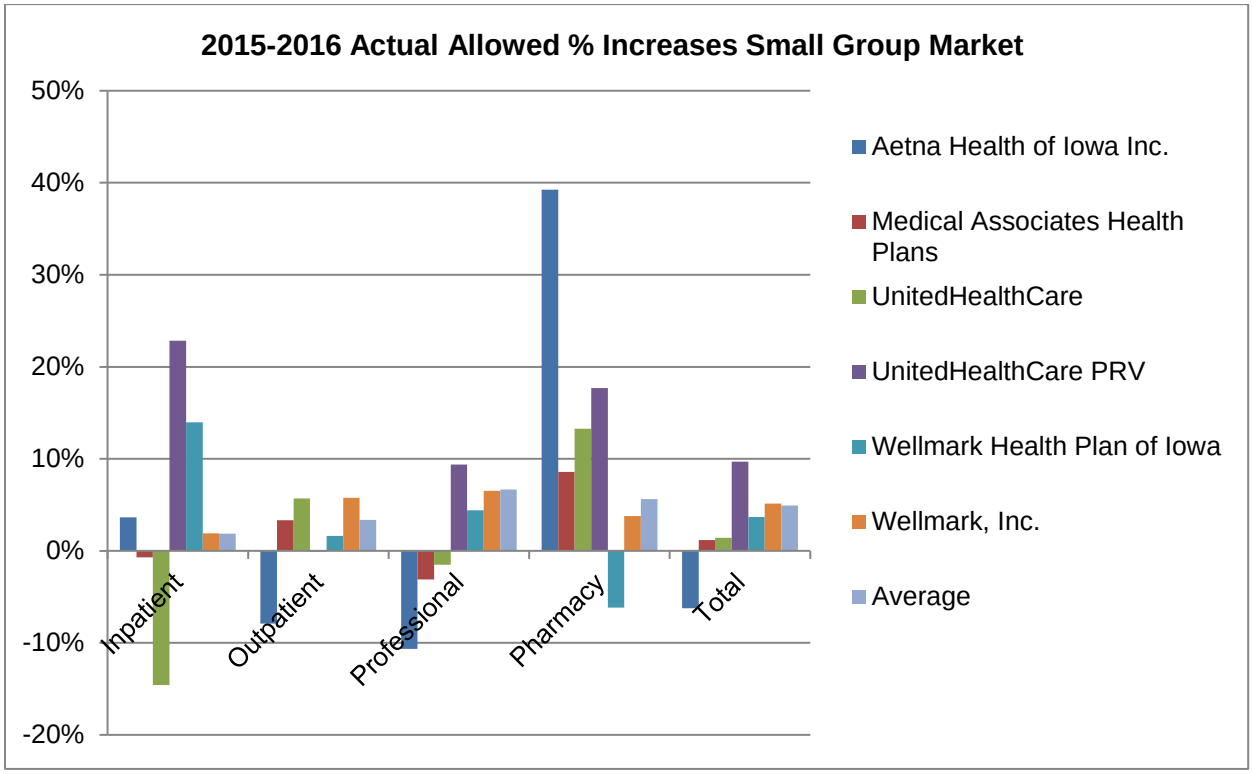
After capturing the allowed cost information by benefit category, we compared this information year over year by company to show how costs by benefit category have been increasing from

2014 to 2015 and from 2015 to 2016. The graphs below show the increases in the allowed costs for the individual and small group markets.[31]





[31] We were unable to provide the increase in costs from 2015 to 2016 in the individual market because Medica Insurance Co. is the only carrier who submitted the URRT for 2018, and their 2016 base experience allowed claims experience is not credible.



For the individual market, the weighted average increase in total allowed costs from 2014-2015 was 24%, this is down from the 28% increase in total allowed costs from 2013-2014. We were not able to capture increases from 2015 to 2016 due to several major carriers not participating in the market in 2018. These significant increases in allowed costs provides some context as to why the rate increases in the individual market continue to be high. The increases allowed costs in the small group market, are much more modest with a 4% weighted average increase in total allowed costs from 2014 to 2015 and 5% from 2015 to 2016. Some carriers have actually reported decreases in allowed costs. Note that the impact of increased health care expenditures and the increase in premiums are not in the same proportion. This discrepancy is due to other factors affecting premiums such as changes in benefits and changes in the population covered by a particular carrier.

Since premiums are typically calculated based on estimated health care claims, as health care expenditures increase, premium rates increase. Premiums typically increase faster than health care expenses for many reasons. One reason for higher premium increases is that deductible amounts do not increase therefore all of the increases in health care dollars are used to increase premiums, which results in a higher percentage increase. For example, if a policy has a $2,000 deductible and a $5,000 estimated claims cost ($7,000 total health care costs), and health care costs are expected to increase $700 or 10%, that is added to the estimated claims cost of $5,000 for a 14% increase in claims cost.

Drivers of Higher Costs and Cost Reductions

d. A ranking and quantification of those factors that result in higher costs and those factors that result in lower costs for each health insurance plan offered in the state.

Many carriers were not able to break out individual, small group, and large group cost drivers. In previous reports carriers also used varying terminology and aggregation levels to describe the health care categories for the cost drivers and we consolidated the cost drivers for all carriers at total market level to avoid providing an inaccurate picture of a market segment based on limited data. This conversion was a bit problematic due to overlapping terms. For example, one carrier may have used inpatient hospital as a category which may have included surgery costs, and another carrier broke out all surgery costs separately. To account for this, in the 2016 and 2017 data calls, we requested the carriers use uniform terminology that we provided when reporting cost drivers so that we would not have to convert the reported information into uniform terminology as we have done in the past. This was a cause for some confusion among the carriers surveyed, and further guidance may be required in future years in order to ensure carriers are clear about how they are expected to report cost drivers. All of the data provided can be found in ***Appendix D***. ***Appendix H*** shows a mapping of the original categories provided to the categories used below.

Overall, carriers reported $119.1 million rise in health care costs from the top five increase drivers (down significantly from the $291.4 million reported in the 2016 data call) and $26.7 million reduction in the top five decrease drivers (similarly down significantly from the $136.7 reported in the 2016 data call). The top five increase drivers accounted for 81% of the increases. In 2015, the top five increases were accounted for 99% of the total increases. This significant decrease seems to show that categories are rising and dropping at a more uniform rate than in past years. We interpret this to imply that more of the "lessor" drivers are playing a role in the increase in health care costs rather than just the top five. The top five decrease drivers accounted for 91% of the decreases.

The top five drivers of health care cost increases reported for 2016 are outpatient hospital, prescription drug, physician, inpatient hospital, and other. The top five services that have decreased costs are inpatient hospital, outpatient hospital, other, physician, and skilled nursing facilities. The explanation of how a service can be on both lists is that some aspects of a cost or service are increasing and some are decreasing. Note: a driver can be included as both an increase driver and a decrease driver because of the level of reporting. For instance, the Physician category includes services that are increasing the costs of healthcare and decreasing the cost of healthcare, which causes carriers to report Physician as an increasing and decreasing cost driver, although the increase outweighs the decrease.

The following is a ranking of the health care services that are driving increases and decreases in health insurance premiums, as reported by carriers in Iowa after consolidation and redefinition.

Increases:

Company Reported Service (Standardized Category)	Increases	% of Total Listed Increases
Outpatient Hospital	$ 39,447,867	27%
Prescription Drug	$ 24,634,114	17%
Physician	$ 21,152,324	14%
Inpatient Hospital	$ 20,795,665	14%
Other	$ 13,074,112	9%
Diagnostic Imaging & Tests	$ 9,012,959	6%
MH/CD	$ 6,402,567	4%
Laboratory and X-ray	$ 5,154,745	4%
Emergency Room	$ 3,500,262	2%
Ambulance	$ 3,458,890	2%
Preventive	$ 229,544	0%
Skilled Nursing Facilities	$ 56,830	0%

Decreases:

Company Reported Service (Standardized Category)	Decreases	% of Total Listed Decreases
Inpatient Hospital	$ (7,991,259)	34%
Outpatient Hospital	$ (5,530,391)	23%
Other	$ (4,492,184)	19%
Physician	$ (2,802,179)	12%
Skilled Nursing Facilities	$ (873,204)	4%
Benefit Changes	$ (673,261)	3%
Emergency Room	$ (581,307)	2%
Diagnostic Imaging & Tests	$ (349,998)	1%
Laboratory and X-ray	$ (199,770)	1%
Ambulance	$ (129,975)	1%
Prescription Drug	$ (103,184)	0%
Medical Technology	$ (23,048)	0%

Increase and Decrease Netted by Service:

Company Reported Service (Standardized Category)	Decreases	Increases	Net Change	% of Total Net Change
Outpatient Hospital	$ (5,530,391)	$ 39,447,867	$ 33,917,476	28%
Prescription Drug	$ (103,184)	$ 24,634,114	$ 24,530,931	20%
Physician	$ (2,802,179)	$ 21,152,324	$ 18,350,145	15%
Inpatient Hospital	$ (7,991,259)	$ 20,795,665	$ 12,804,406	10%
Diagnostic Imaging & Tests	$ (349,998)	$ 9,012,959	$ 8,662,961	7%
Other	$ (4,492,184)	$ 13,074,112	$ 8,581,927	7%
MH/CD		$ 6,402,567	$ 6,402,567	5%
Laboratory and X-ray	$ (199,770)	$ 5,154,745	$ 4,954,975	4%
Ambulance	$ (129,975)	$ 3,458,890	$ 3,328,914	3%
Emergency Room	$ (581,307)	$ 3,500,262	$ 2,918,956	2%
Preventive		$ 229,544	$ 229,544	0%
Medical Technology	$ (23,048)		$ (23,048)	0%
Benefit Changes	$ (673,261)		$ (673,261)	-1%
Skilled Nursing Facilities	$ (873,204)	$ 56,830	$ (816,374)	-1%
Net Listed Changes	$ (23,749,759)	$ 146,919,879	$ 123,170,119	100%

Reserves, Capital and Surplus, Risk-based Capital

e. The current capital and surplus and reserve amounts held in reserve by each health insurance carrier licensed to do business in the state.

Reserves

Reserves represent liabilities that are set aside to pay claims that have been incurred but have not been paid as of the financial statement date. Reserves vary significantly by the size of the carrier. Carriers are required to hold sufficient reserves to pay for claims that have not been paid and for the possibility that in the future claims will be higher than premiums. It is important for policyholder safety that these reserves are set aside to ensure that claims can be paid. If sufficient reserves are not set aside in the form of liabilities, there is a danger that the carrier will not be able to pay claims. Carriers are required to provide an actuarial opinion with their statutory annual financial statement from an actuary with experience in the type of insurance sold by the carrier verifying that reserves will be adequate to pay claims. Therefore, the level of reserves held represent the level of claims that the carrier is liable for and has not paid as of the financial statement date.

The following table shows the 2016 reserves held by each carrier to pay claims:

Company	2016 Reserves
Aetna Health of Iowa, Inc.	52,009,537
Coventry Health & Life Ins. Co.	280,957,810
Federated Mutual Insurance Co.	50,259,758
Golden Rule Insurance Co.	230,183,293
Medica Insurance Co.	191,571,889
Medical Assoc. Health Plan, Inc.	8,255,991
UnitedHealthcare Ins. Co.	5,966,863,745
UnitedHealthcare Plan of the River Valley	466,325,398
Wellmark Health Plan of IA, Inc.	43,019,075
Wellmark, Inc.	448,532,554

Capital and Surplus

Capital and surplus represents the financial resources available to a company that protect it from insolvency in years where it experiences adverse financial situations such as underwriting losses or loss in the value of its assets. These total value of the risks increase by the size of the company, since losses are experienced as a percentage of premiums or a percentage of assets so as a company has higher premium volume or more assets the total amount of risk is larger.

When capital and surplus rise above the level needed for solvency protection, a company can use it for other purposes such as capital investments to continue to operate efficiently, expand operations, stockholder dividends (for-profit organizations), policyholder dividends (mutual insurance companies), or as additional protection against adverse situations.

Capital and surplus by company for 2016 is displayed below:

Company	2016 Capital and Surplus
Aetna Health of Iowa, Inc.	29,413,170
Coventry Health & Life Ins. Co.	1,145,327,792
Federated Mutual Insurance Co.	3,091,100,577
Golden Rule Insurance Co.	166,787,709
Medica Insurance Co.	277,184,986
Medical Assoc. Health Plan, Inc.	19,842,629
UnitedHealthcare Ins. Co.	5,247,446,730
UnitedHealthcare Plan of the River Valley	434,309,068
Wellmark Health Plan of IA, Inc.	153,641,781
Wellmark, Inc.	1,330,274,686

Risk-based Capital

A complete set of data can be found in ***Appendix E.***

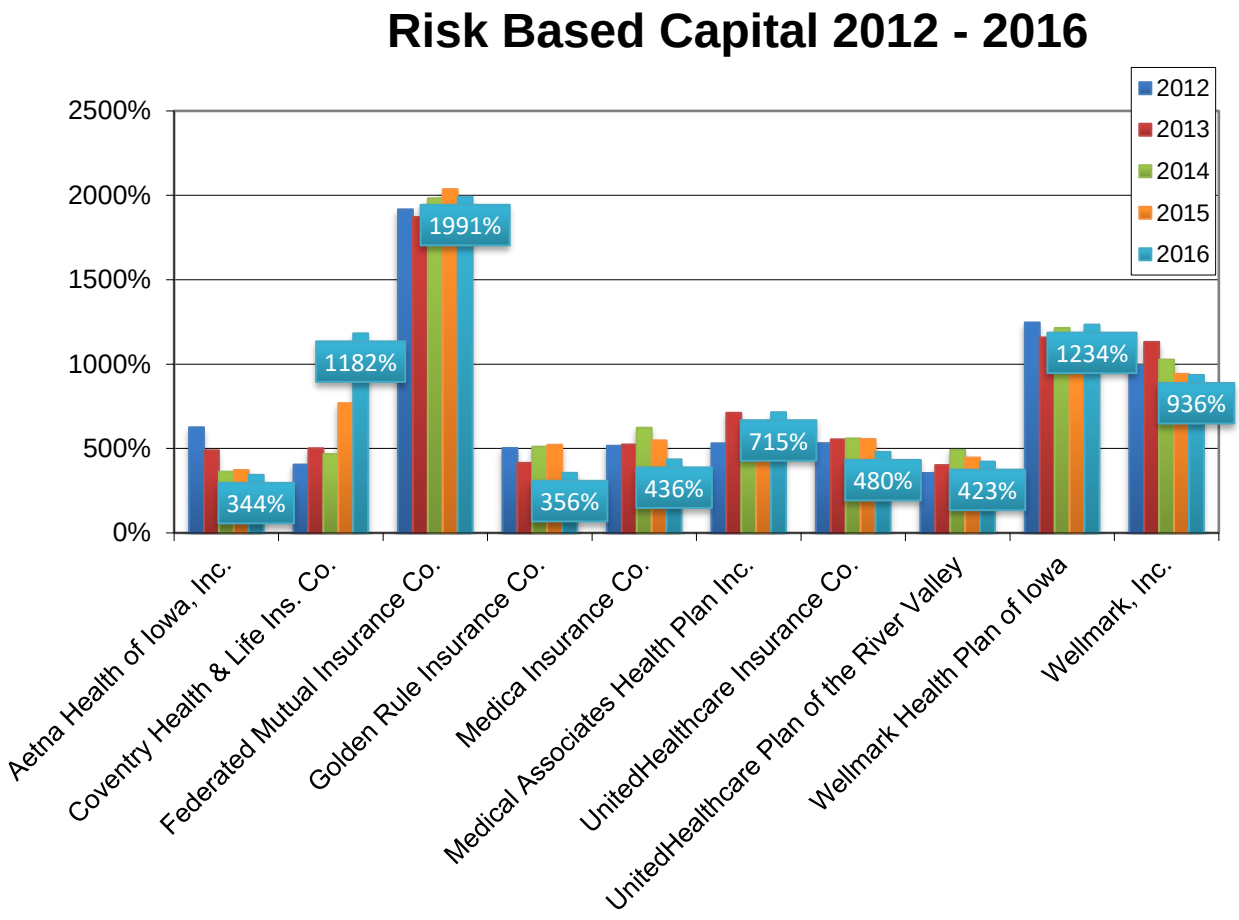
We have included not only the capital and surplus, but also the risk-based capital (RBC). RBC is a measure developed by the National Association of Insurance Commissioners (NAIC) and measures a company's capital compared to some of its risk as measured by the NAIC Health RBC formula.

The 2016 RBC for the companies in this report varied from 344% to 1193%. In 2015 the companies that reported varied from 373% to 2037%.

The following table shows the RBC percentages for 2016:

Company	2016 RBC
Aetna Health of Iowa, Inc.	344%
Coventry Health & Life Ins. Co.	1182%
Federated Mutual Insurance Co.	1991%
Golden Rule Insurance Co.	356%
Medical Insurance Co.	436%
Medical Assoc. Health Plan, Inc.	715%
UnitedHealthcare Ins. Co.	480%
UnitedHealthcare Plan of the River Valley	423%
Wellmark Health Plan of IA, Inc.	1234%
Wellmark, Inc.	936%

RBC by company for the last five years is displayed below:



Generally, falling RBC is an indication of losses in a company and rising RBC is an indication of profits in a company if the premium volume is relatively stable.

Medical Trends

f. A listing of any apparent medical trends affecting health insurance costs in the state.

The answer to item d. above, drivers of higher costs and cost reductions, provides a more thorough response to this question, but carriers listed Outpatient Hospital ($39,447,867) (an increase), as the top driver of healthcare cost overall. The next four largest magnitude drivers are Prescription Drug ($24,634,114 - an increase), Physician ($21,152,324 - an increase), Inpatient Hospital ($20,795,665 - an increase), and Other ($13,074,112 - an increase). In all cases of overlap, the increasing aspects were higher than the decreasing aspects.

We standardized the answers provided by carriers. We tallied how many carriers identified each category as affecting the decrease or the increase of health insurance costs. The most commonly listed trends affecting health insurance costs include: (***See Appendix F***)

	# of Companies	
Company Reported Service (Standardized Category)	**Decrease**	**Increase**
Ambulance	2	3
Benefit Changes	2	
Diagnostic Imaging & Tests	3	2
Emergency Room	2	5
Inpatient Hospital	7	6
Laboratory and X-ray	4	5
Medical Technology	1	
MH/CD		7
Other	1	5
Outpatient Hospital	5	7
Physician	5	8
Prescription Drug	1	5
Preventive		2
Skilled Nursing Facilities	3	2

Additional Data – Risk Adjustment, Reinsurance, and PMPM Costs

g. Any additional data or analysis deemed appropriate by the Commissioner to provide the general assembly with pertinent health insurance cost information.

A complete set of data can be found in ***Appendix G.***[32]

The reinsurance and risk adjustment programs were started by the ACA to stabilize the individual and small group markets during the implementation of the ACA. The reinsurance program was a temporary program that was funded by all health insurers and reimbursed health insurers in the individual market for large claims. The risk adjustment program is a permanent program intended to prohibit risk selection by insurers by transferring funds from plans with low-cost enrollees to plans with high-cost enrollees for the individual and small group market. Every year, CMS produces a

[32] The PMPM values shown in the following charts refer to 2016 PMPM costs for each company.

report which details the payments that were made. We have summarized the information below on a PMPM and a total basis.

Reinsurance PMPM						
	2014		2015		2016	
Company	PMPM	Total	PMPM	Total	PMPM	Total
Aetna Health of Iowa, Inc.	50.68	13,395,052	46.39	23,491,161	18.23	8,633,363
Medica Insurance Co.	NA	NA	NA	NA	37.20	559,351
Wellmark Health Plan of IA Inc	1.99	782,563	4.57	1,963,170	8.54	809,645
Wellmark Inc	14.28	13,566,798	19.17	15,290,589	15.61	10,380,245

ICMM Risk Adjustment Transfer PMPM						
	2014		2015		2016	
Company	PMPM	Total	PMPM	Total	PMPM	Total
Aetna Health of Iowa, Inc.	-34.95	-9,236,606	-21.29	-10,780,079	-22.45	-10,630,845
Medica Insurance Co.	NA	#N/A	NA	#N/A	-3.96	-59,529
Wellmark Health Plan of IA Inc	-6.49	-2,547,980	-10.22	-4,391,486	-61.00	-5,781,185
Wellmark Inc	4.85	4,605,848	20.78	16,573,829	27.57	18,333,353

Small Group Risk Adjustment Transfer PMPM						
	2014		2015		2016	
Company	PMPM	Total	PMPM	Total	PMPM	Total
Aetna Health of Iowa, Inc.	-1.72	-142,787	9.64	459,305	-5.31	-547,629
Coventry Health & Life Ins Co.	-0.55	-19,282	-1.20	-13,858	-0.25	-1,783
Federated Mutual Insurance Co.	-0.89	-24,093	-3.28	-76,811	12.84	296,595
Medical Assoc. Health Plan Inc	-10.37	-285,469	13.35	370,974	8.11	197,923
UnitedHealthcare Ins Co. (CT)	0.88	111,696	-5.49	-608,398	-12.80	-1,265,066
UnitedHealthcare Plan	-0.26	-54,443	5.68	855,195	5.56	697,193
Wellmark Health Plan of IA Inc	2.01	501,033	-4.74	-1,170,300	-12.26	-3,821,569
Wellmark Inc	3.48	3,535,404	3.42	3,724,625	3.77	4,987,083

Information was requested from carriers of per-member-per-month (PMPM) health care cost by market segment. Many factors affect the PMPM costs such as wide variation on benefit design, reduced comparability. That said, PMPM costs do provide some insight into affordability of health insurance in Iowa, because higher PMPM health care costs result in higher health insurance premiums. Note, only 2016 dollar values are shown for readability.

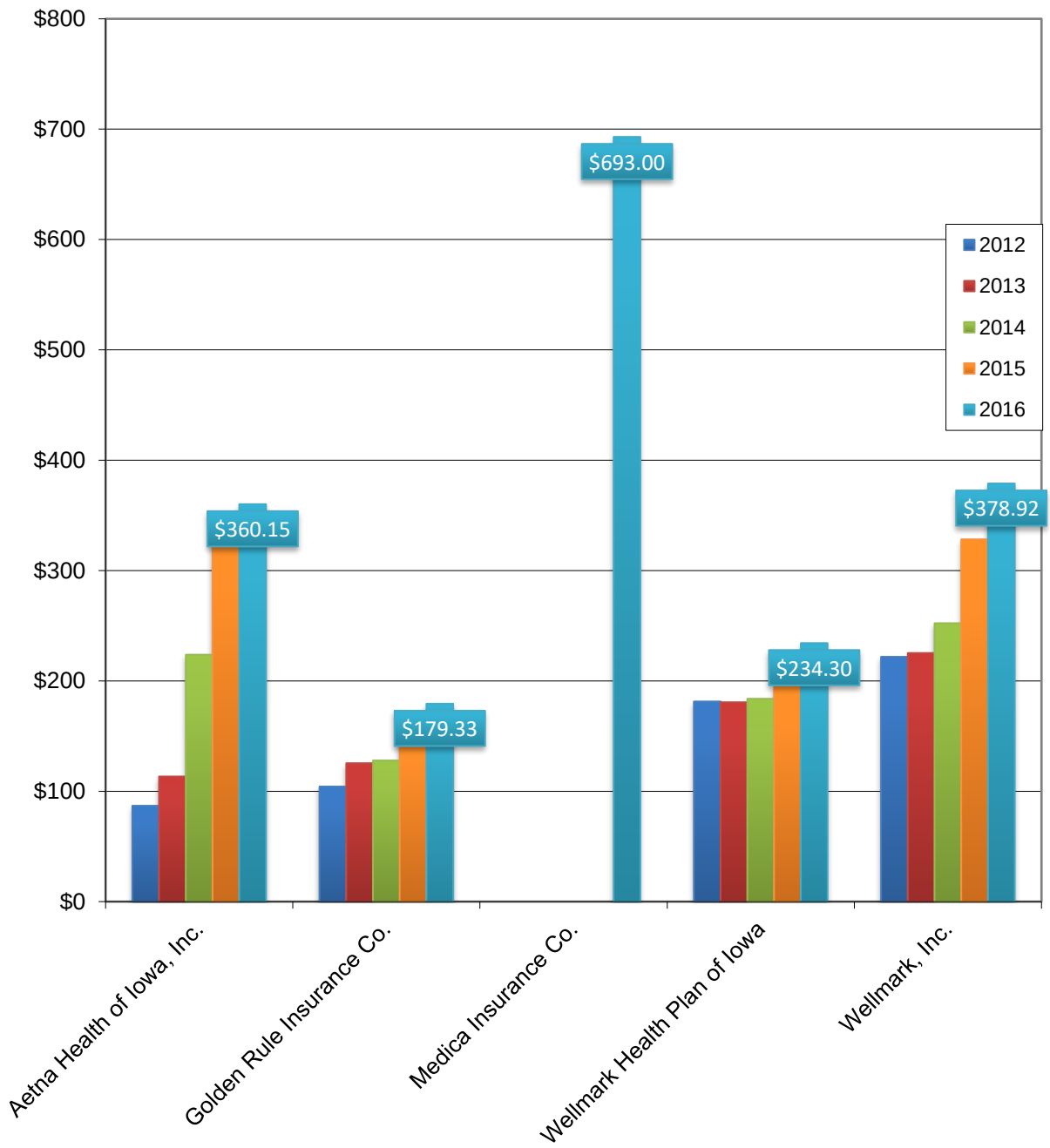
The 5-year individual market weighted average PMPM paid claim cost went from $188.77 in 2011 to $356.12 in 2016 (Increase of 89%) for the companies included in the survey that continue to offer individual coverage. The 3-year and 1-year increase in average PMPM paid claim costs are 78% and 20% respectively.

The 5-year small group market weighted average PMPM paid claim cost went from $270.53 in 2011 to $339.93 in 2016 (Increase of 26%) for the companies included in the survey that continue to offer individual coverage. The 3-year and 1-year increase in average PMPM paid claim costs are 20% and 15% respectively.

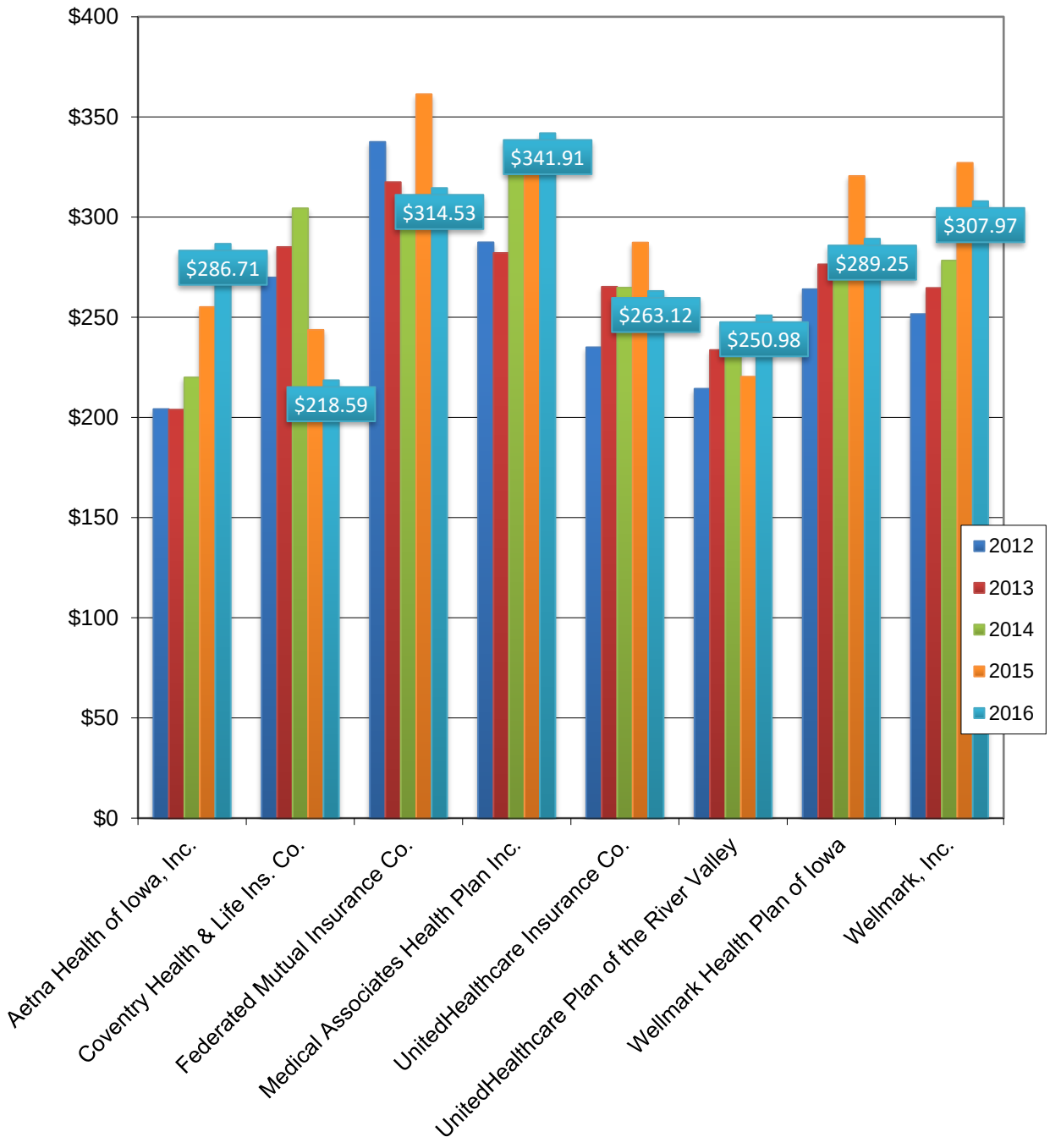
The 5-year large group market weighted average PMPM paid claim cost went from $234.09 in 2011 to $298.41 in 2016 (Increase of 27%) for the companies included in the survey that continue to offer individual coverage. The 3-year and 1-year increase in average PMPM paid claim costs are 15% and -4% respectively.

Information was also requested concerning the level of commissions and administrative costs. This information has been presented with the loss ratio information and details can be found in ***Appendix G.***

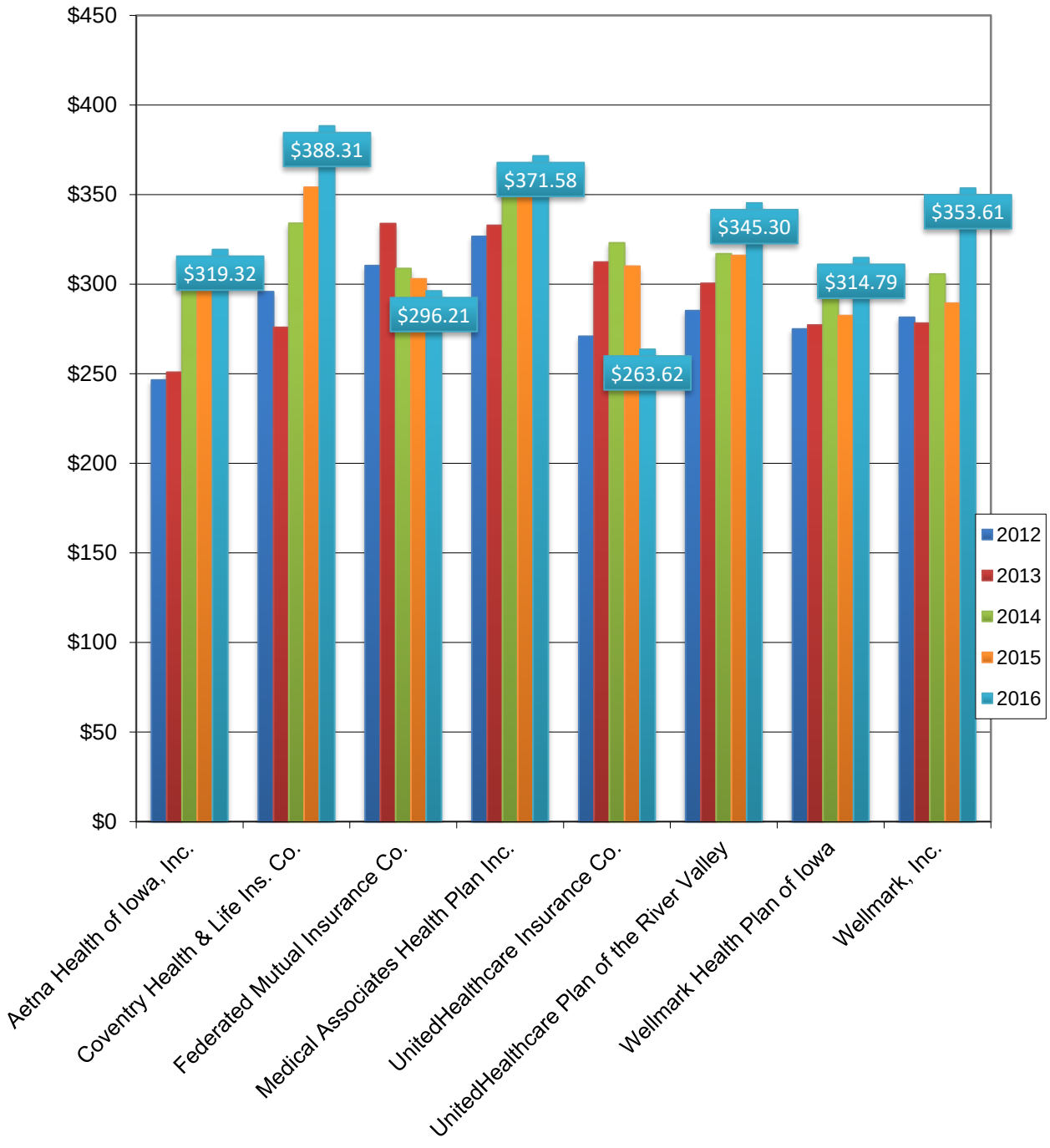
ICCM PMPMs 2012-2016



Small Group PMPMs 2012-2016



Large Group PMPMs 2012-2016



Appendix A: Member Months

ICMM Member Months					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	97,040	123,678	264,310	506,419	473,562
Golden Rule Insurance Co.	105,089	115,225	98,753	74,240	59,905
Medica Insurance Co.					15,036
Wellmark Health Plan of Iowa, Inc.	333,272	378,722	392,731	429,536	94,769
Wellmark, Inc.	1,055,739	1,034,044	949,938	797,469	665,040

Small Group Member Months					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	101,754	113,291	83,014	47,663	103,091
Coventry Health & Life Ins. Co.	81,584	61,618	34,860	11,526	7,168
Federated Mutual Insurance Co.	34,520	34,768	27,096	23,384	23,094
Medical Associates Health Plan, Inc.	30,848	30,812	27,522	27,782	24,406
UnitedHealthcare Insurance Co.	164,111	165,210	126,976	110,755	98,811
UnitedHealthcare Plan of the River Valley	301,064	258,433	207,027	150,528	125,488
Wellmark Health Plan of Iowa, Inc.	227,188	237,727	249,362	246,715	311,797
Wellmark, Inc.	1,031,386	971,283	1,015,623	1,090,463	1,321,494

Large Group Member Months					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	129,425	121,876	144,690	193,142	67,282
Coventry Health & Life Ins. Co.	58,396	70,752	36,132	3,652	80
Federated Mutual Insurance Co.	12,302	10,213	8,573	3,785	1,989
Medical Associates Health Plan, Inc.	138,129	136,932	133,705	114,687	116,718
UnitedHealthcare Insurance Co.	186,971	213,281	219,505	295,241	355,275
UnitedHealthcare Plan of the River Valley	404,137	393,026	308,734	250,070	212,432
Wellmark Health Plan of Iowa, Inc.	550,797	497,631	451,135	500,539	464,967
Wellmark, Inc.	2,973,928	2,929,897	2,852,800	3,097,130	2,589,554

Appendix B: Loss Ratios

ICMM Loss Ratios					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	73%	93%	98%	106%	95%
Golden Rule Insurance Co.	59%	70%	70%	79%	84%
Medica Insurance Co.					128%
Wellmark Health Plan of Iowa, Inc.	96%	94%	89%	93%	91%
Wellmark, Inc.	90%	85%	91%	100%	96%

Small Group Loss Ratios					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	75%	68%	69%	73%	77%
Coventry Health & Life Ins. Co.	99%	90%	88%	69%	67%
Federated Mutual Insurance Co.	92%	81%	71%	87%	74%
Medical Associates Health Plan, Inc.	84%	81%	90%	94%	88%
UnitedHealthcare Insurance Co.	71%	75%	74%	75%	70%
UnitedHealthcare Plan of the River Valley	76%	75%	74%	63%	69%
Wellmark Health Plan of Iowa, Inc.	75%	78%	78%	84%	84%
Wellmark, Inc.	81%	83%	83%	84%	84%

Large Group Loss Ratios					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	77%	73%	82%	86%	81%
Coventry Health & Life Ins. Co.	95%	87%	93%	95%	93%
Federated Mutual Insurance Co.	92%	107%	89%	78%	66%
Medical Associates Health Plan, Inc.	90%	88%	92%	91%	89%
UnitedHealthcare Insurance Co.	78%	88%	87%	85%	83%
UnitedHealthcare Plan of the River Valley	82%	84%	84%	78%	82%
Wellmark Health Plan of Iowa, Inc.	79%	76%	77%	81%	79%
Wellmark, Inc.	88%	84%	87%	89%	88%

Appendix C: Rate Increases

ICMM Rate Increases					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	4%	0%	11%	20%	33%
Golden Rule Insurance Co.	7%	5%	1%	7%	5%
Medica Insurance Co.					N/A
Wellmark Health Plan of Iowa, Inc.	9%	4%	4%	6%	29%
Wellmark, Inc.	9%	13%	5%	7%	19%

Small Group Rate Increases					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	15%	13%	6%	11%	7%
Coventry Health & Life Ins. Co.	15%	13%	9%	5%	-8%
Federated Mutual Insurance Co.	5%	12%	6%	-1%	3%
Medical Associates Health Plan, Inc.	8%	8%	0%	2%	2%
UnitedHealthcare Insurance Co.	6%	7%	3%	3%	3%
UnitedHealthcare Plan of the River Valley	10%	9%	3%	6%	6%
Wellmark Health Plan of Iowa, Inc.	7%	4%	1%	1%	11%
Wellmark, Inc.	7%	8%	7%	9%	9%

Large Group Rate Increases					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	5%	12%	7%	-2%	10%
Coventry Health & Life Ins. Co.	5%	12%	13%	5%	11%
Federated Mutual Insurance Co.	12%	-10%	12%	11%	15%
Medical Associates Health Plan, Inc.	8%	8%	2%	2%	6%
UnitedHealthcare Insurance Co.	-3%	2%	7%	-1%	4%
UnitedHealthcare Plan of the River Valley	5%	5%	5%	10%	3%
Wellmark Health Plan of Iowa, Inc.	7%	6%	6%	6%	8%
Wellmark, Inc.	7%	6%	6%	6%	8%

Appendix D: Ranking of Changes

Increases

Aetna Health of Iowa, Inc.		
1	Inpatient Hospital	964,677
2	Other	783,418
3	Outpatient Hospital	571,875
4	Other	567,232
5	Physician	559,909
6	Physician	336,783
7	Outpatient Hospital	251,318
8	Physician	191,142
9	Physician	190,049
10	Outpatient Hospital	184,540

Coventry Health & Life Ins. Co.		
1	Physician	49,815
2	Outpatient Hospital	46,897
3	Physician	35,912
4	Outpatient Hospital	23,562
5	Outpatient Hospital	16,905
6	Inpatient Hospital	16,267
7	Outpatient Hospital	15,824
8	Outpatient Hospital	14,905
9	Outpatient Hospital	14,551
10	Outpatient Hospital	14,546

Federated Mutual Insurance Co.		
1	Ambulance	56,663
2	Prescription Drug	45,752
3	Skilled Nursing Facilities	34,091
4	MH/CD	18,160

Golden Rule Insurance Co.[33]		
1	Outpatient Hospital	13.70
2	Prescription Drug	3.12
3	X-Ray	1.50
4	Physician	1.38
5	Emergency Room	1.37
6	Diagnostic Imaging	1.23
7	Preventive	0.81
8	Skilled Nursing Facilities	0.38
9	Laboratory	0.06
10	MH/CD	0.02

[33] Golden Rule Insurance Co. provided increases and decreases on a PMPM basis instead of a total amount.

Medica Insurance Co.
Medica did not provide any information because they were new to the market in 2016

Medical Associates Health Plan, Inc.		
1	Other - Outpatient	542,417
2	Prescription Drug	538,421
3	Outpatient Hospital	333,305
4	Other - Outpatient	216,346
5	Physician	197,521
6	Preventive	181,036
7	Other - Outpatient	165,878
8	MH/SA	141,950
9	X-Ray	82,462
10	Emergency Room	72,779

United Healthcare Insurance Co.		
1	Inpatient Hospital	158,863
2	Physician	103,071
3	Emergency Room	97,727
4	Physician	34,054
5	Physician	27,076
6	Physician	27,027
7	Other	26,879
8	MH/CD	18,658
9	Physician	18,183
10	Physician	16,899

United Healthcare Plan of the River Valley		
1	Outpatient Hospital	2,333,621
2	Inpatient Hospital	1,054,401
3	Physician	520,677
4	Other	331,961
5	Physician	302,057
6	Laboratory	192,741
7	Physician	171,529
8	Physician	168,666
9	Other	150,344
10	MH/CD	132,765

Wellmark Health Plan of Iowa, Inc.		
1	Outpatient Hospital	2,135,109
2	Prescription Drug	1,894,211
3	MH/CD	1,503,950
4	Inpatient Hospital	1,096,723
5	Physician	875,498
6	Laboratory	401,631
7	Ambulance	379,961
8	Emergency Room	140,138

Wellmark, Inc.		
1	Outpatient Hospital	32,670,302
2	Prescription Drug	21,968,552
3	Inpatient Hospital	17,504,735
4	Physician	17,243,557
5	Other	10,289,636
6	Diagnostic Imaging	8,939,097
7	MH/CD	4,585,641
8	Laboratory	4,384,414
9	Emergency Room	3,107,400
10	Ambulance	3,022,266

Decreases

Aetna Health of Iowa, Inc.		
1	Inpatient Hospital	-1,945,103
2	Outpatient Hospital	-1,891,299
3	Inpatient Hospital	-1,708,309
4	Outpatient Hospital	-827,726
5	Physician	-758,269
6	Physician	-726,432
7	Inpatient Hospital	-705,056
8	Physician	-626,590
9	Outpatient Hospital	-619,731
10	Other	-532,672

Coventry Health & Life Ins. Co.		
1	Inpatient Hospital	136,229
2	Inpatient Hospital	91,801
3	Physician	88,339
4	Outpatient Hospital	39,584
5	Outpatient Hospital	25,563
6	Inpatient Hospital	24,650
7	Inpatient Hospital	19,660
8	Outpatient Hospital	19,333
9	Outpatient Hospital	18,756
10	Physician	18,722

Federated Mutual Insurance Co.		
1	Outpatient Hospital	-1,200,991
2	Inpatient Hospital	-567,734
3	Emergency Room	-270,928
4	Physician	-242,404
5	Diagnostic Imaging	-140,073
6	Other	-92,070
7	Laboratory	-75,643
8	Medical Technology	-23,048
9	Benefit Changes	-6,848

Golden Rule Insurance Co.		
1	Ambulance	-0.42
2	Other	-0.17
3	Inpatient Hospital	-0.08

Medica Insurance Co.
Medica did not provide any information because they were new to the market in 2016

Medical Associates Health Plan, Inc.		
1	Inpatient Hospital	-1,235,582
2	Benefit Changes	-666,413
3	Ambulance	-104,908
4	Skilled Nursing	-84,601
5	Laboratory	-16,771

United Healthcare Insurance Co.		
1	Inpatient Hospital	-252,954
2	Diagnostic Imaging	-118,908
3	Physician	-105,554
4	Prescription Drug	-103,184
5	Physician	-46,121
6	Outpatient Hospital	-41,717
7	Laboratory	-37,347
8	Inpatient Hospital	-17,566
9	Outpatient Hospital	-17,347
10	Other	-15,143

United Healthcare Plan of the River Valley		
1	Inpatient Hospital	-1,281,868
2	Outpatient Hospital	-828,343
3	Emergency Room	-250,911
4	Other	-183,917
5	Physician	-93,231
6	Laboratory	-70,009
7	Emergency Room	-59,468
8	Physician	-43,065
9	Physician	-33,936
10	Physician	-19,516

Wellmark Health Plan of Iowa, Inc.		
1	Other	-3,658,023
2	Skilled Nursing Facilities	-130,747
3	Diagnostic Imaging	-91,017

Wellmark, Inc.		
1	Skilled Nursing Facilities	-657,856

Appendix E: Risk-Based Capital

Company	2012	2013	2014	2015	2016
Aetna Health of Iowa, Inc.	626%	490%	363%	373%	344%
Coventry Health & Life Ins. Co.	405%	502%	468%	769%	1182%
Federated Mutual Insurance Co.	1917%	1871%	1983%	2037%	1991%
Golden Rule Insurance Co.	503%	415%	511%	522%	356%
Medica Insurance Co.	516%	524%	623%	548%	436%
Medical Associates Health Plan Inc.	531%	712%	585%	591%	715%
UnitedHealthcare Insurance Co.	532%	555%	560%	557%	480%
UnitedHealthcare Plan of the RV	355%	402%	492%	447%	423%
Wellmark Health Plan of Iowa, Inc.	1247%	1158%	1214%	1034%	1234%
Wellmark, Inc.	993%	1132%	1027%	942%	936%

Appendix F: Medical Trends

Below are the medical trends from 2012 to 2016.

Golden Rule Insurance Company has not answered since 2009 due to small membership and replied this year with:

"Since our IA membership is small, any trend analysis specific to particular procedures or services would be deemed non-credible. However, medical insurance has historically been subject to cost factors beyond pure price inflation. Increased utilization, deductible/copay leveraging, changes in technology and services, and the wear-off of underwriting[34] have always played a role in creating medical insurance premium trends that are greater than overall medical inflation. In addition, particular blocks will experience different trends based on the overall changes in insured demographics, benefit selection options, and underwriting procedures."

Medica Insurance Co. was new to the market in 2016 and therefore they could not provide trend experience.

We have included the categories from the 2016 report for comparison purposes. Only the carriers providing data are included.

Aetna Health of Iowa, Inc.					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
IP	-12%	0%	58%	36%	-9%
OP	7%	8%	44%	46%	-10%
PHY	-10%	-1%	15%	23%	-3%
Rx	-7%	0%	14%	48%	12%
Cap	-10%	-5%			
IP/OP/PHY	-6%	1%			
Other			15%	68%	-4%
Total	-6%	1%			

Coventry Health & Life Ins. Co.					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
IP	23%	-15%	22%	-26%	-57%
OP	17%	-2%	13%	-6%	-4%
PHY	10%	6%	7%	-7%	-3%
Rx	2%	11%	17%	-43%	-18%
Cap	198%	6%	18%	26%	-6%
IP/OP/PHY	16%	-4%			
Total	15%	-2%			

[34] Underwriting wear-off is the situation where when policies are underwritten the claims cost are lower in the early years due to the underwriting, but as time passes the effect of underwriting disappears or wears-off.

Federated Mutual Insurance Co.				
Service Category	**2013**	**2014**	**2015**	**2016**
Inpatient Hospital	7%	-20%	13%	2%
Outpatient Hospital	-14%	216%	24%	2%
Professional	17%	-70%	-9%	46%
Other Medical	-11%	410%	-11%	38%
Prescription Drug	-11%	34%	26%	4%

UnitedHealthcare Insurance Co.					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Inpatient - 00 _ Unknown Major Diagnostic Category		99%			
Inpatient - 01 _ Diseases & Disorders of the Nervous			44%		
Inpatient - 04 _ Diseases & Disorders of the Respiratory			65%		
Inpatient - 5 - Circulatory System	50%				
Inpatient - 15 _ Newborns & Other Neonates with			71%		
Inpatient - 17 - Myeloproliferative DDs (Poorly	213%				
Inpatient - 23 _ Factors Influencing Health Status & Other		173%			
Inpatient - Maternity/Newborn				13%	
Inpatient - NICU/Extended Stay				17%	222%
Outpatient - Ambulance				25%	
Outpatient - Dialysis	69%			43%	
Outpatient - DME					66%
Outpatient - Emergency Room			13%	13%	31%
Outpatient - Freestanding Clinical Lab				28%	
Outpatient - Misc OP Facility			27%		
Outpatient - Observation				14%	
Outpatient - Radiation Therapy		42%			
Pharmacy - Diagnostic Agents	83%				
Pharmacy - Hepatitis C			501%		
Pharmacy - Hormones			22%		
Pharmacy - Unclassified Therapeutic Agents		19%			
Physician - Deliveries					47%
Physician - ER Visits				32%	
Physician - Hematology and Oncology		77%	23%		
Physician - Immunizations				19%	
Physician - IP Visits				15%	
Physician – Office Surgery					20%
Physician - Other Allied Provider	30%				
Physician - Professional Drugs					102%
Physician - Therapeutic Radiology			43%		

UnitedHealthcare Plan of the River Valley					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Inpatient - Maternity/Newborn	11%				
Inpatient - Med/Surg/ICU	14%	11%	12%		8%
Inpatient - NICU/Extended Stay			81%		
Inpatient - SNF		21%			
Inpatient - Visits			27%		
Outpatient - Ambulance				36%	
Outpatient - Dialysis	69%				
Outpatient - Emergency Room		13%	10%	16%	
Outpatient - Home Health	63%	27%			
Outpatient - Lab & Path Facility Based					14%
Outpatient - Observation	35%				
Outpatient - Outpatient Surgery					12%
Outpatient - Rx - Facility Dispensed		22%		28%	
Outpatient - UrgiCenter	51%				
Physician - Immunizations		27%			
Physician - Inpatient Surgery					16%
Physician - Outpatient Surgery					14%
Pharmacy - Non Spec			74%	19%	
Pharmacy - Spec Pharma non-Chemo				39%	26%
Pharmacy - Pharmacy Dispensed			103%		
Radiology - Therapy	36%			86%	

Wellmark Health Plan of Iowa, Inc.					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Acute Inpatient Facility	3%	4%	-2%	8%	
Drug	7%	3%	10%	10%	
Outpatient Facility	3%	5%	2%	3%	
Practitioner	2%	4%	4%	4%	
Practitioner – Ambulance					26%
Practitioner – Mental Health/Chemical Dependency					20%
Practitioner – Physical & Occupational Therapy					17%
Practitioner – Speech Therapy					15%

Wellmark, Inc.					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Acute Inpatient Facility	-1%	2%	0%	4%	
Drug	3%	2%	10%	9%	
Facility – Speech Therapy					23%
Home Medical Equipment					12%
Outpatient Facility	5%	3%	3%	4%	
Practitioner	3%	2%	1%	3%	
Practitioner – Ambulance					28%
Practitioner – Mental Health/Chemical Dependency					13%
Practitioner – Physical & Occupational Therapy					13%

Medical Associates Health Plan					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
3-D RADIOTHERAPY PLAN DOSE-VOLUME HISTOGRAMS			48%		
Abilify		69%			
Adapalene				73%	
Adenoidectomy Primary <Age 12				91%	
Adult Residential Program		1122%		110%	
AFLIBERCEPT INJECTION			38%	116%	
Ambulance		2609%			57%
Anchor/Screw Bn/Bn,Tis/Bn				110%	
Androgel		67%		17%	
Anes Arthrs Humeral H/N Strnclav & Shoulder Nos				114%	
Anes Intraperitoneal Upper Abdomen W/Laps Nos				32%	
Anes Iper Lower Abd W/Laps Rad Hysterectomy				898%	
Anesth Open/Surg Arthrs Total Knee Arthroplasty				38%	
ANESTHESIA EXTENSIVE SPINE & SPINAL CORD			224%		
ANESTHESIA FOR INTRACRANIAL PROCEDURES; NOT OTHERWISE SPECIFIED			283%		
Anesthesia Intraoral With Biopsy Nos				36%	
Anesthesia Open Total Hip Arthroplasty				176%	
ANESTHESIA/GENERAL CLASSIFICATION			18%		
Antepartum Care			16%		
ANTERIOR INSTRUMENTATION 2-3 VERTEBRAL SEGMENTS			285%		
ARTHRD ANT INTERBODY DECOMPRESS CERVICAL BELW C2			653%		
Arthrodesis Anterior Interbody Lumbar				208%	
Arthroscopy Hip W/Femoroplasty				419%	
Arthroscopy Shoulder Distal Claviculectomy				454%	
Arthroscopy Shoulder Rotator Cuff Repair				1140%	
Arthroscopy Shoulder Surg Debridement Limited				57%	
Arthroscopy Shoulder Surgical Capsulorrhaphy				1548%	
Arthroscopy Shoulder W/Coracoacrm Ligmnt Release				99%	
Arthrp Acetblr/Prox Fem Prostc Agrft/Algrft				220%	
Arthrp Interpos Intercarpal/Metacarpal Joints				61%	
Arthrp Kne Condyle&Platu Medial&Lat Compartments				38%	
ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ			82%		
Asacol Hd				75%	
BASIC RADIATION DOSIMETRY CALCULATION			95%		
Betaseron		71%			
BLEPHAROPLASTY, UPPER EYELID; WITH EXCESSIVE SKIN WEIGHTING DOWN LID	228%				
Breast Pump, Electric (Ac And/Or Dc), Any Type		8522%			
BRST RCNSTJ IMMT/DLYD W/TISS EXPANDER SBSQ XPNSJ			351%		
Bydureon		143%			
Capsulorrhaphy Anterior W/Labral Repair				614%	
Cardiology/Cardiac Cath Lab		150%			
Cataract Removal, Insertion Of Lens		30%	12%		
Cath, Ep, Othr Than Cool-Tip				202%	
Cefdinir		73%			
CLOBETASOL PROPIONATE			371%	66%	
Cochlear Device, Includes All Internal And External Components		91%			
Colon Ca Scrn Not Hi Rsk Ind		151%		52%	
COLONOSCOPY W/BIOPSY SINGLE/MULTIPLE			14%		
Colsc Flx Prox Splenic Flxr Rmvl Les Snare Tq		16%			
COMPRE METAB PANEL			27%		
Computed Tomography Guidance For Placement Of Radiation Therapy Fields		91%			
COMPUTED TOMOGRAPHY, HEAD OR BRAIN; WITHOUT CONTRAST MATERIAL			23%		
Copaxone		16%			20%
CORONARY CARE/GENERAL CLASSIFICATION	682%	174%	69%	84%	
Corrj Hallux Valgus W/Wo Sesmdc W/Metar Osteot				43%	
Craniec Trephine Bone Flp Brain Tumor Suprtentor				75%	
CT ABDOMEN & PELVIS W/CONTRAST MATERIAL			13%		
CT ANGIO ABD & PELVIS	20%		32%		
Ct Angiography Abdomen W/Contrast/Noncontrast				451%	

Medical Associates Health Plan					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Ct Scan/Body Scan				10%	
Ct Scan/General Classification		161%			
Cyclophosphamide, 100 Mg		369%			
Cymbalta		19%			
Denosumab Injection				3639%	
DEXMETHYLPHENIDATE HCL ER			1324%	69%	55%
Dextroamphetamine-Amphet Er				117%	
Dextroamphetamine-Amphetamine		2344%			525%
DLYD INSJ BRST PROSTH FLWG MASTOPEXY MAST/RCNSTJ			847%		
DME Supplies					10%
Doxycycline Hyclate		3797%			
Drugs Requiring Specific Identification/Drugs Requiring Detailed Coding		678%			
Dulera				152%	
DULOXETINE HCL			1223%		
ECHOCARDIOGRAPHY			49%	29%	
Edg Flexible Foreign Body Removal				296%	
Eeg (Electroencephalogram)/General Classification				87%	
Emer Dept Hi Severity&Urgent Eval		16%			
Emer Dept High Severity&Threat Funcj		11%	18%		
EMERGENCY ROOM/GENERAL CLASSIFICATION			24%		
ENBREL			19%		76%
Endoven Abltj Incmptnt Vein Xtr Rf 1St Vein		33%	35%		
Enoxaparin Sodium		102%			
EPHYS EVAL W/ABLATION SUPRAVENT ARRHYTHMIA			62%		
Epipen 2-Pak				46%	
EXTERNAL AMBULATORY INFUSION PUMP, INSULIN	446%				
Fareston				336%	
FEM/POPL REVAS W/TLA	130%				
FETAL NON-STRESS TEST	140%				
Fibrin Dgradj Products D-Dimer Ultrasensitive				17360%	
Flebogamma Injection		8229%			
Gamunex-C/Gammaked				80%	
GASTRO-INTESTINAL SERVICES/GENERAL CLASSIFICATION			268%		
GLEEVEC			33%		
Glumetza				345%	
GROUND MILEAGE			38%		
Harvoni				62%	
Hhcp-Serv Of Pt,Ea 15 Min				46%	
Hospital Observation Per Hr				29%	
HUMALOG			28%		254%
Human Papilloma Virus Vaccine Quadriv 3 Dose Im		39%			
Humira		18%	28%		274%
Hydroxychloroquine Sulfate				335%	
HYSTSC BX ENDOMETRIUM&/POLYPC +-D&C	66%				
Iadna Respiratry Probe & Rev Trnscr 12-25 Target				896%	
Ibrance					51%
IMADM ANY ROUTE 1ST VAC/TOX	61%				
Imadm Prq Id Subq/Im Njxs 1 Vacc		18%			
Injection - Octredotide	107%				
Injection - Oxaliplatin			995%		
Injection - Ranibizumab		62%			
INJECTION INFLIXIMAB, 10 MG	30%	43%	26%		
Injection, Bortezomib, 0.1 Mg		559%			
Injection, Darbepoetin Alfa, 1 Microgram (Non-Esrd Use)		257%		65%	
Injection, Filgrastim (G-Csf), 1 Microgram				320%	
INJECTION, GEMCITABINE HYDROCHLORIDE, 200 MG	735%				
Injection, Omalizumab, 5 Mg		123%		42%	
INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES, 1 MG	371%				
INJECTION, TRASTUZUMAB, 10 MG	85%				

Medical Associates Health Plan					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Injection,Onabotulinumtoxina				20%	
Ins/Rep Pac Perm Cvdfb Trnsven Leads 1/2 Chamber				111%	
Intensive Care/General		124%		16%	
INTENSIVE CARE/MEDICAL	423%		827%		
Intensive Care/Pediatric		229%			
Intensive Care/Post ICU			48%		
INTENSIVE CARE/SURGICAL	169%	49%		180%	
INTENSIVE CARE/TRAUMA			820%		
Invega Sustenna				183%	
Invokana				448%	
Irinotecan Injection				1167%	
Iv Infusion Hydration Each Additional Hour		44%			
Iv Infusion Therapy/Prophylaxis /Dx 1St To 1 Hr				30%	
Iv Therapy/General Classification		140%			
L HRT ARTERY/VENTRICLE ANGIO	55%				
LABOR ROOM/DELIVERY/DELIVERY			85%	82%	
LABOR ROOM/DELIVERY/GENERAL CLASSIFICATION			427%		
Laboratory/Chemistry		27%			
LABORATORY/GENERAL CLASSFICIATION			11%		
Lam Exc/Evac Ispi Les Oth/Thn Neo Xdrl Lumbar				619%	
LAM FACETEC&FORAMOT 1 SGM LMBR	409%			272%	
Lamotrigine Er				148%	
LANTUS			25%		
LANTUS SOLOSTAR			42%		
Laparoscopic Appendectomy				111%	
LAPAROSCOPY SURG RPR INITIAL INGUINAL HERNIA			1022%		
LAPAROSCOPY TOT HYSTERECTOMY >250 G W/TUBE/OVAR			168%		
Laparoscopy Tot Hysterectomy >250 G W/Tube/Ovar				43%	
Laparoscopy W Total Hysterectomy Uterus 250 G/<		3090%			
LAPAROSCOPY, SURGICAL; CHOLECYSTECTOMY	57%			50%	
Laparoscopy, Surgical; Cholecystectomy With Cholangiography		59%			
LAPS FULG/EXC OVARY VISCERA/PRTL SURF	199%				
Laps Supracrv Hyst 250 G/< Rmvl Tube/Ovary		246%			
Laps Total Hysterectomy 250 G/<W Tube/Ovary		1042%	86%	38%	
LAPS W/VAG HYST 250 GM/<	137%				
Laps W/Vag Hysterect 250 Gm/&Rmvl Tube&/Ovaries				123%	
LEVEL IV SURG PATHOLOGY GROSS&MICROSCOPIC EXAM			13%		
Levemir Flextouch				979%	
Lialda					442%
LITHOTRIPSY, EXTRACORPOREAL SHOCK WAVE	49%		76%		
Localize Cerebral Seizure Cable/Radio Eeg/Video				401%	
Lupron Depot-Ped				123%	
M/PHMTRC ALYS ISH EA PRB CPTR-ASST TECHNOLOGY			1257%		
MASTECTOMY SIMPLE COMPLETE			75%		
Measles Mumps Rubella Varicella Vacc Live Subq		194%			
Medical/Surgical Supplies				148%	
Medical/Surgical Supplies And Devices/General Classification				22%	
MEDICAL/SURGICAL SUPPLIES AND DEVICES/OTHER IMPLANTS			14%	21%	
Medical/Surgical Supplies And Devices/Other Supplies/Devices		42%		36%	
Mental Health Therapy					29%
Methylphenidate Er				16%	
MLC IMRT DESIGN & CONSTRUCTION PER IMRT PLAN			246%		
Mnl Ther Tqs 1+ Regions Ea 15 Min		33%			
Mri Brain Brain Stem W/O Contrast Material				105%	
MRI BRAIN BRAIN STEM W/O W/CONTRAST MATERIAL			25%		
MRI/BRAIN (INCLUDING BRAINSTEM)			171%		
Natpara					170%
NEUPOGEN			702%		
Neuroplasty &/Transpos Median Nrv Carpal Tunne				367%	

Medical Associates Health Plan					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
Newborn Nursery Level IV			2268%		
NEWBORN NURSERY/LEVEL III	425%		245%		
NJX ANES&/STRD TFRML EDRL LMBR/SAC 1 LVL	119%				
NJX C+-DX/THER SBST EDRL/SARACH CRV/THRC			107%		
NORDITROPIN FLEXPRO			415%		
NTSTY MODUL DLVR 1/MLT FLDS/ARCS PR TX SESSION	122%		419%		
NURSERY/PREMATURE NEWBORN	70%		35%		
Observation In Hospital					11%
OFFICE OUTPATIENT VISIT 40 MINUTES			26%		
Oncology Room & Board		119%		38%	
OPERATING ROOM SERVICES/MINOR SURGERY	77%				
Optx Dstl Radl I-Artic Fx/Epiphysl Sep 3 Frag				437%	
Orencia				329%	
Osteopathic, Pt, Chiro Therapy & Treatment					12%
OSTEOT W/WO LNGTH SHRT/CORRJ METAR XCP 1ST EA			286%		
Other Diagnostic Services/General Classification		574%			
Other Hospital Pharmacy	41%		138%		
OTHER IMAGING SERVICES/ULTRASOUND	133%				
Perc Drug-El Cor Stent Sing				82%	
PERIPROSTHETIC CAPSULECTOMY BREAST			2232%		
PET IMAGING CT ATTENUATION SKULL BASE MID-THIGH			37%		
Pharmacy/General Classification		13%			
Physical Therapy/General Classification		34%		15%	
Pneumonia Vaccine				18%	
Prepj& Allergen Immunotherapy 1/Mlt Antigen				21%	
Prescription Oral & Inhalants, Non Rx Drugs					68%
PRESS SUPP VENT NONINV INT			496%		
Preventative Immunizations					11%
Promacta					76%
Prostate Cancer Screening					
Prostate Specific Antigen (Psa); Total		94%	33%		
PROSTHESIS, BREAST, IMP			486%		
Prosthetic Implant Nos				24%	
PSYCHOTHERAPY PATIENT &/ FAMILY 60 MINUTES			36%		
Rad W/Backup Non Inv Intrfc				3668%	
Radiation Oncology					30%
RADIATION TREATMENT MANAGEMENT 5 TREATMENTS			80%		
RADJ DLVR 3/> AREAS CUSTOM BLKING 11-19MEV			321%		
RECOVERY ROOM/GENERAL CLASSIFICATION			23%	12%	
REDUCTION MAMMAPLASTY			242%		
Rehab Bed		64%	45%		
REMOVAL IMPLANT DEEP	214%				
Repair Of Hammertoe				140%	
Repair Umbilical Hernia, Age 5 Years Or Older; Reducible		146%		48%	
REPLACEMENT TISS EXPANDER PERMANENT PROSTHESIS			180%		
Repricing Fees		69%			61%
Residential Subt. Abuse Treatment Ctr.					203%
RESPIRATORY SERVICES/GENERAL CLASSIFICATION	32%				
RESPIRATORY SYNCYTIAL VIRUS IG IM 50 MG E MONOCLONAL ANT RECOMBINANT	162%				
Restasis				55%	
REVLIMID			373%		
Revsc Opn/Prq Iliac Art W/Stnt Plmt & Angioplsty				202%	
Rhinoplasty Primary W/Major Septal Repair				960%	
RITUXIMAB INJECTION			23%		
Robotic Surgical System		142%		24%	
Room & Board - OB	1413%	253%			
Room & Board Semi Private Room	29%		49%		
ROOM AND BOARD-SEMI-PRIVATE TWO-BED/GENERAL CLASSIFICATION	28%		23%	13%	

Medical Associates Health Plan					
Service Category	**2012**	**2013**	**2014**	**2015**	**2016**
ROOM AND BOARD-SEMI-PRIVATE TWO-BED/OTHER	76%	91%			
ROOM AND BOARD-SEMI-PRIVATE TWO-BED/PEDIATRIC			128%	176%	
ROOM AND BOARD-SEMI-PRIVATE TWO-BED/PSYCHIATRIC	51%				
ROTARY WING AIR MILEAGE, PER STATUTE MILE	234%		326%	51%	
ROTARY WING AIR TRANSPORT	230%		412%	58%	
RPR RETINAL DTCHMNT W/VITRECTOMY ANY METH			752%		
SERVICES OF SKILLED NURSE IN HOME HEALTH SETTING, EACH 15 MINUTES	40%			39%	
STELARA			30%		52%
Stereotactic Body Radiation Delivery				40%	
STRSC X-RAY GDN LOCLZJ TARGET VOL DLVR RADJ THER			1473%		
Subacute Care-Level Iii				355%	
Submucous Resection Inferior Turbinate, Partial Or Complete, Any Method		86%		62%	
SUBQ I/P CRITICAL CARE PR DAY AGE 28 DAYS/<			2018%		
SUBSEQUENT INTENSIVE CARE INFANT 1500-2500 GRAMS	125%				
Subsequent Intensive Care Infant 2501-5000 Grams				129%	
SYNVISC OR SYNVISC-ONE			48%		
TASIGNA			1245%		
TECFIDERA			93%		
Tendon Sheath Incision				117%	
Ther Px 1/> Areas Each 15 Min Neuromusc Reeduca				79%	
Ther Px 1+ Areas Ea 15 Min Ther Xerss		17%			
Therapeutic Immunizations & Injections (Excludes Allergy Immunotherapy)					21%
Tonsillectomy & Adenoidectomy <Age 12				30%	
TX DEVICES DESIGN & CONSTRUCTION COMPLEX			121%		
Tx Speech Lang Voice Commj &/Auditory Proc Ind				40%	
Unlisted Procedure Arthroscopy				119%	
Vaginal Hysterectomy Uterus 250 Gm/<				180%	
Vyvanse					47%
Xarelto				305%	
Xifaxan				768%	
XYNTHA INJ			115%		
ZOSTER (SHINGLES) VACCINE, LIVE, FOR SUBCUTANEOUS INJECTION	316%				

Appendix G: Additional Data

I. ICMM, small group, and large group PMPMs, 2012-2016.

ICMM Incurred PMPM Costs					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	$86.88	$113.39	$223.74	$351.60	$360.15
Golden Rule Insurance Co.	$104.27	$125.46	$127.88	$157.77	$179.33
Medica Insurance Co.	Was not included in survey until 2016				$693.00
Wellmark Health Plan of Iowa, Inc.	$181.37	$180.68	$183.84	$196.26	$234.30
Wellmark, Inc.	$221.85	$225.29	$252.29	$328.31	$378.92

Small Group Incurred PMPM Costs					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	$204.20	$203.93	$220.00	$255.14	$286.71
Coventry Health & Life Ins. Co.	$269.87	$285.09	$304.43	$243.71	$218.59
Federated Mutual Insurance Co.	$337.55	$317.47	$297.00	$361.36	$314.53
Medical Associates Health Plan Inc.	$287.43	$282.12	$327.53	$336.65	$341.91
UnitedHealthcare Insurance Co.	$235.04	$265.25	$264.82	$287.32	$263.12
UnitedHealthcare Plan of the RV	$214.35	$233.67	$239.79	$220.37	$250.98
Wellmark Health Plan of Iowa, Inc.	$264.03	$276.43	$279.52	$320.53	$289.25
Wellmark, Inc.	$251.60	$264.66	$278.33	$327.11	$307.97

Large Group Incurred PMPM Costs					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	$246.49	$250.84	$301.56	$309.51	$319.32
Coventry Health & Life Ins. Co.	$295.79	$275.87	$333.99	$354.09	$388.31
Federated Mutual Insurance Co.	$310.36	$333.81	$308.73	$302.97	$296.21
Medical Associates Health Plan Inc.	$326.65	$332.82	$364.21	$364.04	$371.58
UnitedHealthcare Insurance Co.	$270.90	$312.32	$323.06	$310.04	$263.62
UnitedHealthcare Plan of the RV	$285.21	$300.45	$316.94	$316.02	$345.30
Wellmark Health Plan of Iowa, Inc.	$274.97	$277.17	$294.07	$282.46	$314.79
Wellmark, Inc.	$281.50	$278.22	$305.67	$289.39	$353.61

ICMM Allowed PMPM Costs		
Company	**2015**	**2016**
Aetna Health of Iowa, Inc.	$444.53	$455.89
Golden Rule Insurance Co.	$231.73	$255.48
Medica Insurance Co.		$813.00
Wellmark Health Plan of Iowa	$218.90	$326.31
Wellmark, Inc.	$409.66	$465.20

Small Group Allowed PMPM Costs		
Company	**2015**	**2016**
Aetna Health of Iowa, Inc.	$333.58	$377.24
Coventry Health & Life Ins. Co.	$337.65	$312.18
Federated Mutual Insurance Co.	$527.72	$476.20
Medical Associates Health Plan Inc.	$396.68	$387.97
UnitedHealthcare Insurance Co.	$345.85	$322.80
UnitedHealthcare Plan of the River Valley	$290.17	$321.65
Wellmark Health Plan of Iowa	$382.02	$366.06
Wellmark, Inc.	$407.19	$390.24

Large Group Allowed PMPM Costs		
Company	**2015**	**2016**
Aetna Health of Iowa, Inc.	$413.89	$425.76
Coventry Health & Life Ins. Co.	$457.38	$551.77
Federated Mutual Insurance Co.	$339.47	$550.21
Medical Associates Health Plan Inc.	$411.98	$412.72
UnitedHealthcare Insurance Co.	$384.04	$323.09
UnitedHealthcare Plan of the River Valley	$381.85	$421.81
Wellmark Health Plan of Iowa	$354.59	$380.10
Wellmark, Inc.	$367.78	$437.35

II. Commissions as a percentage of premium, 2012-2016

Commission as % of Premium					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	2%	7%	0%	0%	1%
Coventry Health & Life Ins. Co.	2%	1%	0%	0%	1%
Federated Mutual Insurance Co.	2%	3%	2%	2%	1%
Golden Rule Insurance Co.	5%	6%	4%	2%	2%
Medica Insurance Co.					1%
Medical Associates Health Plan Inc.	1%	1%	1%	1%	1%
UnitedHealthcare Insurance Co.	5%	4%	3%	3%	2%
UnitedHealthcare Plan of the RV	5%	3%	3%	2%	2%
Wellmark Health Plan of Iowa, Inc.	3%	3%	3%	3%	4%
Wellmark, Inc.	4%	4%	3%	4%	3%

III. Administrative costs as a percentage of premium, 2012-2016

Admin as % of Premium					
Company	**2012**	**2013**	**2014**	**2015**	**2016**
Aetna Health of Iowa, Inc.	12%	12%	11%	16%	9%
Coventry Health & Life Ins. Co.	13%	11%	13%	16%	8%
Federated Mutual Insurance Co.	14%	14%	21%	17%	15%
Golden Rule Insurance Co.	16%	12%	11%	14%	20%
Medica Insurance Co.					14%
Medical Associates Health Plan Inc.	10%	12%	10%	10%	10%
UnitedHealthcare Insurance Co.	9%	9%	14%	19%	22%
UnitedHealthcare Plan of the RV	14%	8%	11%	12%	11%
Wellmark Health Plan of Iowa, Inc.	5%	8%	11%	11%	11%
Wellmark, Inc.	8%	10%	12%	11%	11%

IV. Additional Cost Factors Beyond Claims (as a percentage of premium)

Aetna Health of Iowa, Inc.					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	2%	7%	0%	0%	1%
Administrative	12%	12%	11%	16%	9%
Profit	10%	13%	2%	-14%	-2%

Coventry Health and Life Insurance Co.					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	2%	1%	0%	0%	1%
Administrative	13%	11%	13%	16%	8%
Profit	-12%	-1%	-4%	9%	21%

Federated Mutual Insurance Co.					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	2%	3%	2%	2%	1%
Administrative	12%	12%	14%	10%	8%
Cost Containment					
Taxes and Fees	2%	2%	6%	6%	7%
Profit	-9%	-2%			

Golden Rule Insurance Company					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	5%	6%	4%	2%	2%
Administrative	16%	12%	11%	10%	16%
Taxes and Fees				4%	3%
Quality Improvement				0%	0%

Medical Insurance Co.	
Factor	**2016**
Commissions	1%
Administrative	7%
Taxes	8%
HCQI	0%

Medical Associates Health Plan, Inc.					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	1%	1%	1%	1%	1%
Administrative	10%	12%	8%	8%	9%
ACA Fees			2%	2%	1%

United Healthcare Insurance Co.					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	5%	4%	3%	3%	2%
Administrative	9%	9%	14%	19%	22%
Premium Taxes					

United Healthcare Plan of the River Valley					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	5%	3%	3%	2%	2%
Administrative	14%	8%	11%	12%	11%
Premium Taxes					
Assessments					
Defined Expenses Incurred for Health Care Quality					
Claims adjustment expenses					

Wellmark Health Plan of Iowa, Inc.					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	3%	3%	3%	3%	4%
Administrative	5%	8%	11%	11%	11%

Wellmark, Inc.					
Factor	**2012**	**2013**	**2014**	**2015**	**2016**
Commissions	4%	4%	3%	4%	3%
Administrative	8%	10%	12%	11%	11%

Appendix H: Health Care Cost Category Standardization

Company Service	Standard Service
Ambulance	Ambulance
Benefit Changes	Benefit Changes
Diagnostic Imaging	Diagnostic Imaging & Tests
Emergency Room	Emergency Room
Inpatient Hospital	Inpatient Hospital
Laboratory	Laboratory and X-ray
Medical Technology	Medical Technology
MH/CD	MH/CD
Other	Other
Other - Outpatient	Other
Outpatient Hospital	Outpatient Hospital
Physician	Physician
Prescription Drug	Prescription Drug
Preventive	Preventive
Skilled Nursing	Skilled Nursing Facilities
Skilled Nursing Facilities	Skilled Nursing Facilities
X-Ray	Laboratory and X-ray