PUBLIC HEARING TO RECEIVE PUBLIC TESTIMONY AND COMMENTS

IN RE: PROPOSED 2026 HEALTH INSURANCE RATE INCREASE

Golden Rule Insurance Company Pre-ACA Policies
Wellmark, Inc., Pre-ACA Policies
Wellmark Health Plan of Iowa Pre-ACA Policies
Wellmark Health Plan of Iowa ACA Policies
UnitedHealthcare Plan of the River Valley, Inc., ACA Policies
Oscar Insurance Company ACA Policies
Iowa Total Care ACA Policies
Medica Insurance Company ACA Policies

IOWA INSURANCE COMMISSIONER DOUGLAS OMMEN, Presiding

Also Present: SONYA SELLMEYER
Consumer Advocacy Officer

TODD RULLESTAD

Tuesday, August 19, 2025
5:00 p.m.

Iowa Insurance Division
Mississippi Conference Room
1963 Bell Avenue
Des Moines, Iowa 50315

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P R O C E E D I N G S

COMMISSIONER OMMEN: All right. Good evening to all of you.

I'm Commissioner Doug Ommen, and I will be presiding over this hearing this evening.

It is August the 19th, and we're just now at 5:00 o'clock.

We're here to receive comments on the filings that were submitted in our individual health insurance market here in the State of Iowa. While I have not yet had the opportunity to review all of the actuarial reviews performed by actuaries on my staff or under contract, it's clear from the number of filings that unfortunately we are experiencing another significant change in the individual market.

Although there are a number of ways to measure annual medical inflation for 2024 and the first half of 2025, we are seeing trends in the high single digits, even as much as 10 percent. Some experts are suggesting it is even higher.

Iowa Code section 505.19 establishes this public hearing on proposed individual health insurance rate increases which exceed the average annual health spending growth rate. This annual health spending growth rate is published by the

Centers for Medicare and Medicaid Services at the United States Department of Health and Human Services. That annual health spending growth rate is 5.6 percent.

The purpose of this hearing this evening is to gather comments and information from individuals who are going to be impacted by the rates that have been submitted in these plans.

My rate review is to determine whether the rates are neither inadequate, nor excessive. This review is done on an individual insurance pool basis. Each company files its proposed rates based on its prior experience of losses and expenses in a particular insurance pool.

The law does not direct me to look at a company's separate group rates or any of its self-funded business that may be governed by the Department of Labor under ERISA.

Our rate review authority is primarily a function of balancing the total dollars paid out to cover healthcare costs in the form of claims for a particular insurance pool with the mix of rates that are designed to collect enough premiums to cover those claims in that pool.

On the docket tonight are three blocks of

business that are Pre-ACA plans. Under the Affordable Care Act we have five insurers competing in the individual market here in Iowa: Wellmark Health Plan of Iowa; UnitedHealthcare Plan of the River Valley, Inc.; Oscar Insurance Company; Iowa Total Care; and Medica Insurance Company.

In reviewing the rates, the impact of rates is important. For tonight's hearing I'm primarily interested in hearing from individuals who would be impacted by those rates. The primary issue is the affordability of those who actually have coverage in these plans. As you know, materials regarding these proposed rates are found on the Iowa Insurance Division website.

So for tonight's hearing we'll start with those who are in attendance in the hearing room. So this hearing is on the record, as we have a court reporter here to be transcribing what is said. So if you're speaking and giving comments, it's important for you to identify yourself, and then to facilitate that process we do have a hearing sign-up sheet that's available--or was available outside the room and is available for you to list your name should you wish to offer a statement.

At this time I would like to introduce to

you Sonya Sellmeyer. Sonya serves as the Consumer Advocate for the Insurance Division.

Sonya.

MS. SELLMEYER: Thank you, Commissioner.

I will just go through some quick housekeeping items before we start getting into the meat of the hearing.

For those of you in attendance, like the Commissioner said, if you want to speak, there's a sign-in sheet, and I think everyone in here pretty much gave me one if they wanted to speak. We'll do it by company, and you can come up to the lectern when it's your turn--company's turn to speak, and I'll call names, and you can make a comment.

If you're on the phone, you are muted.

Do we have anyone on the phone?

MR. RULLESTAD: We have about a dozen.

MS. SELLMEYER: Okay.

MR. RULLESTAD: Not on the telephone, but in the virtual meeting.

MS. SELLMEYER: If you're on the phone, if you called in via phone, during the open comment section for your healthcare provider's proposed rate increase and you would like to make a comment, please dial star 3 to raise your hand, and you will be

advised when it's your turn to make a comment. You will then need to hit star 6 to unmute, and then hit star 3 to lower your hand once you are done.

If you're on a virtual feed, you are also muted. You can also use the raise hand feature on the virtual feed if you would like to make a comment under your healthcare provider's proposed rate increase. You will be unmuted, and you'll know when it's your turn to speak. You can lower your hand with the same button when you're done speaking.

If you do not wish to speak, but would like to leave a comment, you may place your comment with your first name in the chat section online. Just make sure that you name your insurance company and whether or not it's an ACA policy. All consumer comments may be made after remarks by the company.

I'm now going to read my opening remarks for this hearing, and my opening remarks are going to apply to all of the health carriers that we're going to discuss today. Rather than saying it eight times, I'm going to say it once. Okay?

Iowa law requires a public hearing when proposed health insurance rate increases exceed the federal health spending growth rate, which was 5.6 for the plan year of 2026.

My role as the Consumer Advocate is to ensure consumer voices are heard before the Commissioner makes any decision. If you received a premium notice from your health insurance carrier, today is your opportunity to share what that increase means to you. I ask others to allow affected policyholders the time to speak.

Every proposal goes through two independent actuarial reviews: One by the Iowa Insurance Division's health team, the other by an external consulting actuary. Both must substantially agree before a recommendation is made. Our process has earned the federal Effective Rate Review designation, meaning rate proposals are thoroughly analyzed, tested, and challenged.

With regards to the five Affordable Care Act companies to be discussed, in recent years enhanced federal subsidies have helped keep premiums low. In 2025 over a third of Iowa consumers receiving subsidies paid less than $10 a month. But those subsidies expire at the end of this year. Without them, some healthier individuals may drop out of coverage, which would weaken the risk pool and drive up rates.

Today, I will also be mentioning the medical

loss ratio, or MLR, which is the percentage of a health insurance company's premium revenue that it spends on medical care and activities to improve the quality of care.

For example, if an insurer has an 80 percent MLR, it means that every dollar you pay in premiums, 80 cents is used to pay for medical claims and improving care.

Since 2012, failure to meet this 80 percent MLR requirement over a rolling three-year period necessitates issuing a rebate to consumers through a federally prescribed process. Rate change proposals are granted approval only when the federal MLR is expected to meet the 80 percent minimum standard. Thus, for any of the plans discussed today should the MLR fall below that 80 percent over a three-year rolling period, affected policyholders may be eligible for rebates under federal law.

For 2026, Iowa's proposed weighted average ACA rate increase was 14.5 percent. That's below the national median of 18 percent, largely due to smaller increases from our largest carriers. I encourage all consumers to shop early during open enrollment and work with a licensed insurance agent or navigator to explore which ACA plans are best for their situation

and their affordability.

The Commissioner will review this rate increase proposal after conducting public input--considering public input from the hearing, along with the internal team's recommendation and the consultant's final report. Comments may continue to be received until the Commissioner makes the final decision on the proposed rate increase. Any additional comments received before the Commissioner's decision, but after the presentation of the consumer testimony, will be recorded on the public rate hearing site.

COMMISSIONER OMMEN: At this time, Ms. Sellmeyer, I have a couple of comments with regards to the first three plans that are being considered, so I would like to proceed with that.

Again, you're here on--many of you will be here to talk about your individual plan. That's certainly where you can best describe the impact these rates may have on you.

Obviously, in our state there are a number of plans that are Pre-ACA, or referred to as Pre-ACA, and five, as I mentioned, are under the ACA. Those plans that are Pre-ACA are oftentimes referred to as grandfathered plans or sometimes grandmothered plans.

They're transition plans that when the Affordable Care Act was originally signed, the President at that time authorized if you like your plan, you can keep it, but the reality is is with those plans, they are closed blocks, and what that means is new entrants can't participate in those pools. So those pools-- although they've been around for more than 10 years now, those pools, because they are closed, continue to age. That does put a lot of pressure on us as regulators, as well the companies, given the fact that new lives can't join that pool, and that pool is aging, and so that is going to drive some of those costs. So you may see some differences in the rate increases that are being proposed for those plans that are grandfathered.

If you would, please, again, identify which plan you're in so that we can recognize you for purposes of your comments as they relate to the plan that you, yourself, are experiencing.

Again, so those first three plans are the Golden Rule Insurance Pre-ACA plan, the Wellmark Pre-ACA plan, and the Wellmark Health Plan of Iowa Pre-ACA plan.

So with that, I'll turn it back to Ms. Sellmeyer.

MS. SELLMEYER: We'll start with Golden Rule, as stated on your agenda and, as the Commissioner said, a Pre-ACA policy block.

Golden Rule Insurance Company has proposed a 24.6 percent average premium increase for its first Pre-ACA block of business. The proposal affects all benefit plans, with no variations by the plan. Approximately 900 Iowa members are covered under this filing.

The filing was submitted to the Iowa Insurance Division on June 9th of this year, and assigned the same day to Lewis & Ellis for independent actuarial review. The proposed increase translates to an average monthly premium increase of $130, rising from $531 of this year to a projected $661 next year. This average encompasses all members, all benefit plans, age groups, and geographic regions.

The Commissioner will consider the public input, the internal team's analysis, and the Lewis & Ellis final report when reviewing this proposal.

Please note that pursuant to Iowa Insurance Division discussions with Golden Rule on July 23rd, we have tentatively agreed to a modification to a 19.9 percent increase rather than the 24.6, pending the Commissioner's review.

To give a little bit of background with regard to the actuarial basis for this, over the past seven years the average loss ratio for this block is nearly 84 percent. Over the past 12 months the average loss ratio is nearly 96 percent, which is worse than expected. Without a rate increase for 2026, IID, the Insurance Division, projects the loss ratio would rise to nearly 104 percent. With the proposed 19.9 percent increase, the Division projects the 2026 loss ratio will be approximately 87 percent.

The Division further estimates that the federal medical loss ratio will be just over 90 percent under the proposed increase. Lewis & Ellis' projection is similar, also exceeding 80 percent.

Both the Division and Lewis & Ellis have concluded that the proposed rate adjustment should continue to proceed--produce a federal medical loss ratio of at least 80 percent, as required for all ACA and Non-ACA filings.

As of August 17th, on Sunday, I had received only one public comment from a consumer. That comment is: "We are a healthy couple. We have been buying insurance from Golden Rule for 13 years. Our rates have gone from $682.94 a month in 2012 to

$1,865.77 in 2025. This is ridiculous. Please deny Golden Rule a base premium rate increase this year."

To summarize, the average premium increase is approximately $45 a month. This is an average based on all the members, all the benefit plans, all the geographic regions.

Comments received and posted by August 17th have been included in this testimony as required by Iowa Code.

Anyone from Golden Rule online that would like to make a statement?

(No response.)

MS. SELLMEYER: They told me they weren't going to so I just wanted to make sure.

I don't believe anyone in the room is Golden Rule.

Is there anyone on the phone or on the virtual feed that would like to make a comment with regard to Golden Rule?

MR. RULLESTAD: I do not believe so.

MS. SELLMEYER: All right. Is it okay if we go to the next one?

COMMISSIONER OMMEN: Yes. Let's go to the next one.

MS. SELLMEYER: Wellmark, Incorporated, is

the next Pre-ACA policy.

Wellmark, Inc., has proposed a 6.9 percent average premium increase for its Pre-ACA block of business. The proposal affects all benefit plans, with individual rate changes ranging from 3 percent to 10.6 percent. Approximately 20,700 Iowa members are covered under this filing.

The filing was submitted to the Division in June of this year and assigned the same day to Lewis & Ellis for independent actuarial review.

The proposed increase translates to an average monthly premium increase of $45 a month, rising from $654 to a projected $699 in 2026. This average encompasses all members, benefit plans, age groups, and geographical regions.

The Commissioner will consider public input, the internal team's analysis, and Lewis & Ellis' final report when reviewing this proposal.

Per the actuarial review, over the past seven years the average loss ratio for this block has been just over 82 percent. Without a rate increase for 2026, the Division projects the loss ratio would rise to just over 92 percent. With a proposed 6.9 percent increase, the Division projects the 2026 loss ratio will be approximately 88 percent.

The Division further estimates that the federal medical loss ratio will be just over 88 percent under the proposed increase. Lewis & Ellis' projection is similar, also exceeding 80 percent. Both the Division and Lewis & Ellis have concluded that the proposed rate adjustment should continue to produce a federal medical loss ratio of at least 80 percent as required by all ACA and Pre-ACA rate filings.

The Consumer Advocate has received six comments from policyholders and members of the public. I will read one of those into the record.

"Another big insurance rate increase of 10 percent. This is unsustainable. Something needs to change. Americans can't keep picking up the tab because of this. If I kept adding 10 percent increase to the fees that I charge clients in my business, I would be broke in two years."

In summary, the average premium increase is approximately $45 a month. This is an average based on all the members, regions, age groups, benefit plans.

The comments received and posted by August 17th of 2025 have been included in this testimony as required by Iowa Code.

I don't believe there's anyone from Wellmark on.

Anyone online that would like to make a comment on the Wellmark Pre-ACA policy?

MR. RULLESTAD: Not at this time.

MS. SELLMEYER: Okay.

COMMISSIONER OMMEN: Did you check if anyone in the room?

MS. SELLMEYER: Anyone in the room? I don't think anyone-- I think everyone in the room filled out for ACA policies. Correct?

COMMISSIONER OMMEN: Okay. Thank you.

MS. SELLMEYER: All right. This is the last Pre-- Sorry. Yes, it is. This is the last Pre-ACA policy.

Wellmark Health Plan of Iowa has proposed a 3.7 percent average premium increase for its Pre-ACA block of business. The proposal affects all benefit plans, with individual plan changes ranging from 3 to 10.6 percent. That's subject to the hearing.

Approximately 400 Iowa members are covered under this filing. With only 400 members remaining in force on this proposed block of business, it is becoming increasingly more difficult to predict future outcomes.

The filing was submitted to the Iowa Insurance Division on June 9, 2025, and assigned the same day to Lewis & Ellis for independent actuarial review.

The proposed increase translates to an average monthly premium increase of $15, increasing from $406 a month in 2025 to a projected $421. This average encompasses all members, benefit plans, age groups, and geographic regions.

The Commissioner will consider public input, the internal team's analysis, and Lewis & Ellis' final report when reviewing this proposal.

Over the past seven years the average loss ratio for this book of business is approaching 87 percent. Without the rate increase in 2026, the Division projects the loss ratio will rise to just under 82 percent. With the proposed 3.7 percent average increase, the Division projects the 2026 loss ratio will fall to just under 82 percent.

The Division further estimates that the federal MLR will be 82 percent under the proposed increase. Lewis & Ellis' projection is similar, also exceeding 80 percent. Both the Division and Lewis & Ellis have concluded that the proposed rate adjustment should continue to produce a federal

medical loss ratio of at least 80 percent as required for all ACA and Non-ACA filings.

I have had two consumer comments as of Sunday with regard to this block of business. I will read one of those. Actually, I will read part of one of them into the record.

"This proposed rate increase would bring our premiums even higher, pushing an unreasonable cost further out of reach. Just for perspective, I recently reviewed our records and found that over the past 16 years, we've paid over $100,000 in health insurance premiums. That's a staggering amount for a healthy couple with minimal medical needs. That money could have been invested toward our retirement, emergency savings, or future security. Many, many times, we have thought about canceling our policy, but the 'what if' compels us to keep the policy."

In summary, the average premium increase is approximately $15 a month.

Comments will continue to be received until the Commissioner makes a ruling, and all comments have been posted as of August 17th as required by Iowa law.

There's no one else from Wellmark online.

Anyone online that would like to make a

comment with regard to Wellmark's Pre-ACA plan?

MR. RULLESTAD: No.

MS. SELLMEYER: On the phone?

(No response.)

MS. SELLMEYER: Okay. All right. We will move on to Wellmark Health Plan of Iowa, the ACA policy.

And I know there are several of you here in the room, and I'll call your name once I get done with my comments. You can come up to the lectern to make a comment, and just state your name, before you speak, for the court reporter. She's got your names on here, but just so she knows who is who, that would be greatly appreciated.

Wellmark Health Plan of Iowa has proposed a 12.6 percent average premium increase for its ACA block of business. The proposal affects all benefit plans, with individual plan changes ranging from 5.3 percent to 17.6 percent. Approximately 83,000 Iowa members are covered under this filing, for nearly 63,000 members receiving increases exceeding the state's public hearing threshold of 5.6 percent.

The filing was submitted to the Division on June 9th, 2025, and assigned the same day to NovaRest Consulting for independent actuarial review.

The proposed increase translates to an average monthly premium increase of $73, rising from $577 in 2025 to a projected $650 in 2026. This average encompasses all the members, all benefit plans, age groups, and geographical regions.

Over the past 52 months the average loss ratio for this book of business is just over 78 percent. For the period of January through April of this year, the average loss ratio for the block is 83.5 percent, likely worse than expected for such an early snapshot in the year. During this time period, loss ratios will be suppressed due to deductibles still being satisfied. The loss ratios for this block are expected to increase at least 10 percent throughout the year as deductibles are satisfied.

Without a rate increase for 2026, the Division projects the loss ratio will rise to just under 99 percent. With the proposed 12.6 percent increase, the Division projects the 2026 loss ratio will be just under 88 percent.

The Division further estimates that the federal MLR will be just under 89 percent under the proposed increase. NovaRest's projection is similar, also exceeding 80 percent. Both the Division and NovaRest have concluded that their proposed rate

adjustment should continue to produce a federal medical loss ratio of at least 80 percent as required for all ACA and Non-ACA filing plans.

As of Sunday I had received 25 comments from consumers, and all those comments can be viewed online, in case you're interested. I will read one into the record tonight.

"I just received a letter regarding Wellmark's proposed 12.6 percent increase. This amount is well above the inflation rate. I do not believe this is right and should not be allowed. Healthcare should not be a luxury, which is what it is certainly becoming. Please do not let Wellmark have this outrageous increase."

Like I said, all the rest of the comments are on our website.

In summary, the average premium increase is going to be $73 a month for this block of business.

And comments will continue to be received until the final order is issued, and the current testimony has been included for the Commissioner and has been posted online as required by Iowa Code.

Okay. We'll take comments from those in the room first.

Maggie Valentine. Is that right?

Maggie Valentine?

MS. VALENTINE: That's right.

MS. SELLMEYER: Okay.

MS. VALENTINE: Well, recently I've come to understand that this proposed base rate increase of 12 percent in my case, but up to 18 percent for some Wellmark Blue Cross Blue Shield policyholders has been shown by state employees and third-party actuaries to be necessary for Wellmark to do business viably and to be able to continue to provide health insurance.

However, with just a little research, according to Wellmark's 2023 financial statement containing 137 pages and published on the Iowa Insurance Division's website, only 84.8 percent of the money collected from policyholders went to paying claims. 8.8 percent went to administrative costs, including the $845,000 per-year salary for the CEO, who is being paid by policyholders without their approval, and 1.2 percent in taxes and fees. That leaves 5.2 percent in earnings from premiums. That's my math, anyway. And I'm wondering where exactly that 5.2 percent is going.

It's my understanding that Wellmark is a mutual insurance company, meaning that it's

theoretically owned by its policyholders. So at a bare minimum, shouldn't that 5.2 percent either be returned to policyholders or used to pay claims and applied to this discussion? How could Wellmark possibly need to increase premiums if they have 5.2 percent in earnings from premiums?

And I can only assume that the state has analyzed this report or a similar report for 2024 if it's been available, and that any actuary employed to address a base rate increase would have analyzed it as well.

There are numerous valid arguments as to why policyholders should not be asked to absorb such dramatic rate increases, but these numbers alone call into question the honesty and integrity of this process, in my opinion.

I'm also extremely frustrated by the knowledge that the negotiating has already taken place and increases have likely been agreed upon. It feels like this hearing is therefore nothing more than a formality to placate anybody who does want to make a public statement against the rate increases and give them false hope that their statements will be taken into account. Hopefully, I'm misunderstanding that, but that's my understanding.

At the very least, we deserve for our arguments to be heard before any negotiating takes place and certainly before any increases are agreed upon, and I'm simply asking that the Iowa Insurance Commissioner's office put the needs of Iowans above the profit of insurance companies and to please protect us and represent our best interests now and in the future.

Needless to say, I'm against the proposed rate increases and request further negotiations take place to please lower or hopefully reject any increases at this time.

COMMISSIONER OMMEN: I'll answer one of your questions, that is, in terms of your comment with regards to negotiation.

There was reference to one negotiation, and that has to do with the actuaries for the company are negotiating with the actuaries from my office to try to come to an agreement as to what actuarially is justified, but ultimately I make the decision, and my decision is based upon the information that's contained in the file I have not yet reviewed. I've reviewed some of the redacted actuarial provisions-- or reports. But these comments tonight really do matter a great deal, so thank you for being here.

And I'm going to wait to answer some of your other questions after other comments have been received.

MS. SELLMEYER: Matt Durr.

MR. DURR: Well, I guess I don't have much to say. I guess I had a letter in the mail that I'm on an ACA plan from Wellmark Health Plan of Iowa, and the 12.6 percent increase will raise my rate to over $500 a month. I currently pay $456.92 a month.

I haven't been to the doctor in four years, and in four years I had one emergency visit, and they paid $270 of the total bill, so literally paid nothing of a $900 bill, and I had to cover the rest. And I pay, you know, $450 a month for that.

In 2019 my healthcare was like just under $400, and now it's going to be up to $515. That is just astronomical for a person that doesn't go to the--make many visits. I don't know why it would be my healthcare increasing when I don't even go, you know, make any visits. I think that should be--they should see that and say, you know, that that should be something that they take into account for, and it's ridiculous that it has to go up that much for me.

Like I said, I just don't use my plan, and

it's going to be coming to the point that I'm going to have to cancel because, you know, if it gets over $500 a month, that's a lot of money every month, you know. I could have a really nice car, which I don't have; and, you know, that would be real nice.

So that's about all I have to say, so...

MS. SELLMEYER: Chris LoRang.

DR. CHRIS LoRANG: Hi there, everyone.

My name is Dr. Chris LoRang, and I am a Des Moines resident here. Thanks for having me, and thanks for listening to these stories.

My wife and I are both entrepreneurs. We are small business owners, and we provide a small group policy for our team members that need to participate in that and want to participate in that.

And just this last year my wife and I went from our own small group policy replacement to our-- to an ACA policy, and both the group policy and the ACA policy that we're on are technically Post-ACA policies.

I want to step back from the argument of rate increases, even though this ties directly into it. This is an American problem that we're discussing at this level, this minutia. Nations around the globe are struggling. Their healthcare

systems are struggling, but none are failing as much as the American healthcare system, and at the moment what these rate increases seem to imply to many of us is that it's always a losing argument when you're trying to take care of yourself in this healthcare system.

The rates of cost of goods, cost of employers--employees, pardon me, are going up across the country, especially here in Iowa. Iowa--there's a recent report that ranks Iowa as one of the worst economies in the nation. And that doesn't bode well for small business owners. That doesn't bode well for individual policyholders when they see only greater increases coming forward.

Small businesses are the heartbeat of America. We've known that for generations. They are what drive the economy, and at the moment they're being pushed to the brink, and these policy increases--or these rate increases don't necessarily look good for the long-term health of small businesses.

We see a rise in the utilization of high deductible health plans where the gentleman just before me referenced that he doesn't go to the doctor. When he did have to go, he had to shoulder

most of the cost of that care.

That's true for me. That's true for my family members. That's true for my employees, that they may think twice about going to seek care because of the cost that they're going to incur for that, even after having paid for the premiums.

I think many of the statements that you've made today reference this idea that these policies are struggling because they have decreased enrollment or a projected decrease in enrollment, and I want to challenge that argument that if we rethink this whole idea, we can have one big 300 million policyholder policy, and that's an argument for a healthcare system, or something like that, where examples around the globe, systems that operate much more efficiently than we do. We have systems that operate with much better outcomes.

Lastly, my final comment as a provider in this healthcare system, as a provider for Wellmark, my reimbursement rates actually went down in July 2025. So my premium dollars are increasing. My reimbursement rates for the patients I'm seeing on Wellmark are decreasing. And it doesn't seem to make a whole lot of sense to me. And in fact I think it provides a lot of us with what it looks like going

forward in 2026, and I think we're seeing that on all sides of the medical spectrum with such discontent for our healthcare system.

Lastly, I want to comment that Wellmark Health Plan of Iowa has a known practice of restricting chiropractic providers in the network for the HMO-POS networks. That affects my office directly. I am a provider for the HMO-POS networks. My own colleague in my office, my other chiropractic provider, they will not let him into the network. That becomes especially important when next month I go on a vacation. I'll be gone for about three weeks. That's the longest I've been away from my clinic for 12 years. And even though my other provider, Dr. Hartley, is in the Wellmark PPO network, contractually he cannot provide coverage for my patients that are in the HMO network. It's an absurdity, but it's part of the system. We follow the rules for compliance purposes.

But I would like to challenge this rate increase because I don't perceive Wellmark as improving the healthcare outcomes of Iowans. I don't see a rate increase as being tied to dramatic changes in how I'm providing care. In fact, it's a continuation of practices that limit the access of

patients to evidence-based pain management providers around the state.

And I think that in the end, I want to circle back to the idea that this is an American problem. We can solve bigger problems if we all come together with the idea that the healthcare of all of us matters, and if we continue down a path where we have rising rates of chronic disease, we're only going to see devastation of the healthcare system.

This rate increase is a small portion of that, but exemplary of a bigger picture, a bigger problem that we're all experiencing, and we're also very expressing with you about.

So I would encourage you perhaps to consider rejecting all rate hike--rate price increases for the sake of Iowans, because that's who you are here to represent, Iowans that are struggling more now than ever with the struggling Iowa economy, with the struggling U.S. economy, and with a struggling healthcare system that is not necessarily providing any better care through these rate increases.

Thank you.

MS. SELLMEYER: Brian Cain.

MR. CAIN: I have a question, unfortunately, before I start my question--or comment.

Does anyone here know-- We pay in medical. Of that medical, part of it is administration, part of it is pharmacy, part of it is testing, and part of it is hospitalization. Does anyone know the percentage breakdown?

COMMISSIONER OMMEN: Yeah. We measure--when we do a review, we measure what's called medical loss ratio, and so we actually do look at the amounts of money, and we evaluate it on an individual pool basis.

So to the doctor's point earlier about in the State of Iowa, we have about three million people. Nearly 50 percent of the people in our state are in self-funded plans, which means they're not in the business of insurance. They're in basically work-provided non-insurance, self-funded plans that are regulated by the--by ERISA with the Department of Labor. My authority is limited to essentially the insurance pieces of our market.

Ms. Sellmeyer mentioned this particular plan--I think it was Wellmark--with 83,000 Iowans, and that 83,000, we look at that pool, and we do look at their historical experience based on that pool of individuals that are in that individual pool of the market, and we look at both the expenses that are

paid out in the form of claims through--to individuals like Dr. LoRang, who spoke earlier, as well as others, and then we look at, as was mentioned earlier, the amount that does go to expenses, that goes to administration, that goes to the operations with regards to Wellmark.

Does that answer your question?

MR. CAIN: No. I just want to know out of every hundred dollars, 23 is drugs, 14 percent is doctors, 18 percent is testing, you know, 20 percent is administration. I just want a simple percentage breakdown.

COMMISSIONER OMMEN: Some of that, for the amount--the areas we do regulate, we do have access to look at how those funds are actually expended out of the claims.

Now, again, it's not dollar for dollar because I could be perfectly healthy and not have any expenses, and I still pay the hundred dollars. It may be distributed to Sonya.

But, yes, we can look over the population of that 83,000 and have the information available to us as to how that money is expended.

MR. CAIN: I think that answers the question.

Okay. I think that I can make my comment here.

Basically, we have too many small pools, and we have too many administration costs. We have little group, little group, little group, and they're not going into one big pool.

Workers are a big pool. All the other people are a small pool, and so our problem is we need to basically just get to one plan.

But if I'm actually listening to all of this correctly, we have roughly, what, 1.5 million workers in the state, and most of them are full-time workers, and if the workers just pay about 3 dollars an hour for health, that covers our entire health for the state: Dentists, glasses, hearing, babies, hospitals, everything. There's so much money in just three hours of work.

Now, people that don't work, we have to figure out how to make them pay, but making the state one big health plan is a lot cheaper, not having these individual plans, not having to work yourself. You just take workers times the hours worked and the dollar amount per hour, and everything's covered. No forms, no deductibles, no co-pays, nothing. Just go to the doctor.

The second thing, we know there are a lot of costs that are starting to get in for pharmacy management firms, the middlemen, to keep track of all the drugs, and we've noticed that the same drug on one plan to another plan is significantly different, but when you make the drug you have an operating cost. The drug manufacturer makes it. The other company does the research and develops it. That's already a fixed cost. So how can one have such a different cost than the other one?

So if we have all these plans tied together, we could have one price for all of our drugs, and it would be the same for everybody.

So what I want to know is for drugs, to give you an example, why can't we just make our own distribution center for drugs in the center of the state, make that drug and ship it out to the hospitals? Every hospital has drugs. They have to. They've got patients. So they've got a pharmacy. Why don't they have everything and just get rid of all the middlemen?

And as for these insurances, you can't have administration costs with 500 people, 900 people. You need, what, about 250,000 people in the plan to be big enough in bulk to get there.

I mean we only need one plan. If these other people on these other plans only have 60-, 80-thousand people, we all have to combine together in one plan.

So I want to know if my math is correct. I'll tell everyone here what I did. I just took 1.5 million workers at 2,000 hours at 3.5--or 3.8 dollars apiece, and that gave us enough money to cover--let's see. Our state is around 200- to 225-thousand revenue. About 10 percent is health cost, about 25,000--or 25 billion. Why can't we make our own thing?

And the reason I ask that is we have two funds: The state fund, General Fund, has 2.9 billion in it, and we have a backup fund of 900 billion that the politicians talked about this year. Why can't we use that for a seed fund and just make our own health insurance for the state? Just get rid of all of them.

Anyway, we can't have five plans. We can't have five administration costs. Our pool is too small. Our drugs are too stretched out. We need more bulk together. So one plan, put us with the workers. But you can't have five plans.

Okay. That's it.

MS. SELLMEYER: Thank you.

Mr. Darr.

Are you ready?

COMMISSIONER OMMEN: Sure.

MR. DARR: Hello. My name is Terry Lee Darr. I've been at Wellmark for several years, and it is the ACA plan.

I went to Wellmark. I've got a $5,000 deductible, which that kind of lowered the premiums. But let's see. The premiums were--shot up to $35.03 a month, which is $420.36 for the year 2024. For 2025 it shot up to 96--or to $97.30, or $1,167.60.

I kind of asked my health insurance primary what was going on here. She was telling me something, which I said that's just going against what I think because Wellmark had less claims. Then if you want to call it the government healthcare or Obama plan, whatever, that credits the health insurance companies so much, and if they don't use that up in claims, then it's almost like they're penalized for the next year. They're not going to fund you as much. So there's some truth there. I don't know if you have answers here.

COMMISSIONER OMMEN: Well, yeah, the tax subsidy structure, it can actually depend upon who

else is in the market. So I don't know the specifics of your plan, but you're receiving those tax credits as a way to reduce your experience under the plan. So that is not a policy that I review. I don't review those subsidy structures. That's all set by federal law.

But anyway, it can just depend upon the relative rates between the insurance companies, if that makes any sense, because it's actually set by the second lowest silver plan.

So, anyway, I'm sorry. It's pretty complicated. Certainly I understand why you would want to talk to an insurance specialist to help you navigate through that. I have no regulatory authority over that. That has been set by federal statute.

MR. DARR: One other thing. More people, but, yeah, that huge increase for 2025, I found out just a few months later at income tax time, my tax preparer said, well, here's some of the problem, is my financial adviser changed things up a little bit so I could get a higher income than what I put down at the start of the new year.

COMMISSIONER OMMEN: So your health status doesn't--no longer affects your rate experience.

Under the Affordable Care Act it's actually set based on level of income, so you're sort of left with instead of managing your risk, you're managing your financial experience.

And, again, I know there are all sorts of opinions as to how that is to work.

To the point earlier of the gentleman that spoke with regards to his health experience, that is not--there's no differentiation allowed based upon that, so it is dependent upon your financial adviser and your tax adviser to figure out what your experience will be if you're within that range of individuals who received advanced premium tax credits. And I don't mean to explain that to you tonight. It's far too complicated for us to do it in this opening hearing. But, again, I'm trying to address your comment.

MR. DARR: I guess that's about it. I'll turn it over to somebody else.

COMMISSIONER OMMEN: Thank you, sir, for being here.

MS. SELLMEYER: Do we have anyone online that would like to comment?

MR. RULLESTAD: No.

MS. SELLMEYER: Okay. I will move on to

UnitedHealthcare of the River Valley has proposed an 18.82 percent average premium increase for its ACA block of business. The proposal affects all benefit plans, with individual plan changes ranging from an increase of 16.32 percent to an increase of 21.38 percent. Approximately 600 Iowa members are covered under this filing, with all 600 members receiving increases exceeding the state's public hearing threshold of 5.6 percent.

The filing was submitted to the Division on June 9th of 2025, and assigned to NovaRest Consulting for an independent actuarial review.

The entire rate filing was refiled on 8/8 of 2025 to remove potential impacts of prescription tariffs.

The proposed increase translates to an average monthly premium increase of $121, rising from $640 in 2025 to a projected $761 in 2026. This average encompasses all its members, benefit plans, age groups, and geographic regions.

UnitedHealthcare Plan of the River Valley is new to the Iowa market in 2025 and only has six months of reportable experience. For the period January through June of 2025, the average loss ratio for this block is nearly 77 percent, likely worse

than expected for such an early snapshot. During this time period, loss ratios will be suppressed due to deductibles still being satisfied. The loss ratio is expected to increase around 10 percent throughout the year as deductibles are satisfied.

Without a rate increase for 2026, the Division projects the loss ratio would rise to nearly 93 percent. With the proposed 18.82 increase, the Division projects the 2026 loss ratio will fall short, to just over 78 percent.

The Division further estimates that the federal medical loss ratio will be just under 81 percent under the proposed increase. NovaRest's projection is similar, also exceeding the 80 percent. Both the Division and NovaRest have concluded that the proposed rate adjustment should continue to produce a federal medical loss ratio of at least 80 percent as required under the ACA and Non-ACA rate filings.

I have received one comment from an Iowa policyholder, and I will read a portion of that.

"As someone with limited means, paying over $875 a month for health insurance is already an immense strain, especially now, with the added expenses and responsibilities of caring for my

newborn baby girl. Additional rate hikes, particularly in the current economic climate, risk making essential healthcare unaffordable and could lead to lapses in coverage for individuals like myself who rely on stable premiums to budget for necessary medical expenses. Maintaining the current rate will help ensure continued access to care without creating undue hardship."

In summary, the average premium increase is $121 a month.

And the comments received by August 17th have been posted and have been given to the Commissioner, and we will continue to take comments until the final decision is rendered per Iowa Code.

I don't believe there's anyone in the room that wanted to comment on UnitedHealthcare of the River Valley.

Is there anyone online?

(No response.)

MS. SELLMEYER: And I know the company is not available.

Okay. I will move on to Oscar.

Oscar Insurance Company has a proposed increase of 12.47 percent as an average for its ACA block of business. The proposal affects all benefit

plans, with individual plan changes ranging from an increase of 3.95 percent to an increase of 37 percent. Approximately 26,500 Iowa members are covered under this filing, with over 22,500 members receiving increases exceeding the limit of 5.6 percent.

The filing was submitted to the Iowa Insurance Division on June 9th, 2025, and assigned the same day to NovaRest Consulting for independent actuarial review.

The entire rate filing was refiled on 7/23 of this year.

The proposed increase translates to an average monthly premium increase of $64, rising from $516 in 2025 to a projected $580 in 2026. This average encompasses all its members, benefit plans, age groups, and geographical regions.

The Commissioner will consider public input, the internal team's analysis, and NovaRest's final report when reviewing this proposal.

Over the past 17 months the average loss ratio for this block has averaged 72 percent. Due to this favorable performance since Oscar's entry into the Iowa market in 2021, the company implemented three prior rate reductions: 9.14 percent decrease was effective January 1 of '22; 1.5 percent decrease

on January 1 of '24; and a 5 percent decrease effective January 1 of 2025.

However, for the period January through June of this year, the average loss ratio for the block is 81 percent, likely worse than expected for such an early snapshot. During the period, loss ratios will be suppressed due to deductibles still being satisfied. The loss ratios for this block are expected to increase at least 10 percent throughout the year as deductibles are satisfied. Without a rate increase for 2026, the Division projects the loss ratio would rise to just over 90 percent. With the proposed 12.47 percent increase, the Division projects the 2026 loss ratio will remain just under 81 percent.

The Division further estimates that the federal medical loss ratio will be just over 84 percent under the proposed increase. NovaRest's projection is similar, also exceeding 80 percent. Both the Division and NovaRest have concluded that the proposed rate adjustment should continue to produce a federal medical loss ratio of at least 80 percent as required for all ACA and Non-ACA rate filings.

The Commissioner will review this rate

increase proposal after considering all the public input from this hearing and the public comments made prior, along with the internal team's recommendation under the--and the consultant's final report.

As of Sunday I have received two comments from policyholders, and I will read one.

"I got the letter from Oscar Insurance Company about the increase. I do not approve of the increase, so thank you."

The average premium increase is approximately $64 a month. This is the average based on all its members, age groups, benefit plans, and regions.

The comments received and posted by August 17th have been included in the testimony report as required by the Iowa Code.

I believe we have two people in the room that would like to make a statement.

Evelyn--is it Teah?

MS. TEAH: Teah.

MS. SELLMEYER: Teah.

MS. TEAH: Hello, everyone.

My name is Evelyn Teah.

I'm not a policyholder to Oscar Insurance, but I feel that they used me, and I've been wanting

to talk to somebody about it, and I don't know where to go. But this time they sent me two different letters for this conference, so I feel that I should come here to express what they did to me and to seek help.

Okay. 2024--yeah, 2024, beginning, I saw a letter in my son's mailbox from Oscar with six insurance cards to me that I'm preapproved, so I call them. I asked for them to explain about the letter they wrote me, and they explained it, so at which time he said Obama was giving subsidy back, so they took all my information, and they said they were going to get back to me.

I waited. Nobody got back to me. Nobody sent me a letter, no insurance card. I never attended no clinic. I don't know my provider. And when I call, they always refer me to my agent, and my agent never take my call up to this time.

So I don't know at what point in December they wrote me with a letter inside that required a 1095. It was a 1095 income tax. I should fill it out for tax return.

So I said I'm not going to do it because they took my information. They didn't give me an insurance card. They didn't give me anything. They

didn't give me a subsidy back, and when I called my agent, my agent never take my call or say anything to me.

So the whole year they say I am the policyholder. How do--who paid insurance on me, because that insurance got paid every month, so how is everything paid for me every month for a whole year up until December that they are sending this 1095 to me? So it just confused me.

So I came here to tell you that Oscar--they used me. They used me for a whole year, and they sent me a letter that I should renew. I did not renew. So at which point that they feel that I'm still a policyholder? Why? Why are they treating me like this?

I went to Medicare. I applied for Medicaid, and I'd only been on Medicaid for six months. So after I got a job, I called them and they took the Medicaid away.

So I went to the Medicare office, and they give me something. I don't know. A 1095. I carried it to the United Way and did my taxes to go to the Medicaid office.

But still Oscar is still writing me letters like I'm the policyholder. I'm not the policyholder.

I need someone to help me to get them off my back. Yes, I'm not a policyholder. They used me. They used my information. That's why I want to be here.

MS. SELLMEYER: We can discuss this after the hearing. I'll be happy to discuss it with you.

MS. TEAH: Okay. Thank you.

MS. SELLMEYER: Uh-huh.

Jill Gearhart.

MS. GEARHART: Hello. My name is indeed Jill Gearhart.

Like this lady was expressing, I also have Oscar Insurance. In May of 2024 I requested a quote off of Marketplace, a quote. They indeed took my information, my Social Security number, my date of birth, my maiden name, everything. They signed me up for a policy without my knowledge.

I was not aware of this until it was brought to my attention by my tax preparer saying that I had my work insurance and Oscar insurance. Like this lady, I did not receive a policy, a signed contract, an insurance card, any information about doctors within the network, any information.

So I did call Oscar. All of this, all of this (indicating).

I filed a complaint with Oscar, a

Marketplace appeal request. I appealed my insurance through Marketplace. Every time I called Marketplace, they said deal with Oscar. Every time I called Oscar, they said deal with Marketplace.

I have proven to them through my own insurance that all of my medical--medical was not sent to Oscar for claims. It was sent through my work insurance. This has been proven and documented, and Oscar flat-out told me it didn't matter that I had documentation saying that these claims were submitted through a different insurance, Oscar had claims, and they were not going to cancel my insurance for not only this year, which they refused to let me cancel, but also to send me a letter saying that I was not registered for insurance for 2024, that I have not filed my taxes for because I am not going to sign taxes for somebody for an insurance that I did not sign up for.

I'm also seeking legal--legal issues because not only did they violate HIPAA by pulling my doctors' visits and medical records off of the website from the doctors' offices, they also used my Social Security number fraudulently. They know the name of the person, the insurance agent, that used the information.

I was told by the first representative that there were several people that this happened to. So if Oscar is covering 25,000 Iowans and they're claiming 80 percent losses on claims that, one, were not filled out because all of them on Oscar in here you will see that they paid out zero, because I was outside of network, so none of my claims were paid, but yet they had the audacity to sign me up for a tax credit and take my tax whatever--my tax refund to pay the premiums that I did not pay for an insurance that I did not register for. And now I look forward to higher premiums for them taking another year of my taxes because I'm not paying them either.

So Oscar should be eliminated from the list.

MS. SELLMEYER: If you want to stick around, we can talk.

MS. GEARHART: Yes. Thank you.

COMMISSIONER OMMEN: Thank you for being here, and please stay around.

MS. GEARHART: Oh, I will.

COMMISSIONER OMMEN: Thank you.

MS. SELLMEYER: Anyone online that would like to make a comment regarding Oscar?

MR. RULLESTAD: No.

MS. SELLMEYER: Thank you.

Okay. Iowa Total Care.

Iowa Total Care has proposed a 26.92 percent average premium increase for its ACA block of business. The proposal affects all benefit plans, with individual plan changes ranging from 24.54 percent to 34.95 percent. Approximately 7,000 Iowa members are covered under this filing, with all members receiving increases exceeding the state's public hearing threshold of 5.6 percent.

The filing was submitted by the--to the Iowa Insurance Division on June 9th of 2025 and assigned the same day to NovaRest Consulting for independent actuarial review.

The entire filing rate was refiled on June 28th of 2025.

The proposed rate increase translates to an average monthly premium increase of $140, rising from $522 a month in 2025 to a projected $662 in 2026. This average encompasses all members, benefit plans, age groups, and geographical regions.

The Commissioner will consider public input, the internal team's analysis, and NovaRest's final report.

Iowa Total Care is new to the Iowa market in 2025 and only has six months of reportable

experience. For the period January through June of '25, the average loss ratio for the block is 83.4 percent, likely worse than expected for such an early snapshot. During this time loss ratios will be suppressed due to deductibles still being satisfied. The loss ratios for this block are expected to increase at least 10 percent throughout the year as deductibles are satisfied. Without a rate increase for 2026, the Division projects the loss ratio would rise to nearly 102 percent. With the projected 26.92 percent increase, the Division projects the 2026 loss ratio will fall to 80 percent.

The Division further estimates that the federal medical loss ratio will be 82.3 percent under the proposed increase. NovaRest's projection is similar, also exceeding 80 percent. Both the Division and NovaRest have concluded that the rate adjustment should continue to produce a federal medical loss ratio of at least 80 percent as required for all ACA and Non-ACA rate filings.

As of Sunday, the Consumer Advocate has received one--actually, as of this morning I received one comment from consumers, and I do not have that since that was after my trial notebook here, my hearing notebook, was put together, but I will make

sure the Commissioner gets that, and it might be posted online.

The average premium increase is approximately $140 a month. This is an average based upon all members, age groups, benefit plans.

And the comments received and posted by August 17th have been included in this testimony report as required by the Iowa Code.

I don't believe we have anyone in the room for Iowa Total Care. Is that correct?

(No response.)

MS. SELLMEYER: Anyone online for Iowa Total Care?

MR. RULLESTAD: There is not.

MS. SELLMEYER: We'll go to Medica.

Medica Insurance Company has proposed a 26.76 percent average premium increase for its ACA block of business. The proposal affects all benefit plans, with individual plan changes ranging from 8.74 percent to 47.73 percent. Approximately 10,000 Iowa members are covered under this filing, with all members receiving increases exceeding the state's public hearing threshold of 5.6 percent.

The filing was submitted to the Division on June 6 and assigned the same day to NovaRest for

independent actuarial review.

The proposed increase translates to an average monthly premium increase of $157, rising from $586 in 2025 to a projected $743 in 2026. The average encompasses all members, benefit plans, age groups, and geographical regions.

The Commissioner will consider the public input from the comments already received and today, and the internal team's analysis and NovaRest's final report.

Over the last 29 months, the average loss ratio for this block is 80 percent. The loss ratio for this block for the first five months of 2025 is over a hundred percent, significantly exceeding normal expectations.

Without a rate increase for 2026, the Division projects the loss ratio would rise to nearly 105 percent. Without the proposed--with the proposed 26.7 percent increase, the Division projects the 2026 loss ratio will be nearly 83 percent.

The Division further estimates that the federal medical loss ratio will be just below 85 percent under the proposed increase. NovaRest's projection is similar, also exceeding 80 percent. Both the Division and NovaRest have concluded that

the proposed rate adjustment should continue to produce a federal medical loss ratio of at least 80 percent as required under all ACA and Non-ACA requirements.

The Commissioner will review this increased rate proposal after considering public input from this hearing, along with the internal team's recommendation and the consultant's final report.

I received five comments from policyholders. I will read one.

"I am a medical insurance consumer living in Ankeny, Iowa. Like many, my health, and the health of my household, is covered by an insurance policy from Medica that was obtained from Healthcare.gov. The plan has a high deductible, and is barely affordable, but it is the best I could manage. I rely on this coverage for my healthcare needs. Recently I received a notice from Medica informing me of a proposed rate increase of 26.8 percent to take effect January 1 of '26. I am writing to urge you in the strongest terms to reject this proposal."

In summary, the premium increase is approximately $157 a month. This is an average.

And the comments received and posted by August 17th have been included in this testimony

report as required under the Iowa Code.

And Medica is in attendance today.

Do you guys want to come up? State your names, and you can provide your comments.

Thank you.

MR. SCHAFER: Thank you for the opportunity to comment.

For the record, my name is Matt Schafer. I am the senior director of government relations for Medica.

I'm here to introduce my colleague, Carolyn Ringhofer, who serves as our vice president and general manager of individual markets.

Before I turn it over, I wanted to emphasize that we do not make this decision about our proposed 2026 rates lightly.

I would like to speak to one of the contributing factors to the rate increase, which has been alluded to a couple of times this evening.

Since 2021 the federal government has provided enhanced premium tax credit assistance for individuals and families in this market. A number of those subsidies will expire at the end of the year. This could result in Iowans paying double or triple their current effective premium when you factor in

the reduction in subsidies.

We believe as many as 30,000 Iowans may forgo their health coverage as a result. Many of those individuals who will forgo that care are in better health, and that dynamic will result in care being--becoming more costly for those who remain in the market.

I'll now turn it over to Ms. Ringhofer, and appreciate the opportunity to comment.

MS. RINGHOFER: Thank you for the opportunity to participate and testify today.

My name is Carolyn Ringhofer, and I am the vice president and general manager of the individual and family business at Medica.

As Mr. Schafer mentioned, our decision about our 2026 rates was not taken lightly. I've read the public comments and, understanding the impact, regret the necessary action.

Factors driving our rate increase have been discussed: Increases in medical utilization, increases in costs of those services, particularly prescription drugs, as well as the anticipated consequences of the end of the enhanced tax subsidies.

Medica has proudly served the Iowa market

for nine years, including in 2018 when we were the only carrier in the Marketplace.

Again, I thank you for the opportunity to be here and hear comments.

COMMISSIONER OMMEN: I want to thank you for being here, and for your courage to be the only carrier to appear, Thank you for that. So I'm reluctant to even ask you a question in the event you're not prepared.

And as I mentioned earlier, I mean I take this information that I hear tonight, but I also sit down with my actuaries and individuals, and we go through this in great detail.

I am curious about the first half of this year and what you report as essentially having a loss ratio of over a hundred percent in the first five months. Any suggestion you wish to publicly make about the reason for that? That is not a trend that is only being seen--experienced by Medica. Any-- If you're not prepared to answer it, I can ask you at a later time, but I'm curious tonight in front of these people if you have any explanation that you're prepared to provide.

MS. RINGHOFER: Certainly we would welcome the opportunity to respond in writing in a little bit

more detail, but like I said, the increases that we're seeing, not only in utilization just being significantly higher than we have seen in the past several years, but also the cost of those services, particularly prescription drugs, and then, of course, the risk pool changes that we are anticipating based on the end of the subsidies.

COMMISSIONER OMMEN: And I understand about that. That's looking forward.

MS. RINGHOFER: Sure.

COMMISSIONER OMMEN: I mean frankly what I'm actually really interested in is what you've already seen, because those subsidies are in place today, and these loss ratios that you're describing here, I mean, again, for the benefit of those in attendance, could you just explain the hundred percent loss ratio? What does that mean for your company, because there were questions earlier about administrative costs.

Again, I am so sorry you're the only one here to provide education, but part of the benefit of this hearing is actually to help people understand like what's going on.

MS. RINGHOFER: Sure, sure.

COMMISSIONER OMMEN: So can you describe a

little more about medical loss ratios and your experience?

MS. RINGHOFER: Sure. I mean the gentleman earlier talked about the different pieces of the rate, including administrative costs and including the medical expense costs, and as we measure medical expense ratio--or medical loss ratio, you know, the requirement is that we hit 80 percent, so that 20 percent of the additional dollar, 20 cents on the dollar, can be used for administrative costs and, you know, improving our systems, and those kinds of things. And we are at a point where we are literally using every dollar we take in to pay medical expenses, so we're not covering our overhead at this point.

COMMISSIONER OMMEN: Well, that's why with 105, you're actually paying out $105 for every hundred dollars that you're collecting.

MS. RINGHOFER: Uh-huh, uh-huh.

COMMISSIONER OMMEN: So I think, again, it's just--again, I deal with this, these numbers all the time. Most people do not. And so, again, I just think this is--last year was a challenge, but nothing like this year. I mean I think there's something certainly going on that's concerning to all of us.

MS. RINGHOFER: And we've seen increases in inpatient. Again, the drug costs, particularly GLP-1, which we cover for diabetes and heart conditions, those are incredibly expensive and very popular. The behavioral health expenses, I think, you know, after COVID, we've seen those numbers continue to rise. And, you know, the good news is people are getting help that they need, but the bad news is that that adds to the medical costs.

COMMISSIONER OMMEN: Yeah. And, again, I would just share here for the audience, I mean these are the individual--this is the individual market. I know there's been discussion about even a bigger group. I mean the frank reality is is that these trends we're seeing across all of the market, and it has to do with utilization and expense, understanding your concern over changes in terms of the subsidy.

Thank you, again, very much for being here tonight.

MS. RINGHOFER: Thank you, Commissioner.

MR. SCHAFER: Thank you.

MR. CAIN: Maybe you can answer a question. How much of those dollars are you committing to drugs?

MS. RINGHOFER: I don't have an answer for

that. I'm sorry.

COMMISSIONER OMMEN: Drug costs are a significant concern. Thank you, sir.

Anything further?

MS. SELLMEYER: Is there anybody online that would like to make comments?

MR. RULLESTAD: If you would invite Jacquie to unmute on her end because I have to click a button and then she has to click a button.

MS. SELLMEYER: Jacquie, do you want to unmute on your end so you can make a comment?

MS. HOLM-SMITH: Can you hear me?

MS. SELLMEYER: Yeah, yeah.

MS. HOLM-SMITH: Okay. Great. Thanks, everyone.

My name is Jacquie Holm-Smith. I'm from Ankeny, Iowa.

I've been an Oscar plan customer for two years now. I do not qualify for any of the subsidies. I paid probably one of the highest rates for the premiums.

I am opposed to these rates going up, not that--I can certainly afford it, but the point is that I know there are a lot of people who can't, and I mean health insurance shouldn't be more than a car

payment.

I'm really sorry to hear about those people in the room who had an unfortunate experience with Oscar, you know, legally, et cetera. But my experience with Oscar itself as a carrier has been great. I'm just concerned by what healthcare is doing to our fellow Americans and shouldn't be--the choice shouldn't be either, you know, go poor paying premiums or risk, you know, medical bankruptcy.

So I just want to go on record as saying please try to keep it to a minimum. I understand costs go up, but it's really an unfortunate situation that we're in.

So thank you.

MS. SELLMEYER: Thank you, Jacquie.

MS. HOLM-SMITH: Oh, by the way, I did submit public comments, and I don't know--I think I missed your deadline. I'm hoping that you can still include those for the record.

MS. SELLMEYER: Yes, I do have them. Thank you.

MS. SMITH-HOLM: Thanks.

MR. RULLESTAD: If you want to invite Carter to unmute.

MS. SELLMEYER: Carter, would you like to

speak?

MR. KNIGHT: Hello.

MS. SELLMEYER: Thanks, Carter.

MR. KNIGHT: Hi. Can you hear me?

MS. SELLMEYER: Yes.

MR. KNIGHT: Okay. Hello. My name is Carter Knight. I am an actuary for Oscar. I have been working on the Iowa market for the past four years now.

The one comment I have is I will personally look into the transcript of those members that were claiming there's some fraudulent enrollments and see that those are investigated into. Otherwise, I have no further comments on our filing.

COMMISSIONER OMMEN: Thank you, Carter, for being here.

MS. SELLMEYER: Okay. Any other comments from policyholders either online or in the room?

(No response.)

MS. SELLMEYER: We have one non-policyholder, Xavier, that would like to make a brief comment.

MR. CARRIGAN: I do appreciate your time and allowing me to speak because--and I should say my name is Xavier Carrigan.

I don't come here today as what it is that I

do, and in full disclosure, I am running for U.S. House. That is not why I am here. The reason why I'm here--and I wrote this down. If you don't mind, I'm just going to read it as quickly as I can.

I'm here today as a citizen who has been forced to navigate the ACA Marketplace when I had no other insurance options. I know what it's like to lose your insurance and be thrown into a system where every choice is a bad choice or a difficult choice. When you're uninsured and dealing with a chronic condition, the Marketplace becomes a cruel joke disguised as help.

I have asthma, and without insurance my Breo Ellipta cost nearly $500 a month, and my albuterol, 75. That's about $600 a month just so I can breathe.

So when I lost insurance I had to ration a three-month supply of Breo and stretch it over 15 months. Imagine cutting your oxygen by four-fifths and then praying you don't collapse before you can afford your next prescription.

I also ended up in the ER with a leg infection while uninsured, two-and-a-half days in the hospital, and the bill was over 30 grand. Every doctor who poked their head in the room billed me as

if I had begged for their time. They were billing my sickness like a mechanic charging for parts I never asked for and, more importantly, never received.

That experience taught me something important, that when you have no choice but the ACA Marketplace, you're not choosing healthcare. You're choosing how you want to go broke. And today you're being asked to make those choices even more impossible.

I'm not going to read off the stats because we all know what the stats are as far as the price increases they want to do.

And tip the hat to you guys for showing up. I can understand that kind of bravery. While I do currently work in the corporate sector, it takes a lot of guts to show up. So, you know, I don't necessarily always agree with what the companies do, but good on you.

So the federal growth rate standard is 5.6 percent. Every percentage point above that I would argue is not medical necessity. It's corporate greed.

So let me tell you what these numbers mean for real people:

When someone like me with a chronic

condition, who've lost their employer insurance, has to choose between the Marketplace, we're already choosing between rent and medication, between groceries and prescriptions, between keeping the lights on and keeping our lungs working.

These rate increases don't just affect premiums. They affect whether people like me and the others in this room and online and the people who couldn't attend can afford to be sick at all.

Meanwhile, UnitedHealth raked in 14.4 billion in profit last year; Owens Health made six billion; and Cigna made 3.4 billion. These companies are not struggling. They're operating on thin margins. They are extracting maximum profit from people who have no choice but to pay.

And when I was in that ER, uninsured and facing a $30,000 bill, UnitedHealth executives were getting bonuses. When I was rationing my breathing medication, insurance company shareholders were getting dividends.

So here's what I'm asking, if not demanding, on behalf of everyone who has been forced into the Marketplace with no alternatives:

Do not approve the increases that exceed federal growth standards unless these companies can

prove, down to the last cent, that every dollar is for actual patient care.

Impose complete transparency so the public can see exactly how much money goes to medical care versus executive compensation and shareholder profits, and remember that people forced into this Marketplace don't have other options.

When you approve these increases, you're not just affecting numbers on a spreadsheet. You're deciding whether people can afford to stay alive.

The last thing is is we are not walking ATMs. We are not profit centers. We are people who get sick and lost our insurance, and we deserve a system that treats our health as more important than corporate quarterly earnings.

Please deny these excessive increases, stand with the people who have no choice, not the companies who created that lack of choice.

Thank you.

MS. SELLMEYER: I have nothing further, Commissioner.

COMMISSIONER OMMEN: All right. With that, I want the record to reflect the public testimony of Consumer Advocate Sonya Sellmeyer is received into the record.

In addition, I do have other electronic comments that have been received, and those will also be shown as in the record.

I think--again, I know we do a lot of this electronically. But, Ms. Sellmeyer, is there a recommended time period in which to allow others to continue to submit comments? I mean I can take any comment prior to my decision. You know, I do anticipate meeting with members of my staff, as well as consulting actuaries, to further discuss this and, as mentioned, may be in contact with some of the companies.

But do you have a recommended time frame for any other additional comments that could be received?

MS. SELLMEYER: The sooner the better.

COMMISSIONER OMMEN: All right. With that in mind, what I'll do is I'll leave the comment period open, again, since we're meeting in the evening, until tomorrow at the end of--close of business tomorrow, so that would be August the 20th.

Do you have any objection to that?

MS. SELLMEYER: No. Thank you, Commissioner.

COMMISSIONER OMMEN: With that, the record will remain open for online filings. Again, I prefer that--again, given the lateness of the hour, I expect

nothing will be received by mail tomorrow, so any individual that wishes to provide additional comments, if it's submitted electronically through the means by which were made available on our website, that record will be held open until 5:00 p.m. tomorrow evening, which is August the 20th.

Anything further, Ms. Sellmeyer, for the record?

MS. SELLMEYER: No. Thank you, Commissioner.

COMMISSIONER OMMEN: All right. With that, I want to thank all of you for being in attendance tonight. Again, I know this is taking time out of your schedule. I very much appreciate you being here and offering your comments.

I do want to share again, I don't take any of this lightly. There have been--I've been serving as Commissioner since 2017. Those were really difficult years.

You heard comments from Medica. There was a time when they were the only carrier providing coverage to us in this state. We're very pleased that other carriers have joined. Obviously, you know, with competition, you would expect there to be some improvements.

This is a really difficult time--I would

agree with those comments--a difficult time for our country.

I am not just seeing these rates in the individual market. The utilization is changing, expenses are continuing to go up. Some of that is an expense that's realized just directly by the insurance company as a passthrough. There's a lot of policy issues involved that, frankly, don't relate to insurance.

But with that, again, I appreciate you coming and offering your comments.

We are going to be off the record.

Thank you.

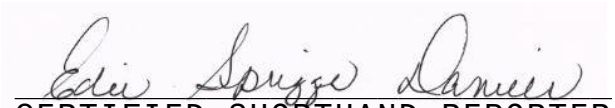
(Proceedings concluded at 6:25 p.m.)

C E R T I F I C A T E

I, the undersigned, a Certified Shorthand Reporter of the State of Iowa, do hereby certify that I acted as the official court reporter at the hearing in the above-entitled matter at the time and place indicated;

That I took in shorthand all of the proceedings had at the said time and place and that said shorthand notes were reduced to typewriting under my direction and supervision, and that the foregoing typewritten pages are a full and complete transcript of the shorthand notes so taken.

Dated at Des Moines, Iowa, this 25th day of August, 2025.



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