BEFORE THE IOWA INSURANCE COMMISSIONER

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IN RE: IOWA'S STOPGAP :
MEASURE :
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Des Moines Social Club
Culinary Loft Meeting Room
900 Mulberry Street
Des Moines, Iowa
Monday, August 14, 2017

The above-entitled matter came on for public hearing at 5:30 p.m.

BEFORE: DOUG OMMEN, Iowa Insurance Commissioner

Also Present:

CHANCE McELHANEY
Communications Director and Legislative Liaison
Iowa Insurance Division

ANDRIA SEIP
Assistant Commissioner, Product and Producer Regulation Bureau
Iowa Insurance Division

THERESA [redacted] - CERTIFIED SHORTHAND REPORTER

I N D E X

P R O C E E D I N G S

COMMISSIONER OMMEN: Good evening. I am Doug Ommen and I am your Insurance Commissioner and this is a hearing--a public hearing here in Des Moines regarding the Iowa Stopgap Measure, so I want to thank you for being here.

As we begin, I know some of you may have comments, but I'm going to go ahead and cover some slides because even though if you have those slides in front of you, I think it probably is worthy of a little bit of explanation.

The slides were prepared because of the types of questions that we in the Division were receiving, and so I'll run through those relatively quickly.

The first slide really is just an overview of what I'm going to cover tonight, but I think it's really important to keep in mind that although--when we look at an insurance market, we think about numbers. Certainly for a market to work it has to involve numbers, but it really is designed to make sure that people, when they need to access care, they have coverage in order to do that.

The ACA market before the Affordable Care Act here in Iowa is a very strong working market. I

think that the statistics that I could offer to you really bear that out, that the people in Iowa generally have looked at health as a really important issue and we took care of people.

Basically the rules were different, and we had, with multiple carriers in our market competing with underwriting, we needed to have a place for individuals that had persistent conditions to go, and that was our high-risk pool, which is still operating here in Iowa.

It's important to sort of look at the problem that we have here in Iowa, that is in our individual market in the context of our overall population. And I included a slide on this because I think sometimes you hear a lot of news about the health insurance market and you may not understand that the insurance market is divided up into these segments.

Certainly if you look at our three million person population, over half of our population accesses its coverage through group or health insurance plans through group coverage. Some of that is federally covered under ERISA, some of it is fully insured under state law. But the reality is is a lot of people here already have coverage through the

employer-based plans.

We have a large Medicare population, and you can also see by the number here up on the screen that we've expanded Medicaid to cover a large number of individuals.

What the ACA did here in Iowa was a number of things, but the first of which is--and you've heard this discussion quite a bit publicly, and that is our Medicaid expansion. The Medicaid expansion differentiates us from a number of states, but certainly it has worked here.

It also, through the text of the Affordable Care Act, created these grandfathered plans and those are individuals that prior to the enactment of the ACA had coverage.

The--post the implement--or post the filing and passage of the Affordable Care Act there was also introduced this concept of transitional plans. And, again, that's part of our individual market here, so I'll talk about that and then I'll talk about the ACA-compliant plans.

The Medicaid expansion is what really made the biggest difference in terms of addressing the issue that we did have here in Iowa regarding uninsured--our uninsured population. In fact, if you

look at the Medicaid expansion of 144,000, that really is the change that occurred in reducing our numbers of individuals without coverage.

The reality is that we actually have fewer people today in the commercial insurance market than we did before the passage of the Affordable Care Act.

The grandfathered plans are those plans that were already in existence in the individual market prior to the passage of the Affordable Care Act. These were recognized in the text of the law as--for those individuals that were essentially promised if you like your plan, you can keep it. And that's a significant number of people in our state. It's not really large. It numbers now under 40,000, but these are people that have held onto their plans throughout the course of the last seven or eight years.

The transitional plans are often widely discussed here in Iowa, and these are the plans that came into being following the passage of the Affordable Care Act, but before it was actually implemented. And, again, there's been discussion about this. This, like grandfathered plans, are a closed block. They're not designed to be allowed to be sold to anybody, but they are people that have--were originally underwritten, and they are people

that oftentimes are in agriculture here in our state.

But that was expanded by act of the President at the time, as well as the Secretary of State--excuse me--Secretary of Health and Human Services. The principal behind it was if you like your plan, you can keep it.

All right. The ACA pool is where we've had most of the concerns in terms of stabilization and keeping our market functioning. And the reason for that is under the Affordable Care Act the issue of not denying anyone for a preexisting condition is a social good that I think people generally have agreed with, but what happened is, is that the individuals that we previously were treating and had coverage through our high-risk pool were then--they then entered the ACA compliant market.

And so with them, because of their persistent and high-cost experiences, they brought with them some costs that started to impact everybody that shared that pool with them.

The rules are that there can be no underwriting. And so, again, that was something that I think generally was well-accepted as a good thing, but you do need to know that under prior law here in Iowa with our high-risk pool, we didn't deny for

preexisting conditions, either. We allowed people into the high-risk pool and were able to provide coverage there.

It's only in the ACA plan that you can get--access these tax credit subsidies that are often described in the media, and those are based upon a percentage of income. And I'll explain that shortly. But it's also the place where you can access what's called cost-sharing subsidies.

If you look at our ACA-compliant pool of 72,000, you can see here in Iowa--this is a little different than the experience in some of even our surrounding states. But if you look at our population of 72,000 that are in this pool, about 44,000 of those individuals are now in the subsidized segment. As rates went up, people started to exceed what was allowed under the Affordable Care Act as their contribution, and so they then became subsidized, and I'll explain how that works shortly.

There is still 28,000 Iowans we estimate that are not subsidized; that is, they pay--individuals who pay the full amount of the rate that annually I need to approve, along with the Federal Government.

Again, as I mentioned, the ACA pool became

to include individuals with persistent health conditions. What was happening over the last several years--and I became the Commissioner just this winter, but I served as a deputy before that, and the prior Commissioner every year would look at the rates as they would be filed to try to keep up with dealing with this issue of individuals with high cost, and then that led to some adverse selection.

In other words, we were losing healthy people. And as rates were being filed, they kept going up. In fact, they were going up at a much faster pace than previously we experienced here.

But the effect of that is adverse selection. That is, people start to look at those rates as they increase and they make a decision that it doesn't work for them and they stop participating.

The other thing that we've seen, and this is borne out in the experience of the companies that we've reviewed, is that under the federal rules regarding special enrollment, it was easier to gain--you could wait until you actually had an event, or an event was coming, and then you could enroll and then buy coverage after you'd already had an experience or had an event. And clearly the trouble with that is if you're only paying premium when you're sick, it's

not going to work very well.

In other words, you know, insurance is about sharing risk, and if the only people that are paying premium are those that are in the midst of an experience, it's not going to work in a commercial market.

Also, because of the fact that there has been some unknown circumstances regarding those cost-sharing subsidies that really date back--some uncertainty that dates back a number of years, you probably have read about this in the papers, but the House of Representatives filed a lawsuit against the President at the time. It went to court. There was a decision in favor of the House of Representatives, and so that matter is now on appeal but it does create a lot of uncertainty as the companies are trying to make a decision on how to rate the products.

You have to understand what has happened in terms of pricing to really understand what I would describe as one of the structural problems of the ACA which we believe is corrected through the Stopgap Measure. And that is this issue of how the subsidies work. What I did is--and these are overly simplified. Certainly you can probably look through

the insurance rate tables and find things like this, but I really just tried to simplify it to help you better understand that--the way the subsidies work.

For an individual with a percentage income of up to $48,000, the text of the ACA actually attaches a percentage to that percentage, that income level.

So for an individual with less than $48,000 in income, by statute the amount of their contribution by and large is about nine-and-a-half percent. And so regardless of what the rates become, what is asked of them is only up to nine-and-a-half percent.

So as you can see, over the years as premium rates were going up, more and more people were falling into that subsidized segment because of the fact that their premium rates started to exceed those caps that are found in the ACA.

So as an example, in year one if the premium was $4,000, that would be below their statutory contribution limit and so they would pay all of that premium. But if it went up to $8,000 a year, you can see that their contribution is limited to 4,600, so the rest of that would be then covered by other taxpayers through the tax credit system.

The following year if it went up to $12,000, again, their contribution is limited to the 4,600, and the other taxpayers through tax credits would cover the $7,400.

And, again, the reason that matters in an insurance market is consumers can then become indifferent to the rate competition.

This is our current market in 2017, and this is important for you to understand because as we looked at going forward into 2018, what happened in 2017 really impacted our circumstance.

This is broken out based upon company, but between the blue and the red, the blue are the segment of the market that is within the Exchange or on-Exchange. Those are the ones you would find at healthcare.gov. That's where people would enroll through healthcare.gov.

The red is off-Exchange, which means you can still access it through the company. It's done in a manner that's consistent with the law through the Affordable Care Act, but it's only in the segment that is blue or on-Exchange that you can access the subsidies.

So when Wellmark withdrew from our market or indicated its interest in--or its decision to

withdraw, that was of concern to us. So when Aetna left, that mattered a lot as well because of the fact that Aetna was covering a very large number of individuals on the Exchange.

So when that started to happen--when that happened, the decision that we made within the Division was we were very concerned about Aetna's departure and Wellmark's departure because between--Aetna was, by far, significantly lower in terms of rate and we were concerned what that might mean both in terms of sustainability beyond 2018 but also for 2018.

When Medica did file it still appeared to me and to us within the Division that the impact of a market under the ACA still had us in a collapse, and I'll explain why that is.

So we decided to move forward and request emergency regulatory relief but also try to work within the framework of this vehicle called 1332. Under the 1332 waiver, there are certain requirements that we have to meet. I've got those up here for you. You can kind of look through those. They're also in front of you.

But essentially what we're asked to do is to compare what the world would look like in our market

with the waiver versus what it would look like without the waiver. And we have to compare the impact and in order to meet this requirement, establish that the market is going to be better and that it will impact people in a better way by having the waiver, and we believe we have met these requirements. They're called guardrails.

But one of the things that you also need to be aware of, we are either a state under the ACA, or we are a state with the Stopgap Measure. It's not a circumstance where we're able to do both. So it is one or the other, which is why these hearings are so important.

All right. Under the ACA, Medica did file, as I mentioned, they filed in all 99 counties. They proposed premium rates, which I will review, between 43 and 56 percent, and those are premium increases based on their rates. So if you're an Aetna-- currently covered under the Aetna plans, again, historically your rates were lower, but you would see even larger increases than those percentages.

As part of the 1332 waiver application, we did conduct an economic analysis and an actuarial analysis. And as part of that, based upon the impact, which I'll go over shortly, we believe and

our actuarial consultant believes that these rates that have been filed by Medica will cause from 18 to 22 thousand Iowans to leave the market. Because what you'll see is for those that are not subsidized, the rates are becoming so high that they actually become, for any middle class family, just very, you know, unmanageable.

We also estimated that based upon the actuarial analysis that three to four thousand will reduce the coverage where they are now.

But one of the important factors of what we're seeing in the market, as the market shrinks and healthy people leave, they will leave behind people that need care. And often, as I mentioned earlier, those that really do need care have expensive care.

And so what happens is as the people that are healthy shrinks, the premium that's coming in from people that are healthy shrinks, which means then the rates have to go up and the subsidies go up.

So we're estimating, again based on the economic analysis, that this year, that is in 2018, the amount of federal tax dollars that would be flowing in as a part of the tax credit structure for this individual market would be about 400 million

dollars.

All right. This sheet is a little bit difficult to see from where you sit but I will cover it because you have it in front of you and it's really important to help understand what's going on in our market.

We broke this out based on the current law and based upon the filings that we have received. Now, again, I am very appreciative that Medica has filed in our state, because if we're not able to get the waiver it does provide coverage for some Iowans. But at the same time the rates that are being filed, if you're not subsidized, are really significant.

What I did was across the top of that page you can see I took two individuals that are 55 years old, you can think of them as a 55-year-old couple, and based upon their income levels, again, their subsidy--or actually their contribution is determined based upon where they are in that scale of against federal poverty level.

So if you look at just below 200 percent federal poverty level, with an income--that would put a couple's income at 32,500, I believe. The cost of the silver plan under the Medica filing--and this is the average silver plan. There are some variations,

but it's $2,700.

But under the text of the ACA the maximum that that couple will pay would be 6.43 percent. And as I mentioned earlier other taxpayers through tax credits cover all the rest of that rate. So their monthly contribution, then, would be $173 for a maximum premium contribution of $2,078. The tax credits they're receiving to their benefit from other taxpayers would then amount to $30,600. Because if you look at the bottom chart--or the bottom line, right there (indicating), that $32,688, that's the actual cost of the premium for those two 55-year-olds.

If you go back up to the second line, again, you can see as income increases--and, again, this is the subsidized--this is a subsidized couple, but if their income is just shy of 400 percent, that puts their income at about 64,797. Their statutory contribution is capped at 9.69 percent. So their monthly payment is the $523 for the maximum personal contribution for that family of 6,278, again which leaves for others through the subsidies, through those tax credits, a contribution coming from other taxpayers of the $26,410.

Again, what happens, then, is the way the

statute was written is if you exceed the 400 percent, you receive no subsidy.

So this is where we're really concerned, which is where the actuarial analyst said you will lose 18 to 22 thousand people because if you're above that subsidized amount, you're going to see some very significant increases from where you are now.

Did the same thing with a family of four, two 30-year-olds, as well as children. And, again, you can see the federal poverty level break point. The percentage break points are a little bit different, but the income levels, you know, essentially between having a subsidy and not having a subsidy for a couple with two children is going to be around 98,000. You can again see the substantial impact on individuals that are not subsidized. Their maximum annual payment without a subsidy would be 30,944. Again, so that's a third of the income of a family with $100,000 family income.

All right. So when we, again, looked at what had to happen in terms of trying to preserve or stabilize our market it became very clear that we needed to develop a way to hold onto the healthy people that are in the unsubsidized part of the market because if we lose 20,000 individuals who are

healthy, the market will be worse, in worst shape next year.

So what we did is we devised a standard plan that we believe is already allowed by state law, but it allows us to set that standard plan and we would use the silver plan in order to do that. But even by doing this with these rates, with where we are, we still expect that there could be people, as many as four to six thousand people, who still may choose to leave. We expect that those people would be in those higher levels of income.

What we would be doing is redirecting that 400 million dollars to flat premium credits based on income as well as age in order to address a lot of the flight that we've seen among people that are young and often healthy. And I know there's been discussion about this, but if you actually look at the data, we've been adding people, even in a collapsing market, we've been adding people between 55 and 65, but we are losing large numbers of people that are in those younger age brackets.

So, again, you can see here the proposal would set up a reinsurance mechanism that would have an attachment to deal with those issues of people with--traditionally who were in high-risk and it

would take care of that issue. And by doing that, it actually lowers it for everybody in the market, but we would also create flat credits.

And the reason that's significant is when you have a market where you have multiple carriers, if the population that is making the choice becomes indifferent to rates, you end up in a circumstance where people may pick a more expensive rate; therefore, have higher credits; therefore, have more expense. But it really is a circumstance where carriers are no longer competing on rates and service in the same way they could be competing if 44,000 additional Iowans held the power of making those decisions.

Again, the Stopgap Measure is a standard plan and it--it appears in front of you. You've got some of the basic provisions, but it would be, again, similar to the current silver plans that are available on the market.

It would cover all the essential health benefits. There would be no cost-sharing. What we did with that is we worked by redirecting in the scheduled flat credits, we directed a lot more of those subsidies to individuals in moderate income levels to help lower those premium costs. And also

as part of that there would be no coinsurance, except those that might be required by state law. But, again, so consumers would know what it is that they would be facing.

And then a big part of it is the continuous coverage requirement, to basically make the mandate effective by making sure that if people departed the market in midyear, they might have some difficulty coming back in.

Again, this is the stopgap numbers and you can see those and peruse those on your own. The reason the premium, I believe, based on the data that I've seen, would be lower is the reinsurance mechanism, but also because we would be keeping 20,000 healthy people in the market, and we believe it's a substantial difference in rates, but you can also see the scheduled examples for the subsidies.

Again, if you put these side by side, the Stopgap Measure is not perfect, but we believe it's superior to what we're going to have in the individual market. And, again, I've got to look at not just 2018, but also 2019 and what that means if 20,000 people exit our market.

So that's it for my presentation. Again, I appreciate your patience. I did leave enough time,

I'm certain, for some comments and questions.

So do we have a microphone?

As a part of this process, we are reporting--we have a court reporter here to take this down. This is part of our hearing process that needs to be submitted to the Federal Government. So if you could identify your name, that would be very helpful, and then you may proceed with questions or comments.

Andria?

MS. SEIP: Anyone who has a question or a comment, I'll bring the microphone around.

MS. TERRY [redacted]: Hi. Terry [redacted].

So just a show of hands, how many people are buying their insurance on the Exchange right now? Anybody in the room? Three people? Three people. Okay. Super.

So am I, and I'm one of those three or four thousand that's getting a subsidy, but I still have concerns about costs because I think it's important that we all keep in mind that it's called the Affordable Care Act, okay? Affordable, okay?

And so my--one of my first questions here is so in these two examples that you had of the ACA and then stopgap, why is the estimated monthly premium,

why is it different from one comparison to the other comparison?

This says "Second low Silver," and it's for the 199 percent of FPL, it's 2,270--2,724. But on the Iowa Stopgap for the 199 FPL, age 55 I'm looking at, it just says "Region 6, 2018, Iowa City." It doesn't say second low silver, and the estimated monthly premium is 1,627.90.

Are we comparing apples to apples, or why are those figures different in that--

COMMISSIONER OMMEN: That's a good question. We're comparing apples to apples in terms of the basic shape. They're both--in other words, the standard plan that we proposed is a silver plan so it's got the same actuarial value that is the standard--the silver plan under the ACA.

The subsidies are pegged for a large part of the population to that second lowest silver plan, so that's why we used it as comparison.

The difference in the rate is what I explained in terms of two things that are really important. The first is that we're redirecting some funding to go to reinsurance, which takes the--I guess I would describe it as the unpredictability of movement of people that are very high-cost individuals.

The carriers have had to build in, because there has really not been effective reinsurance, they've had to build in prices to deal with people moving from one carrier to another. So moving some of those subsidies out of the ratemaking process and putting it into a reinsurance is designed to actually stabilize it so you're really in a better position as a carrier to evaluate the risk.

But the biggest difference in that rate, which is very substantial, is that the rates that are filed by Medica under the ACA, they have presumed a large number of people leaving. We estimate that the people leaving will be between 18,000 and 22,000 healthy people.

Again, I don't mean to pry into anybody's business in this room, but part of the problem is, again, as rates go up, which is what has been happening, and again, through no fault of Medica's is happening yet in their filing, if 20,000 Iowans leave and they're healthy, that's less premium to come in to cover the cost of people who are sick.

So a lot of the difference that you pointed to there between the rates under the stopgap and the rates under the current ACA is because of that adverse selection.

MS. TERRY [redacted] Okay. So getting to that adverse selection, too, so I understand that, you know, you want all these young and healthy participants in the ACA, but what's the population in the State of Iowa? Are there more 55- to 65-year-olds than there are young people?

So, I mean, how can we expect--you know, I'm just wondering about the expectations there, you know.

COMMISSIONER OMMEN: Very good--

MS. TERRY [redacted]: I mean, it's a wonderful actuarial idea and I do understand insurance. I've worked in it my entire career, so--I mean, maybe that might have been helpful to see on some of these charts, too, is the age distribution of the population, you know, where some of that was shown.

MR. OMMEN: Yeah.

MS. TERRY [redacted]: So as I understand it, so the standard plan proposed by the Stopgap Measure is a silver plan, more or less; correct?

COMMISSIONER OMMEN: Yes.

MS. TERRY [redacted]: For the three or four of us that are on the ACA now, there's bronze, silver, and gold, and just like in the Olympics, you know, bronze is cheaper, silver is more expensive,

gold is, you know, really--people that can really afford it, I guess.

So I'm on a bronze plan, too, and I'm concerned that I won't even be able to afford--I'll be forced--if the Stopgap Measure is approved, I'll be forced to have a silver plan and I am concerned that I won't be able to afford that because I can't afford a silver plan now even with subsidies.

So I'm concerned there and I would encourage the other folks on your website, that last appendix, I don't remember the letter number of it, but where the actual measure is documented and has those supporting documents and appendices, if I look at that last appendix listed there, I mean, it looks outrageously expensive for me next year under the stopgap plan. So I'm concerned whether I'm better off with the ACA as it is, or go to this Stopgap Measure for my age group and my circumstances, even as a subsidized person under the ACA currently.

And so I find it quite ironic that, you know, I see this quote in here about if you like your plan you can keep it. Well, I like my bronze plan but I can't keep it. I find that very ironic.

And so I'm early--I'm one of those early retirement people and I'm married and my husband is

still working and he works for a small employer, and maybe someone will address small employer concerns here because when my husband first took that job they didn't offer health insurance as a benefit because it's a small employer, and so I told him not to take that job.

But then under the circumstances we were in, yeah, you better take that job and I guess we're not going to have insurance.

And, you know, now it's, like, I feel like we're getting squeezed here, like--I don't know. Are we going to have to leave the State of Iowa? Is my husband going to have to leave his job?

MR. LOU [redacted]: Yup.

MS. TERRY [redacted]: You know, I'm feeling it. I'm feeling it. So I'm really concerned and I appreciate that, you know, the State of Iowa is trying to stand up and help solve some of these problems that real families out here are having but, you know, who are these real families, you know? I don't see that young group of people that you're trying to get and--I don't know.

I guess I'm just really concerned and I would encourage everybody to, you know, fully look at the measure and check that last appendix.

MR. OMMEN: Thank you for that comment.

Other comments?

MR. NICK [redacted]: I appreciate your presentation. My name is Nick [redacted]. I'm a farmer from Traer, Iowa. Additionally I serve on the Farm Bureau Federation Board of Directors. I appreciate the opportunity to come and visit with you guys. I appreciate all the work you guys have done coming up with the stopgap plan, basically providing options.

I'm here representing the Farm Bureau side, about 159,000 members, about 6,000 policyholders who will be without an option or at least a far more expensive option come January 1st.

Farm Bureau and Wellmark have worked together for decades. We provided a lot of services to both small businesses, individuals, farmers, many people here across the State of Iowa, you know, not just self-serving for the organization, but actually it's a service to Iowans. They do a big chunk of business.

There's no question the Affordable Care Act needs fixed. I think proof of that is the fact that on one of the nicest Monday nights in the summer in August we're all sitting in this room right now talking about health care when we could be doing other things.

It was well-intentioned legislation. Obviously it is flawed. That's why we need a fix. In the meantime I support the stopgap idea for all the reasons that you've illustrated with the high costs. We need to allow Congress more time to get a permanent fix. Even with the stopgap and the grandfathers and grandmothers, that's not perpetual continuation. You know, we can't keep going on with this particular situation. Stopgap, by it's very definition, is a stopgap. So I appreciate that.

On a personal note, I'm one of the 18 to 22 thousand that likely will not be able to afford insurance if Medica is the only option. My fiancee is also in the same boat, my brother also in the same boat. All three of us, very healthy people, you know, don't really smoke, you know, don't overeat, take care of ourselves and we're the kind of business that in a normal functioning health-care market you would think insurance companies would be flocking to us to try to get our business and yet the market is evaporating in the State of Iowa and we have no options.

So to that point, I guess, you know, my biggest fear has been over the last several months, you know, looking at the impending first of the year.

Yeah, I've always been healthy and sure enough, you know, on January 2nd, that's going to be the day I slip on a banana peel and have an injury or, you know--that's, you know, the Murphy's Law thing. I mean, you know how bad luck strikes.

And that's my biggest fear. And, yeah, I'm a farmer. I have a few assets, you know, starting to try to buy the family farm back. I hate to think if I slip on a banana peel it's going to cost me 40 acres of the family farm because they come back after my assets.

And that's a fear that a lot of farmers and a lot of small businesses have is, you know, they can't afford the premiums that--you know, their life's work is going to be imperilled if they can't get something that's more affordable.

The people I know that are at risk of losing this insurance, or at least having the incredibly high premiums, that's their biggest fear is losing their life's work and, you know, not having any control financially.

Every one of us would like to pay health insurance. You know, I wouldn't get a subsidy. I don't want a subsidy. I just want, like I used to be able to do, pay a somewhat reasonable premium for a

somewhat reasonable product. And, you know, the health-care market, prior to the Affordable Care Act, obviously I'm not going to sit here and defend it and say it was perfect by any means, but I think since then, as I said before, it's obviously flawed legislation and we need something like the stopgap to buy us time so Congress, however they can do it, and at some point come together to come up with a proper solution.

So I guess that would be my comments. Thank you.

MR. OMMEN: Thank you for that comment.

Other comments?

MR. LOU [redacted]: Yes. My name is Lou [redacted].

Could you go back to your slide where you talk about the age 55, age 30, Iowa City, for a second?

MR. OMMEN: Certainly. Under the ACA or under stopgap?

MR. LOU [redacted]: Stopgap.

MR. OMMEN: Sure. Yes.

MR. LOU [redacted]: What I find remarkable when I take a look at this thing, when you go back, when you look at age 55, income of 64,800, and you get

down to 66, it goes up $200. But a multiple of the monthly premium jumps from 291 to 1,300. How do you explain that?

MR. OMMEN: That's a great question. Again, you have to understand under the guardrails, as they're called, with the waiver we have to demonstrate that people, by and large, are no worse off under the waiver as under the current federal law.

So I agree economically it still is an impact. And, you know, I think--I guess that's why I would say this isn't perfect. The stopgap is not perfect, but the ACA itself in the text of the law makes these break points that move people from kind of an affordable income-based contribution to covering the full rate.

And so I guess that's why I would offer to you we believe that what we try to do here, and we believe we are successful, is we did lower it enough that we can keep those people. That's why if you looked at that one slide where I said we will still lose some people--

MR. LOU [redacted]: Right.

MR. OMMEN: --and that's a problem, too, but you have to understand that we're restricted under--I

call it the rigidity of the ACA, which doesn't seem to work well, and the rigidity of the waiver provision, which makes it still difficult. But, yeah, I would agree with you, this is not perfect, but that's what we were working with.

MR. LOU [redacted]: I mean, you've got an example of a 55-year-old, and you look at 291 to 1,300. You know, I really can't even guess what a 62-, 64-year-old would be at the same income. You're probably looking at net monthly premiums approaching three, four thousand dollars if you take that scale up at the--the way you're going here.

MR. OMMEN: No, we didn't do that. We tried to stay within general ranges, and I can get that information to you. I don't have it in the form of a slide. It is in our--it is in the proposal in the waiver request, and it is higher.

Again, I'm not going to disagree, but you have to understand that the challenge is that for us, in the Stopgap Measure, it's to keep the people in the market and also not--I can't--anybody who suggests somehow we're repealing the ACA is not accurate. We can't do that with a waiver.

We are held to a lot of those same requirements, but we believe, based on what we were

able to do, is we were able to keep a much larger number of people in the market because if you compare these rates, which, again, you can see it's the annual premium of 15,000--just to go back a couple of slides, and I could have put these side by side--it's the difference between 15 and 32.

MR. LOU [redacted]: Right. Exactly.

MR. OMMEN: And, again, I appreciate the comment, it's a great question, but that's what we were trying to address because we're not going to--I guess I would describe it this way: Today if you look at these rate increases, we have been losing annually a lot of young and healthy people. These rates will drive out older and healthy people, and that's a problem. And, again, that's why we've been calling on Congress to fix it. The Stopgap Measure does buy us time.

MR. LOU BARLOW: I think the other thing that the lady here just mentioned, what options do you have? One of the options is moving out of state. I have investigated several of those options. And what's amazing to me is a lot of the neighboring states don't have just one carrier. Sure, Wellmark has pulled out. A lot of the neighboring states still have two, three, some even have four carriers.

So why Iowa being the first, basically, out the door? We've got three million people. If an insurance company really wants to save money, go after Florida, go after California. There you can really put dollars to the bottom line. Three million people, 22,000 affected, that's peanuts to these guys. They round that much off in a week.

So why is Iowa picked on first of all the other surrounding states and the big states in the Union? I also understand that they tried to pull out of New York but the State of New York strong-armed some of the insurance companies basically stating, "You want our state business, then you provide health insurance." Why haven't we put a gun to their head?

I'm sure that we, as taxpayers, don't appreciate the State of Iowa employees getting health insurance for our money and we can't. So why would you have health insurance on my money when--put a gun to their head and say, "You want the State of Iowa business, then you will provide insurance in our state."

MR. OMMEN: Thank you for that comment.

Any other comments?

MR. RON [redacted]: I'm Ron Davidson and I just want to say thank you, Commissioner, and your

staff for the efforts in at least trying to get us something. I know obviously it's not perfect, but at least you're making an excellent effort and my wife and I thank you.

Kind of a comment/question: I know the Governor and our senators are encouraging this to pass. How about the representatives, King and Young and Loebsack and Blum? Are they part of it? Are all the Iowa delegations encouraging the CMS to go along with this?

MR. OMMEN: Thank you. Very good comment and question. The answer to that is yes. This is a request for a waiver by the State of Iowa. So there will be a number of signatories on it. But ultimately the decision on whether or not the waiver is granted is a decision that falls with the Secretary of Health and Human Services and the Secretary of Treasury.

But, yes, those offices have been engaged in that, they've offered helpful suggestions and, you know, we expect that they would support it.

MR. RON [redacted]: The last, kind of attached to that, I saw your interview on Channel 5 yesterday. Thank you for that. It was very informative. Do you and those parties still feel cautiously optimistic

about getting the waiver approval?

And thank you very much.

MR. OMMEN: Thank you. Again, that's a common question I get. I do feel cautiously optimistic. I think we feel cautiously optimistic. The work that has gone into this I think demonstrates that this is better for Iowa. Again, it's not perfect, but we do view that we've met the guardrail and we do feel optimistic.

We are starting to run up against some hard deadlines, though. In other words, if you look at the 1332 waiver process, there is some rigidity in it that, frankly, is the reason we made this really a request for emergency regulatory relief. And what I mean by that is the original provisions were designed to encourage innovation. It really wasn't designed to deal with an emergency where we had 20,000 Iowans leaving our market, even leaving our state. And so-- I mean, there are some time frames that are really difficult.

And this is a balancing. I mean, it's really clear, we've heard different comments even tonight, this is a balancing because people are impacted differently depending on where they sit. I think we've done a good job, and I think the economic

analysis shows we've done a good job in addressing some of the intent of making it affordable for people of moderate income levels. And I think that if you actually look at those premium rates and study it, if you're subsidized now, I think the premium rate would be very comparable to what it is that you're paying now. And, again, that's apples to apples, silver to silver.

And I appreciate those concerns, that's very helpful, but--thank you for that comment.

Other comments? Yes, ma'am?

MS. JEANINE [redacted]: My name is Jeanine [redacted] and I'm here just as a citizen. I'm on Medicare, so I'm not affected by this but certainly family members are.

I just have two questions, and one is--and first of all, I also compliment you on your hard work and thank you very much.

On the Stopgap Measure, if it is approved at the--by the Federal Government, is the entire Iowa insurance marketplace governed under the Stopgap Measure?

So we're going from ACA Exchange participants, but would this be the entire insurance--individual insurance market?

And my second question is, are the health plans on board with this, Wellmark, Aetna, and other health plans that would be hopefully offering coverage?

MR. OMMEN: Again, very good question. The answer to your question is this is designed to address the circumstance for the ACA-compliant plans, which we estimate this year to be 72,000. It could be--we know people have been leaving every year so that number actually could be a little bit higher. But it's really designed to address that segment of our population.

As for the plans themselves, yes, Medica and Wellmark both very early came in and expressed a willingness to work on this, to help.

Now, again, I'll repeat that we're getting into a place and time on the calendar that presents a challenge for carriers to actually participate, but I think that we're still in a place where we can get approval and get that delivered.

I think it's--the 99 county issue, Medica in their ACA filing has said they'll cover all of the state. And so, again, I appreciate that. I'm mostly concerned about what it does to families this year, the 20,000 that I fear will be priced out, but also

then what it looks like next year, you know.

In other words, you can't continue to have adverse selection and healthy people leave again, leave the market or leave the state, and figure out a way to make this work. And for people to leave the state, that's just not good for us here in Iowa.

You know, again, if you're in a place in the market where you're getting some subsidy, your jobs, you know, are often provided by people that are in a different place. And I guess I just would say this is designed to stabilize it to give Congress time to act. Thank you.

Other comments?

MS. TERRY [redacted]: I was just going to--I think this is--

COMMISSIONER OMMEN: You're on.

MS. TERRY [redacted]: I was just going to also address Aetna has decided to pull out of the marketplace for 2017, so it does--

UNIDENTIFIED VOICE: 2018.

MS. TERRY [redacted]: --excuse me, 2018. The existing carriers on the marketplace in 2018 are possibly Wellmark and Medica.

MR. OMMEN: Yes. Again, that's a good supplement. The design, though, is actually to allow

carriers to compete and to--we believe we could attract others back in for 2019, but we have to have a market and we're in a collapse.

Yes, sir?

MR. LOU [redacted]: What is the date, probably the longest we can go on the stopgap before it cannot--not work?

COMMISSIONER OMMEN: Okay. When you say "not work," I think you're talking about some sort of sense of approval?

MR. LOU [redacted]: Right.

MR. OMMEN: Again, great question. We'll be submitting our waiver request on Monday, and when that is filed, that will then trigger a clock that allows CMS to do some answering and give us some, I guess, answers to the questions. They have to determine it's complete, and we'll work with them through that process.

The real challenge, though, is the carriers. You know, Medica has also--at the same time they're--we're going down a path with them where I have a hearing, a rate hearing on their ACA rates on August the 24th. They then have to submit their final rates to CMS on September the 6th, and then they have to enter into a contract late in September. So the

reality is that it's important that CMS act quickly so that we can save these--save people that will otherwise leave.

Additional comments? I think we're about out of time but I think we have a little more time. All right. And, again, if you could reidentify yourself.

MS. TERRY [redacted]: Terry [redacted] from here in Des Moines.

So if the Stopgap Measure is approved for 2018 and I can't afford insurance in 2018, and I decide to stay in Iowa as an uninsured person, when I go to file my tax return for the year of 2018, am I going to have to pay a tax penalty?

COMMISSIONER OMMEN: The mandate is administered by the federal law, so that would be--we're not asking that that be waived, so it really would be--

MS. TERRY [redacted]: Oh, okay. Wow.

MR. OMMEN: I think the administration has already decided that a lot of people under hardship are not paying that.

MS. TERRY [redacted]: Okay. So the ACA hardship--

COMMISSIONER OMMEN: But that's a good question.

MS. TERRY [redacted]: --criteria would still be in effect even though the Stopgap Measure is replacing the ACA? I don't understand.

MR. OMMEN: Again, yes, the waiver doesn't replace the ACA. As an example, we'll be meeting the essential health benefits under our standard plan, but there are going to be pieces, like what you've suggested, that still would involve federal issues.

MS. TERRY [redacted]: So that fork in the road is not--

COMMISSIONER OMMEN: Well, yes, it is.

MS. TERRY [redacted]: --100 percent total, or what? So you're saying, then--okay.

COMMISSIONER OMMEN: Yeah, the fork in the road really is more just to make sure that people understand that you can't do a Medica on-ACA, on-Exchange plan. That's why these comments are so important. That was not designed to do anything more than explain that concept.

MS. TERRY [redacted]: This might help me to decide whether to put my house up for sale now when I can get a good price for it. And, like--so you're saying that--just to be sure--be clear here, you're saying if the Stopgap Measure is approved for 2018 and I don't get health insurance in 2018, I make

that decision myself, then when I file my tax return for 2018, my federal tax return, I will have to pay that penalty for not having health insurance?

COMMISSIONER OMMEN: We have not asked to waive the mandate.

MS. TERRY [redacted]: So that means yes. Okay.

COMMISSIONER OMMEN: I do believe--well, I do believe--the Treasury recently has said that they didn't think that was to be enforced. But, again, that's a very good question and I'd be happy--

MS. TERRY [redacted]: I'm not--I'm the person paying all the tax that I can, I'm that person. I never shy away from paying all my taxes.

Okay. I thought I had another comment or question. I don't know, maybe it will come to me, but I think we're out of time. Thank you.

MR. OMMEN: Thank you.

Anything further from anyone?

(No response.)

COMMISSIONER OMMEN: All right. Well, again, thank you very much for being here this evening.

We'll go off the record.

(Proceedings concluded at 6:24 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 22nd day of August, 2017.

Theresa [redacted]

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