

BEFORE THE IOWA INSURANCE COMMISSIONER

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IN RE: IOWA'S STOPGAP :  
MEASURE. :  
- - - - - X

Council Bluffs Public Library  
400 Willow Avenue  
Council Bluffs, Iowa  
Wednesday, July 19, 2017

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

BEFORE: DOUG OMMEN, Commissioner

- - -

 - CERTIFIED SHORTHAND REPORTER

I N D E X

| <u>SPEAKER</u>       | <u>PAGE</u> |
|----------------------|-------------|
| Dr. Glenn [REDACTED] | 18,20,28,44 |
| Michelle [REDACTED]  | 25          |
| Joy [REDACTED]       | 27          |
| Nancy [REDACTED]     | 29          |
| Marti [REDACTED]     | 30,42       |
| Diane [REDACTED]     | 35          |
| Susan [REDACTED]     | 39          |
| Todd [REDACTED]      | 41          |

1                   P R O C E E D I N G S

2                   COMMISSIONER OMMEN: Let me introduce  
3 myself. I'm commissioner Doug Ommen, and I'm hosting  
4 this event. I'm truly appreciative to have you come  
5 out to provide some comments to us as we move forward  
6 in this process.

7                   Real briefly, you know why you are here so I  
8 don't have to tell you all about that, but my intent  
9 is that, before we get in to receiving comments and  
10 accepting questions, I did want to just do a real  
11 quick overview of the Stopgap Measure and why we see  
12 it as something that's important for us here in Iowa.  
13 I will give you a little bit of a background about  
14 where we've been here in Iowa because I think that's  
15 useful to sort of level-set the discussion.

16                  Prior to the ACA market Iowa did have one of  
17 the lowest uninsured rates in the country. We are a  
18 state that had a very high number of individuals who  
19 had insurance in the large part because we have a  
20 very low unemployment rate. I don't know if you saw  
21 the numbers again recently, but our unemployment is  
22 really low.

23                  Many people, many citizens, were able to  
24 access insurance coverage through employer-based  
25 plans. And so that combination of circumstances

1 really resulted in us having low uninsured rate  
2 numbers.

3           We also had, prior to the ACA, a number of  
4 carriers in our market. Most significantly the  
5 change, though, that occurred under the ACA is we  
6 also had a high-risk pool which functioned pretty  
7 well. I know there were some people that did  
8 experience some challenges in that, but it worked  
9 pretty well and it worked pretty well mostly because  
10 people that have been in a high-risk pool are  
11 individuals that have persistent health conditions  
12 that have expensive care treatments that they need,  
13 and that we, as Iowans, want to provide for them.  
14 But in a high-risk pool historically that was  
15 generally funded. And so that's how we were able to  
16 take care of that circumstance.

17           Again, I appreciate color so I used color  
18 for this slide. I wanted to demonstrate under the  
19 ACA that although the concept of the Affordable Care  
20 Act was a single-risk pool, that's really not what  
21 happened here in Iowa.

22           Basically what we did is we did participate  
23 in the Medicaid expansion, and by doing that--that's  
24 represented by that blue slide--what we did is we  
25 added 144,000 Iowans into the ranks of those

1 individuals who were covered, and we did that by  
2 simply expanding Medicaid coverage.

3 Now, that's expanding, essentially, free  
4 coverage. It made it available for people really at  
5 the lowest end of the income levels. But these were  
6 Iowans that were working, but, frankly, were priced  
7 out of the commercial market. And so that expansion  
8 is how we reduced the level of the uninsured in our  
9 state.

10 Frankly, the number of people in the  
11 commercial market declined since the passage of the  
12 ACA. So if you look at our commercial market we have  
13 fewer people today than we did prior to the ACA. But  
14 the effect that we had with Medicaid expansion is, we  
15 did bring people who were unable to afford purchasing  
16 coverage into those ranks of people that did have  
17 coverage.

18 Under the ACA, the other thing that's kind  
19 of unique to farm states in a large way, although I  
20 think probably looking in some of the southern states  
21 as well, we had a good population of people that were  
22 in what we described as the grandfathered plans. And  
23 these grandfathered plans were really--that was part  
24 of the compromise of passing the ACA. The people in  
25 Iowa, and elsewhere, were told that if you like your

1 plan you can keep it. And we had people that, in the  
2 text of the ACA, were told that they could keep their  
3 plan. It's a closed block, but it's a very stable  
4 block of individuals. Many of the people in the  
5 grandfathered group are folks that are in  
6 agriculture.

7           The green slide represents a large number of  
8 individuals that are in transitional plans. And  
9 those plans have been--they have been tabbed as  
10 grandmothers plans. But, again, those are the plans  
11 that came into being after the passage of the  
12 Affordable Care Act, but before the implementation of  
13 the Affordable Care Act. Again, that's a closed  
14 block. And both the grandfathered and the  
15 grandmothers plans have been reducing in number,  
16 frankly, because of the fact that it's a closed  
17 block. And so some people that have been in these  
18 plans moved into the ACA-compliant market.

19           What's different about the ACA-compliant  
20 market, and that's represented by the orange, is that  
21 that is where the individuals that I earlier talked  
22 about, those that are in the high-risk pool, that's  
23 where those people primarily have been placed.

24           One of the policy decisions about not  
25 denying preexisting conditions, that allow people

1 with chronic persistent, expensive conditions to come  
2 into the individual market. And, frankly, as the  
3 insurance regulator, I've been saying this for some  
4 time, in Iowa the numbers just didn't add up. We put  
5 in a circumstance where we had individuals with high  
6 costs and we were trying to spread that over the  
7 individual market.

8           What happened as part of that process is we  
9 tried to deal with it for the early years with rate  
10 increases. The insurance companies would come to us  
11 and they would say, well, the rates we're charging  
12 aren't adequate. And so we were seeing these rate  
13 increases.

14           Well, you can imagine, what will happen to  
15 that is adverse selection. Individuals--people that  
16 are healthy, they view those rates as climbing and  
17 they view it as something that doesn't really entice  
18 them to participate. So even though there was a  
19 mandate, we were seeing young, frankly, and healthy  
20 people departing.

21           This is our current 2017 market. You can  
22 see, and I'll go through this rather quickly as well,  
23 but this is the ACA-compliant market. And the  
24 difference that I wanted to demonstrate with this is  
25 we had a large carrier in our state that was covering

1 a lot of individuals in the individual market,  
2 previously known as Coventry, they were bought by  
3 Aetna, and they covered a lot of people here.  
4 Wellmark was the first company to advise me that they  
5 were not going to be writing in the ACA-compliant  
6 market. That gave me a lot of concern. But what  
7 really changed for me was when Aetna decided to not  
8 write.

9           The reason for that is if you look at our  
10 market, there is a distinction between those people  
11 who are on the exchange and those that are off the  
12 exchange, as represented by the blue and the red.

13           Those that are on the exchange, those are  
14 the people that are able to access these premium  
15 subsidies that you hear talked about. And those that  
16 are off exchange don't access those subsidies.

17           And so when Aetna decided to leave, that put  
18 us in a position where we had a quite a number of  
19 individuals that were receiving subsidies who were  
20 going to only likely have possibly this one carrier,  
21 Medica. And we didn't really know exactly what that  
22 was going to mean for us.

23           Medica had conversations with us about  
24 wanting to stay in our state and write in our state,  
25 but we also knew what the aggregate losses were for

1 the entire ACA market, and we were very concerned  
2 about having losses concentrated with one carrier.

3 The other issue to be very much aware of is  
4 the fact that Aetna was the lowest--they had the  
5 lowest rates in our state, by in large nearly every  
6 region. But with their departure we knew that  
7 something was needed to be done, and I'll explain  
8 why.

9 So we're really at the point, and the  
10 purpose of this hearing is really to bring to the  
11 public this issue of we can either be a waiver state  
12 or we can continue to operate under the Affordable  
13 Care Act as it is currently in law, but it's one or  
14 the other. So you can think of it as a fork in the  
15 road.

16 What we have seen is, and this is national,  
17 we have seen companies, carriers, fleeing the market  
18 because of these increasing rates. Because for a  
19 company you think well, the rates increasing, that  
20 must be good; it's not. And the reason it's not good  
21 is because the healthy population leaves.

22 But consumers are leaving. And especially  
23 what we saw when you look at the demographics of the  
24 people that are in our individual market, we were  
25 seeing slightly increasing numbers between people

1 between 55 and 65, but we were seeing dramatic  
2 decreases in participation between--for individuals  
3 that were in those younger age brackets.

4           So back at the time we started to think  
5 about, well, what can we do in Iowa to address the  
6 problem. We anticipated Congress would act, but  
7 whether or not Congress acts, we don't believe that  
8 some of the things that have been discussed will  
9 really provide an answer for Iowa in 2018.

10           So we went to the carriers. We spoke to  
11 Aetna. We spoke to Medica. We spoke to Gunderson,  
12 which you saw was a small carrier in our state. We  
13 spoke to Wellmark and Medica as well. We talked with  
14 all the carriers.

15           The two carriers that were most interested  
16 in talking further with us were Medica and Wellmark.  
17 And so we discussed with them some of these concepts.  
18 But basically our Stopgap Measure is designed to  
19 stabilize the market by having a standard plan.  
20 There's going to be a short time by which the  
21 companies will be needing to stand up and make this  
22 available for people. It will cover all the  
23 essential health benefits under the current law.

24           Our effort is to redirect the premium tax  
25 credits. It's called, basically, pass-through

1 funding. The funding that's coming in currently in  
2 the form of the advanced premium tax credits can be  
3 redirected in a pass-through. Our belief is we have  
4 several issues to address, which you can see the  
5 bottom bullet is one of the most important, and that  
6 is to address those individuals who really  
7 historically were in the high-risk pool.

8           So part of the pass-through funding would be  
9 to set up a reinsurance mechanism so that we're able  
10 to relieve the insurance companies of the uncertainty  
11 of whether those people move into their particular  
12 pool.

13           And so that is-- We would use some of the  
14 federal mechanisms already in place to go through  
15 HIPIOWA in order to achieve that. The other issue we  
16 needed to address is that issue of age. The  
17 individuals with the mandate, seeing the mandate,  
18 didn't have the effect of persuading young and  
19 healthy folks to underwrite the cost of people that  
20 were outside of their particular risk perspective.

21           You know, people may think differently about  
22 things in the abstract, but when they actually start  
23 evaluating it, consumers are going to evaluate it  
24 based on whether or not the price they're paying is  
25 reflective of the risk they view. And so what was

1 happening is young folks were choosing to not do  
2 that.

3 Our proposal will adjust that in the form of  
4 some age subsidies. But also our thought is to  
5 continue to create some benefit for those individuals  
6 in the lower income spectrum and to do that through  
7 basically a six-banded approach.

8 One of the other issues in our Stopgap  
9 Measure is a requirement to make sure it's guaranteed  
10 issue at the inception. We want everybody to  
11 participate. At the same time, there is a suggestion  
12 in our waiver, proposed in our waiver, to deal with  
13 the issue of people coming in and then leaving.

14 I know that there's been conversation about  
15 this. If you think of it in terms of home ownership.  
16 If we had an insurance system where people could buy  
17 insurance for their house after their house was on  
18 fire, it would be a real challenge for the rest of  
19 the market to say, well, we think that that's a good  
20 system.

21 Well, we saw that. We see that in the way  
22 consumers are behaving. You know, they'll use some  
23 of the special enrollment opportunities to come in  
24 and get insurance when they have some surgery coming  
25 up, and then they leave or they stop paying their

1 premium when they no longer present to be in the  
2 hospital. So our issue with that is to really have  
3 much more limited special enrollment.

4 All right. These are numbers that I wanted  
5 to put in front of you, again, before I take  
6 comments, just so you can see a little bit about what  
7 we're thinking. Now, these numbers are--I would  
8 describe these as estimates. And I do that because  
9 of the fact that one of the problems that we see in  
10 the structure of the--under the Affordable Care Act  
11 is that the distinction between those that are in the  
12 subsidized market and those that are not.

13 And, you know, you can see it's a pretty  
14 dramatic change of circumstance depending on whether  
15 you fall below 400 percent of poverty level or find  
16 yourself above 400 percent poverty level.

17 And I'll start here with the average  
18 55-year-old couple. You can see that under the  
19 current circumstance-- Again, these are estimates,  
20 but these are representative numbers. You can see  
21 under this circumstance, because of the way the  
22 tax--the tax credit structure is built, the--what  
23 people feel if they're in the subsidized segment of  
24 the market is they only feel what is--their income  
25 percentage reflects.

1           So as an example, the 55-year-old couple  
2 with a household income of \$32,000, that puts them at  
3 about 199 percent of federal poverty level. The  
4 silver plan is going to cost, in essence,  
5 \$2,400-a-month, but the maximum that that couple pays  
6 is a percentage of their income, which is  
7 \$173-a-month. So the maximum premium that they  
8 contribute is \$2,000-a-month.

9           But what people may not be recognizing is  
10 that under the current framework of the ACA with this  
11 concentration of individuals with high costs, is that  
12 the actual premium, whether you're at the lower  
13 income level of 199 percent, or you're just above the  
14 400 percent, the actual premium for that couple based  
15 on--again, under the ACA framework, is actually  
16 \$29,000.

17           So for the individual at the lower end, it's  
18 \$173-a-month that they're feeling, and the annual is  
19 \$2,000, but other taxpayers are covering the \$27,000  
20 difference.

21           All right. What that then causes is a real  
22 dramatic--you know, I would call it basically  
23 stepping over the edge of an economic cliff for that  
24 household. But what you see then is that as incomes  
25 in Iowa increase to get people out of the subsidized

1 segment of the market, they no longer have other  
2 taxpayers covering the difference.

3           So for the income-- You can see there's a  
4 very slight difference there between the--between the  
5 \$399 and the \$411. So it's not a dramatic  
6 difference. It's, you know, a couple thousand dollar  
7 difference. But what happens then is you go from a  
8 percentage of income contribution to where the family  
9 that has--the family that is the couple with income  
10 of almost \$67,000, their premium will actually be  
11 \$29,000.

12           So for us as insurance regulators, what's  
13 going to happen, what I see happening, is for the--  
14 assuming that this were to move forward in this  
15 circumstance, we would see dramatic loss of people  
16 that are outside that subsidized market. We don't  
17 know specifically how many people that is, but we do  
18 estimate it to be a substantial number of people, you  
19 know, in that market.

20           Now, these numbers here, again, are  
21 estimates. These are our numbers from the  
22 department. You can see that what we've decided is  
23 based upon what we know about the experience in our  
24 state. We believe these are representative premiums.

25           Now, the companies have not yet filed these,

1 but I wanted to use this, again, just as an example  
2 to show--to explain why our proposal involves a fixed  
3 contribution. Whether or not the income changes,  
4 there is still some--there's still going to be a jump  
5 in premium, but our credits are fixed on a schedule.

6 So you can see our attempt is to reduce.  
7 It's still going to be a change as your income  
8 increases, but the intent is to try to levelize it.  
9 Because what will happen in our state is that if we  
10 lose all of these people, it will be even worse next  
11 year. And part of our responsibility is to try to  
12 find a solution so that we do have an individual  
13 market.

14 All right. I'm going to go to the next one  
15 again, because this is interesting as well when you  
16 start to look at family impact. This is-- We just  
17 picked two 30-year-old parents with twins. And I  
18 like to actually think of there could be another one  
19 on the way. Depending on the birth of that child,  
20 whether it's this year or next year, what that means  
21 for this family.

22 Likewise, you can see the current impact  
23 is--these are very affordable premiums unless you end  
24 up in the unsubsidized structure of the market. In  
25 our state these are, again, a significant number of

1 people. Other states may have differing experiences  
2 than that. Again, you can see that the taxpayers  
3 are--other taxpayers are picking up the difference  
4 between what is the rate as we think will be  
5 occurring under the current ACA if the Stopgap  
6 Measure is not approved.

7 DR. GLEN [REDACTED]: How are you justifying  
8 using two grossly different premiums in this  
9 comparison? That's not a comparison.

10 COMMISSIONER OMMEN: There are a couple of  
11 things at play. First, probably the most important  
12 thing at play is the Stopgap Measure involves a pass-  
13 through funding with about--between \$80 and \$100  
14 million, and we haven't decided exactly what that's  
15 going to look like, in reinsurance.

16 A lot of the risk that the insurers are  
17 facing is they don't know how these really high cost  
18 individuals will move in the market. Again, when I  
19 talk about high cost, I mean exceedingly high costs.  
20 And so a lot of that rate up here is reflecting some  
21 of that risk.

22 But the other piece of it as well is that  
23 the Medica, which has filed-- I really appreciate  
24 the fact that they have filed because it gives us a  
25 really important option. But the experience is that

1 Medica's rates have been higher than some of the  
2 other rates. Now, I think that that has to do with  
3 some of their history within our state. Again,  
4 that's an observation.

5 But I want you to know that these are not  
6 final rates, but I think it's important for people to  
7 see what we're trying to achieve in terms of  
8 levelizing. A big part of it is that reinsurance  
9 piece.

10 DR. GLENN [REDACTED]: Right. But there's a huge  
11 portion that's not accounted for. A portion of  
12 people and payments from somewhere that's not  
13 accounted for in this.

14 COMMISSIONER OMMEN: Okay. What do you mean  
15 by that?

16 DR. GLENN [REDACTED]: This reinsured group.

17 COMMISSIONER OMMEN: Right. Well,  
18 pass-through funding is, I'll just explain that here.  
19 It's in our draft proposal.

20 But when we started in this process we--  
21 Pass-through funding, what that means is for this  
22 calendar year-- And I'll go back to here because  
23 this is really the best place to explain that. I  
24 estimate it's about--again, these are my numbers,  
25 they're supported, but I'm going to estimate it's

1 about \$450 billion in premium to support the market.  
2 We received advance premium tax credits of about \$197  
3 million. So to support this-- Now, again, what  
4 we're talking about is we're talking about support  
5 for the APTC's are only flowing into the blue.

6 But the point of that--the 1332 process  
7 allows us to see pass-through funding so we can take  
8 that money in another manner and use it in another  
9 manner in order to make our market more efficient.

10 The issue with the approval process,  
11 however, is that we have to make an assumption of the  
12 market with and without the waiver. That \$197  
13 million actually resulted in very substantial losses  
14 throughout this market.

15 And so we actually estimate, with Aetna  
16 leaving, which was the lowest rated--the lowest rates  
17 within our market, even to levelize those for  
18 purposes of a market with Medica, Gunderson and  
19 Wellmark, we estimated it to be \$304 million in tax  
20 credits. With Medica only we expect it to be even  
21 higher.

22 So one of the things that we're working  
23 through in this process under 1332 is to establish  
24 the baseline of what are the tax credits that will be  
25 flowing in, and then in turn what is available for

1 reinsurance, as well as for our redistribution of the  
2 age and income tax credits.

3 So, yeah, there is a large amount of federal  
4 money involved in this process.

5 All right. I think I've covered what I  
6 wanted to, and I want to make sure that I leave  
7 plenty of time for questions as well. We did have a  
8 sign-up list so we can make sure those people that  
9 came in who signed up and would like to ask  
10 questions, or offer comments, we address those. I'll  
11 start with that.

12 So Nancy [REDACTED]. Are you here and would  
13 you-- Do you have a question or do you wish to offer  
14 any--

15 MS. NANCY [REDACTED]: I just signed it in case I  
16 had one, but at this point I don't.

17 COMMISSIONER OMMEN: All right. There will  
18 be plenty of time for others to ask questions, but  
19 I'll continue through the list.

20 Glenn [REDACTED].

21 DR. GLENN [REDACTED]: I'm Glenn [REDACTED]. I'm a  
22 family practice physician from Minden, Iowa. I'm  
23 very concerned about the proposal.

24 What it looks like we're putting forward  
25 really takes responsibility off of the payers

1 shoulders and puts the burden back on the taxpayers  
2 and really doesn't accomplish the goal of trying to  
3 attract that young, healthy premium to the system.

4           What this sounds like is, and the AHCA  
5 lacked, that we've taken the proposal that passed  
6 through the House of Representatives that was opposed  
7 by many in the State of Iowa, and tried to now just  
8 bypass getting it federally approved, and we're just  
9 going to implement it here at the state level and see  
10 if we can slide it past everybody. There is very  
11 good reason to be opposed to that type of system.

12           Again, I am opposed to the reinsurance and  
13 the high risk pool. I believe if you are an  
14 insurance company your job is to make--is to accept  
15 risk. If you're going to cut all of the sick people  
16 out of the health insurance, and only enroll those  
17 healthy people who can pay a premium, what are you?  
18 You are not a healthcare provider. You're not  
19 covering any lives.

20           I have lots of patients who come into my  
21 office who are very upset about paying these  
22 premiums, but they're also very worried about losing  
23 the coverage that they've got now. And this type of  
24 program puts us at risk for losing lives.

25           I don't see this attracting young, healthy

1 people to now, well, I'm not going to chip in  
2 \$500-a-month to take care of people over 60. I'm not  
3 going to chip in \$200-a-month either. I'm not going  
4 to chip in \$100-a-month. Why would I chip in  
5 \$100-a-month? Because they aren't going to qualify  
6 for the--to pay the fine. What's it called? The  
7 mandate. They're not going to have to pay the  
8 mandate anyway. 87 percent of the people who don't  
9 get insurance don't have to pay the mandate.

10 So what I would propose is that we really  
11 hold insurance companies responsible for covering  
12 lives and taking care of people.

13 AN UNIDENTIFIED SPEAKER: That's impossible.

14 DR. GLENN [REDACTED]: And that's right, that's  
15 not-- It is--it is impossible.

16 AN UNIDENTIFIED SPEAKER: How could you hold  
17 a private company responsible?

18 DR. GLENN [REDACTED]: Well, we have an insurance  
19 commissioner. We have regulations. And we can  
20 regulate industry. And what I would propose is that  
21 any payer who provides an employee-based plan in this  
22 state must participate in the pool. They must  
23 participate in our individual plans and offer  
24 individual plans.

25 And you can base that on an employer who

1 covers, you know, 15 percent of the market, 20  
2 percent of the market. You put in some regulation  
3 that says these people are not just going to come  
4 in here and gamble on the lives of healthy Iowans.  
5 They're gonna take--if they're gonna be an insurance  
6 company, they're gonna take responsibility for |  
7 lives.

8           The other one is if you've got a group that  
9 has no-- If you've got this group of people who have  
10 no insurance. So those people who pay the mandate,  
11 that money should come back and it should go into a  
12 pool that creates an insurance program for that group  
13 of people.

14           They are automatically enrolled in a, at  
15 least a bronze-level program. Which part of this  
16 already suggests that people have to--they have to  
17 offer a program that allows these people a chance to  
18 buy in at a certain rate, a fair rate.

19           Those people who don't have to pay, who have  
20 a hardship requirement, those people, if they have a  
21 hardship, shouldn't they meet the standard for  
22 Medicaid? So we get people on Medicaid and we get  
23 more lives covered. Because this is about getting  
24 more lives covered.

25           So all of the groups on the market must

1 provide a bronze plan offer at that rate, the rate of  
2 dollars received for--from the mandate divided by the  
3 number of people who are in the state that had to pay  
4 for that mandate. And then we use our federal  
5 reimbursement to create these bronze-level packages.  
6 That's how we define the level.

7           That increases covered lives, it increases  
8 low utilizers into the system because they're  
9 automatically enrolled, and it's an appropriate use  
10 of that shared responsibility payment, and it puts  
11 pressure on the payers to cover lives in Iowa.

12           If they're going to do business here, then  
13 they're going to do business on our terms.

14           Thank you.

15           COMMISSIONER OMMEN: Thank you. Thank you,  
16 Dr. Hurst. I appreciate those comments. That's why  
17 we're here, is to receive those comments and hear  
18 those points--that point of view.

19           Maybe I wasn't really clear on the high risk  
20 piece, the reinsurance piece. That would still fall  
21 within the responsibility of the insurance company,  
22 except for the fact that there would be an attachment  
23 point to--so that individual consumers would stay in  
24 that same selective benefit with that insurance  
25 company, but the large expenses that exceeded certain

1 attachment points would be then generally spread, is  
2 what the reinsurance piece is. As opposed to the  
3 insurance companies being in that position of trying  
4 to guess whether a certain customer or certain  
5 consumer enrolls in that particular plan. And that  
6 has been a problem in our state.

7 I really want to thank you, Doctor, for  
8 those comments.

9 Michelle [REDACTED].

10 MS. MICHELLE [REDACTED]: I guess I didn't  
11 really know I was signing up to ask a question, but I  
12 do have a question.

13 I guess I should be flattered. You talk  
14 about young people that don't want to participate in  
15 the program, or whatever. I am not young and I don't  
16 want to participate in the program. I should have  
17 the right-- I already pay enough property taxes as  
18 it is. I shouldn't be required to buy something I  
19 don't want.

20 I don't have health insurance. I can get it  
21 where I work, but I choose not to have it. It  
22 shouldn't be required. I exercise every stinking  
23 day, I eat right, I don't drink pop, I don't smoke  
24 cigarettes. I take care of my health. I take care  
25 of my life.

1           There are a lot of people out there  
2 who--there are a lot of things they could do to make  
3 their health better, but they choose not to. I'm not  
4 talking about the people who have something really  
5 bad wrong with them, but people can do things to make  
6 their life better than what it is. It's not my fault  
7 that they don't and I shouldn't have to pay that  
8 penalty.

9           I've had to pay it for the last two years, I  
10 think. I shouldn't have to pay for it. If people  
11 want to have health insurance, then let them have it,  
12 but I don't want to have it and I shouldn't have to  
13 have it.

14           I mean, what's going on with the  
15 Republicans, you know? They were trying to get rid  
16 of it. Don't make me pay for something I don't want.  
17 I don't tell you, you, or you that you can or you  
18 can't do this, so don't tell me what I can and can't  
19 do.

20           COMMISSIONER OMMEN: Thank you for those  
21 comments.

22           Again, that mandate is in federal law. But  
23 I really do appreciate those comments.

24           MS. MICHELLE [REDACTED]: There are a lot of  
25 people out there, and someone, even in my family, who

1 get a lot of assistance. They tell me about every  
2 time they go to the doctor they get probed and  
3 prodded on. They get sent in for this test and that  
4 test. And I don't think they need it. I mean, I  
5 think it's a big scam going on. It's unbelievable.

6 COMMISSIONER OMMEN: Thank you very much.

7 Joy [REDACTED].

8 MS. JOY [REDACTED]: My husband and I are  
9 60. We can retire in two years, but we won't be able  
10 to afford that kind of insurance, \$29,000-a-year.  
11 No. So what do we do? That means one of us needs to  
12 keep working and not enjoy our retirement. We've  
13 been working since we were 15, both of us. It's  
14 like--it's so tilted against us.

15 COMMISSIONER OMMEN: And, again, that's one  
16 of the reasons why we need an individual market and  
17 we need an individual market that actually reflects  
18 what you view as your risk. That's why we're trying  
19 to move forward.

20 The Stopgap Measure is not perfect, and I  
21 don't want to suggest that it's perfect. There  
22 clearly are differences of opinion. But I also know  
23 the current ACA market is going to put us in a much  
24 worse place next year, and I fear that.

25 That is not in any way a criticism of the

1 carrier, a willing carrier that has stepped forward  
2 to make sure we have something. But I think we will  
3 see some very severe adverse selections, which will  
4 put us in a worse place if Congress doesn't act.

5 That's the reason we put forward the Stopgap  
6 Measure. That's why I'm here to hear that--to hear  
7 these comments.

8 MS. JOY [REDACTED]: We work so hard to put  
9 money away in different retirement accounts. If we  
10 have to pay \$29,000 that would be like buying a brand  
11 new nice car every year. We'll have nothing.

12 AN UNIDENTIFIED SPEAKER: And that doesn't  
13 include the deductible. That's just, you know--

14 COMMISSIONER OMMEN: That's actually a very  
15 good comment. I want to come back to you on that.  
16 You are correct, it does not include the deductible.  
17 The deductibles are \$7,000 on the silver plan.

18 DR. GLENN [REDACTED]: None of these make sense  
19 in terms of dollars. You're not going to spend any  
20 of this amount of dollars paying out-of-pocket coming  
21 to a physician's office and getting general  
22 healthcare. You are not going to spend  
23 \$29,000-a-year unless it's time for a heart cath, or  
24 some other major medical issue.

25 You are paying more than you would pay

1 out-of-pocket going to the office. Insurance makes  
2 almost no sense.

3 MS. JOY [REDACTED]: My husband has already  
4 had quadruple bypass and a stent, so I know the  
5 costs.

6 DR. GLENN [REDACTED]: Right.

7 COMMISSIONER OMMEN: Thank you very much.  
8 I'm happy to go to you now.

9 If you could, for the record, if you could  
10 just identify yourself as we make the record.

11 MS. NANCY [REDACTED]: Okay. I'm Nancy Cohen.  
12 And I was just going to clarify the question.  
13 Because under this proposal her cost next year would  
14 be \$16,208.64, or estimated about that; is that  
15 correct?

16 COMMISSIONER OMMEN: Okay. Again, where is  
17 this?

18 MS. NANCY [REDACTED]: Well, she's talking about  
19 a premium payment of \$29,000. And I was just wanting  
20 to clarify that under the stopgap proposal she would  
21 be looking at a premium payment of \$16,000.

22 COMMISSIONER OMMEN: That is correct.

23 MS. NANCY [REDACTED]: Which is still high, but I  
24 guess I just wanted to clarify that the proposal  
25 would bring it down, estimated, by a significant

1 amount.

2 COMMISSIONER OMMEN: That is correct. And  
3 that's the--that would be the household premium.  
4 Yes, that is correct.

5 MS. NANCY [REDACTED]: That was just a  
6 clarification.

7 COMMISSIONER OMMEN: And, again, that's why  
8 I said, this is stopgap. We do need Congress to act.  
9 Yes. There's another question or comment.

10 MS. MARTI [REDACTED]: My name is Marti  
11 Nerenstone and I intend to submit comments both as an  
12 attorney for a lot of folks who are affected, as well  
13 as my personal story.

14 When I had a catastrophic medical event I  
15 got thrown off of insurance, had to go to HIPIOWA,  
16 and now under the ACA paying full payer for a bronze  
17 plan.

18 I have a couple of questions. One is, one  
19 of the issues that I found this year between Medica  
20 and Aetna was that medical provider choice and how  
21 does this affect that. Because a lot of us doctor  
22 across the river in Omaha where the specialists are.

23 And then I have another question if you  
24 could answer that.

25 COMMISSIONER OMMEN: Certainly. Yes. I

1 mean, one of the reasons why we believe that a fixed  
2 subsidy-- Again, I recognize we still have, clearly,  
3 issues here. But one reason a fixed subsidy actually  
4 makes more sense is that if you are making a choice,  
5 for those that want to find a lower rate, they may be  
6 willing to give some--you know, it's that individual  
7 choice part of it--they may be willing to give some  
8 of the--give away a little bit of access.

9           And, you know, that's something that we saw  
10 with Aetna. They had a tiered network, some people  
11 were good with that because their rate would be  
12 lower. But what the fixed subsidy would do is it  
13 would allow those people in the market that are down,  
14 that are getting a fixed rate, to actually see the  
15 benefit of that.

16           See, one of the things that happened under  
17 the ACA is consumers, if they're only being asked to  
18 contribute a percentage of income, they become  
19 agnostic to the rate, and, therefore, they are more  
20 likely to pick the network that's the richer network.

21           That is an issue that we are attempting to  
22 address in the Stopgap Measure. Because there were  
23 other things under the ACA that would then make it  
24 more difficult for a company with a tighter network  
25 and lower rates in order to compete.

1           But, yes, I understand. The Stopgap Measure  
2 would allow you to pick from whatever carriers are in  
3 the market, you would be able to actually get the  
4 benefit of a lower rate, and you would weigh that  
5 then against your decision over which carrier has the  
6 network that best fits your needs.

7           MS. MARTI [REDACTED]: I guess my overall  
8 question is, why aren't you all thinking outside the  
9 box? The purpose of insurance is to make money. I  
10 would like your coverage, or the coverage of the  
11 legislature, or the coverage of the governor, or let  
12 us all pay into Medicare or Medicaid instead of  
13 paying private insurance companies.

14           I think that, you know, everybody-- You  
15 need to think outside the box so that--so that we're  
16 not paying into--into somebody's profit to make  
17 shareholders richer.

18           I don't understand either at the federal  
19 level, and I know you are not the feds, but at the  
20 state level, why can't we who are not--who are not  
21 insurable, because somebody decided we're not  
22 insurable, for whatever reason, not because we were  
23 irresponsible, pay into whatever is being covered by  
24 state employees or the state legislature.

25           COMMISSIONER OMMEN: Again, I'm not elected.

1 I have no vote on that issue. But at the same time I  
2 appreciate that comment.

3           What I would offer to you is that we have--  
4 out of three million people in our state, we have  
5 over half of our population in group coverage. Those  
6 individuals are accessing shared risk through that  
7 employer-based system.

8           I know that doesn't solve it for the 72,000  
9 that are dramatically being impacted in our  
10 individual market. I think that there are some  
11 changes that are being considered that actually could  
12 solve that part of that problem.

13           As for the insurance companies, you do need  
14 to know that although Aetna is publicly traded and  
15 they're dealing with investors, the companies that  
16 are still participating and have stepped forward to  
17 try to help us solve our problem in 2018, they're  
18 not.

19           Wellmark is a blue plan, but it's a mutual  
20 company, which means it's owned by the people that  
21 are participating. Medica is a nonprofit insurance  
22 company. They're a regional carrier up in Minnesota.  
23 You know, I don't know what they pay their CEO, but I  
24 guess I would just offer to you that it's a  
25 nonprofit. It's the nonprofits and the mutual

1 companies that have stayed in the game with us here  
2 in this part of the country.

3 I know that there is a desire to try to  
4 change the laws. I encourage citizens to get  
5 engaged, get involved and go make those changes. The  
6 purpose of my presentation today is to try to address  
7 a problem that I see in our market in 2018, and  
8 that's-- But I thank you for those comments.

9 MS. MARTI [REDACTED]: Finally, I don't know  
10 who created this or who is on your committee. Do you  
11 have people on your committee who are actually in the  
12 market, who are on ACA?

13 COMMISSIONER OMMEN: Okay. I'm not sure  
14 exactly that I'm understanding. You mean people that  
15 actually are in the midst of--that are experiencing  
16 what's happening?

17 MS. MARTI [REDACTED]: Right.

18 COMMISSIONER OMMEN: Well, my hope is that  
19 some people in here may be in the midst of that and  
20 share that.

21 Yes, we do. I had a meeting this morning  
22 with some individuals. There was one individual in  
23 that meeting. That individual is a professional.  
24 They serve, you know, in a professional capacity.  
25 But they operate in an environment where they are

1 alone. And so the individual market needs to be  
2 available for that 57, or whatever, year-old  
3 individual.

4 But as for helping shape that, that's the  
5 purpose of these public comments.

6 MS. MARTI [REDACTED]: So are you talking to  
7 the federal legislature?

8 COMMISSIONER OMMEN: Our-- We have been  
9 asked to go and speak to our congressional delegation  
10 and our senators, and we have. They have this  
11 information.

12 The issues at the federal legislative level  
13 are clearly out of my hands. I'm a state regulator.

14 Again, thank you for those comments.

15 Diane [REDACTED]. Yes.

16 MS. DIANE [REDACTED]: I do have a question on  
17 the federal waiver that you're talking about. So you  
18 have to have the federal government-- Let's see.  
19 How do I want to say this? If you request a waiver,  
20 they have to what, is that voted on by whom to get a  
21 waiver for the State of Iowa to, you know, start this  
22 program, whatever?

23 COMMISSIONER OMMEN: That's a very good  
24 question. The federal government, under the  
25 Affordable Care Act, has the authority to permit

1 innovation at the state level. This waiver process  
2 was not designed to deal with crisis management. At  
3 the same time, it's the best available tool that we  
4 view that we have.

5 Yes, we have to get permission. This  
6 comment period is part of getting that permission.

7 MS. DIANE [REDACTED]: And who gives permission,  
8 Congress?

9 COMMISSIONER OMMEN: It's given by-- It's a  
10 decision that's ultimately made by the Secretary of  
11 Health, which is Secretary Price, and I think the  
12 other secretary--Treasury Secretary Mnuchin.

13 MS. DIANE [REDACTED]: And that can be  
14 implemented before the enrollment period, November  
15 1st?

16 COMMISSIONER OMMEN: Yes. We believe it  
17 will be and can be approved by that--within that time  
18 frame.

19 We're working with the carriers to try to  
20 make sure that can be done. Now, you have to  
21 understand that the federal government can still say  
22 no, and they may say no, because we, as a state,  
23 can't do anything without their permission. But at  
24 the same time, we will be completing an economic  
25 analysis, which is still not yet out, which I would

1 encourage you to go online.

2 Even this comment period today is not  
3 intended to be your final moment of giving comments.  
4 It will run for a period of time. It will exceed 30  
5 days. During that time we will receive an economic  
6 analysis, which will do a better job than I ever  
7 could do today, in comparing the world in Iowa with  
8 the waiver versus without the waiver.

9 I would encourage you to go online to review  
10 it, to think about it and offer comments about it.  
11 But that will impact the decision by the federal  
12 government.

13 MS. DIANE [REDACTED]: So Wellmark is  
14 considering, if the waiver would come about, whether  
15 they're going to--they would then decide that they  
16 are going to be in the market then?

17 COMMISSIONER OMMEN: Yes. Under current law  
18 the carrier, the one carrier that we still--

19 MS. DIANE [REDACTED]: Medica.

20 COMMISSIONER OMMEN: We're very appreciative  
21 of Medica.

22 MS. DIANE [REDACTED]: But they're going to go  
23 up 43 percent; correct?

24 COMMISSIONER OMMEN: Pardon?

25 MS. DIANE [REDACTED]: They're going to raise

1 their premium 43 percent?

2 COMMISSIONER OMMEN: It's an average of 43  
3 percent. So for some people it will not be 43  
4 percent, some people it will be more than 43 percent.  
5 It depends on where you are found in that market.

6 Again, they're filing under current law, and  
7 some of the current questions about what was going to  
8 happen. So, I mean, I guess I don't want to in any  
9 way minimize that filing. But I do believe it  
10 presents some problems for us going--certainly in  
11 this year for families that are sitting around the  
12 kitchen table trying to figure out how they're going  
13 to get insured.

14 They are going to probably have that problem  
15 anyway, but the Stopgap Measure, I think, will make  
16 it a better discussion for a lot of families.

17 Anyway, back to answer your question. In  
18 terms of the permission, we have to go to the federal  
19 government to get the permission. The carriers have  
20 already expressed to us a desire to participate.  
21 Wellmark has publicly committed to participate.

22 Under the ACA even the current carrier that  
23 has filed, if things don't go--look like it's  
24 something they want to move forward in, they can step  
25 back. Now, they've committed that they intend to,

1 but there's still a lot of uncertainty federally as  
2 to what it's going to mean for that carrier. I think  
3 that's part of the problem, is we look at this market  
4 and we see a lot of losses there. And so, you know,  
5 carriers have to evaluate, they have to evaluate  
6 shore term and long term. Short term is can they  
7 absorb more losses and then what's that going to mean  
8 going forward.

9 Any further questions or comments?

10 Yes, ma'am. If you could just identify  
11 yourself.

12 MS. SUSAN [REDACTED]: Susan [REDACTED]. If this  
13 is not approved, or if further estimates make it look  
14 unfavorable for Medica, or any other insurance  
15 company, and they subsequently choose not to remain  
16 in the market, what happens next year when there is  
17 no plan?

18 COMMISSIONER OMMEN: Again, I'm not going to  
19 answer that because I insist that there will be  
20 coverage. I mean, it's just not acceptable for there  
21 to not be coverage. But I think that we really face  
22 a challenge. And so I'm not going to answer that  
23 question.

24 I mean, I think we need to get to a place  
25 where we have coverage and it's available to

1 everyone. People can choose to not participate, but  
2 it needs to be available. We need an individual  
3 market.

4 I mean, the other discussions, you know, are  
5 significant, they're important, but they won't impact  
6 2018.

7 MS. SUSAN [REDACTED]: If I may rephrase the  
8 question then. In other states where there are no  
9 carriers or other counties where there are no  
10 carriers, what has happened in those areas? Has the  
11 federal government allowed catastrophic only plans to  
12 be sold? What sort of provisions have been made for  
13 people nationwide who do not have a carrier in their  
14 location?

15 COMMISSIONER OMMEN: There are other states  
16 that are struggling with no carriers in some areas.  
17 I mean, we're back on the list that we have a  
18 carrier, but there are some states that don't. And  
19 those states, they're trying to find different ways.  
20 I know in Missouri, there were a number of states,  
21 and they were able to persuade a Medicaid carrier to  
22 write.

23 I mean, again, it's really hard to know  
24 exactly how that's going to play out. Nevada is  
25 facing some issues. Ohio is facing issues. Indiana

1 is facing issues as well. And there are other states  
2 that I think once we see rates start coming in,  
3 you're gonna see a reaction.

4 All right. Any further comments or  
5 questions?

6 MR. TODD [REDACTED]: My name is Todd [REDACTED].  
7 The only thing-- I really-- We pay, you know,  
8 individual, and we're pretty doggone close to that  
9 age right there. We're paying probably about  
10 \$22,000, \$23,000-a-year right now. We're tapped out.  
11 Can't do it anymore. If it goes up even further,  
12 \$30,000 is--it's not a program.

13 And that's one thing I would like you to,  
14 you know, take back with you. It's just-- You don't  
15 have the money to, you know, allocate that much to  
16 health insurance. Especially with the large--like a  
17 \$7,000 deductible. Because that puts your  
18 maximum--your out-of-pocket already at \$36,000, if  
19 I'm just doing some rough math.

20 If you're making \$66,000, that's over half  
21 of your income. It doesn't count your house payment,  
22 doesn't count your taxes. That's before tax income,  
23 that's not after tax income. It doesn't work. It  
24 just--it really doesn't.

25 You know, we don't qualify for the--we're

1 fortunate for that, we don't qualify for the  
2 subsidies, but we're not at that point where--you  
3 know, it's such a huge chunk now that what I think is  
4 going to happen, and we've talked about it even this  
5 last year, is we may have to drop out because we  
6 can't afford it. So you will lose people just based  
7 on they can't afford it anymore.

8 COMMISSIONER OMMEN: Yeah, I think that's  
9 what we're going to see in our economic analysis, is  
10 that we have had young folks depart. We will now see  
11 healthy people depart.

12 That is the cratering of the market. When  
13 you're only left with people who are sick, it's not a  
14 market. And that's--you know, that's what's  
15 happening with these rates. So it has to be  
16 addressed. And I'll repeat it here, not that people  
17 in Congress are listening, but we need the rules  
18 reset. Because a commercial market can work, but  
19 it's been--it's started to be very stressed with  
20 putting individuals with higher risk into the  
21 individual market and then asking you alone to cover  
22 that. That's the challenge, is that it needs to  
23 be--those costs need to be covered.

24 MS. MARTI [REDACTED]: In that situation,  
25 would the state consider resurrecting HIPIOWA?

1           COMMISSIONER OMMEN:   HIPIOWA, we never  
2 eliminated.   HIPIOWA is still there to deal with  
3 catastrophic circumstances.   And so people that are  
4 in the midst, even in a collapsing market, will still  
5 have access to that.   But that's not an answer for a  
6 lot of people that are generally healthy and they're  
7 trying to keep themselves protected from a serious  
8 event that they don't yet see, which is what  
9 insurance was designed to be.

10           I mean, I think that you've got to kind of  
11 keep that in mind.   We're talking about 72,000, and  
12 literally I would say that the vast majority of the  
13 costs in that pool of 72,000 is about 4,000 people.  
14 But the insurance has to be available to both the  
15 65,000 and the 4,000.

16           It's just a question of if you are in a  
17 persistent circumstance and your costs are very high,  
18 how is it that you deal with that.   Because a lot of  
19 people may come in and out of good and bad health  
20 circumstances, but there are people with chronic  
21 conditions that don't.   And so we have to have a  
22 better system.   I think you're hearing those  
23 conversations about reinsurance, which is more  
24 generally funded, as a way to do that.   That's part  
25 of our proposal.

1 Other questions?

2 DR. GLENN [REDACTED]: I just-- As we're  
3 wrapping up here, it sounds like the conversation  
4 that we're all having here is about how do we--how do  
5 we help insurance companies exist and cover our  
6 lives, and they've got us talking about how do we pay  
7 \$29,000-a-year for them to cover us for a possible  
8 medical condition versus talking about how do we  
9 ratchet down healthcare costs, like this nice lady in  
10 the back shared. How do we ratchet down abuses and  
11 costs and the skyrocketing charges.

12 Because the problem-- They're diverting us  
13 from the problem. The problem is that we all need  
14 healthcare. Everybody is going to need healthcare.  
15 Eventually every one of us is going to have some  
16 healthcare need and everybody should have that  
17 option.

18 So if we get the insurance companies out of  
19 the way and get everybody covered, all lives in this  
20 country covered, Medicare for all, then we can talk  
21 about healthcare. Then we can talk about healthcare  
22 costs and save us all that much.

23 UNIDENTIFIED SPEAKER: Amen. Single payer  
24 is the answer.

25 COMMISSIONER OMMEN: Again, I appreciate

1 those comments. And I think we are ready to conclude  
2 the hearing.

3 So, again, I don't want to turn anyone away  
4 with the opportunity to offer a comment, but not  
5 seeing any further hands, I think we can go off the  
6 record.

7 I want to thank you all for coming and for  
8 offering your thoughts on this project. Thank you  
9 very much for being here.

10 (Hearing concluded at 6:25 p.m.)

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## 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 7th day of August, 2017.

  
CERTIFIED SHORTHAND REPORTER

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| <b>\$</b>   | <b>30-year-old</b> [1] - 16:17<br><b>35</b> [1] - 2:5<br><b>39</b> [1] - 2:6   | 8:14, 8:16, 31:8, 43:5<br><b>accessing</b> [1] - 33:6<br><b>accomplish</b> [1] - 21:2<br><b>accounted</b> [2] - 18:11, 18:13<br><b>accounts</b> [1] - 28:9<br><b>achieve</b> [2] - 11:15, 18:7<br><b>act</b> [3] - 10:6, 28:4, 30:8<br><b>Act</b> [6] - 4:20, 6:12, 6:13, 9:13, 13:10, 35:25<br><b>acts</b> [1] - 10:7<br><b>actual</b> [2] - 14:12, 14:14<br><b>add</b> [1] - 7:4<br><b>added</b> [1] - 4:25<br><b>address</b> [7] - 10:5, 11:4, 11:6, 11:16, 20:10, 31:22, 34:6<br><b>addressed</b> [1] - 42:16<br><b>adequate</b> [1] - 7:12<br><b>adjust</b> [1] - 12:3<br><b>advance</b> [1] - 19:2<br><b>advanced</b> [1] - 11:2<br><b>adverse</b> [2] - 7:15, 28:3<br><b>advise</b> [1] - 8:4<br><b>Aetna</b> [9] - 8:3, 8:7, 8:17, 9:4, 10:11, 19:15, 30:20, 31:10, 33:14<br><b>affect</b> [1] - 30:21<br><b>affected</b> [1] - 30:12<br><b>afford</b> [4] - 5:15, 27:10, 42:6, 42:7<br><b>Affordable</b> [6] - 4:19, 6:12, 6:13, 9:12, 13:10, 35:25<br><b>affordable</b> [1] - 16:23<br><b>age</b> [5] - 10:3, 11:16, 12:4, 20:2, 41:9<br><b>aggregate</b> [1] - 8:25<br><b>agnostic</b> [1] - 31:19<br><b>agriculture</b> [1] - 6:6<br><b>AHCA</b> [1] - 21:4<br><b>allocate</b> [1] - 41:15<br><b>allow</b> [3] - 6:25, 31:13, 32:2<br><b>allowed</b> [1] - 40:11<br><b>allows</b> [2] - 19:7, 23:17<br><b>almost</b> [2] - 15:10, 29:2<br><b>alone</b> [2] - 35:1, 42:21<br><b>amen</b> [1] - 44:23<br><b>amount</b> [3] - 20:3, 28:22, 30:4 | <b>AN</b> [3] - 22:13, 22:16, 28:12<br><b>analysis</b> [3] - 36:25, 37:6, 42:9<br><b>ANN</b> [1] - 1:25<br><b>annual</b> [1] - 14:18<br><b>answer</b> [7] - 10:9, 30:24, 38:17, 39:19, 39:22, 43:5, 44:24<br><b>anticipated</b> [1] - 10:6<br><b>anyway</b> [3] - 22:8, 38:15, 38:17<br><b>appreciate</b> [6] - 4:17, 17:23, 24:16, 26:23, 33:2, 44:25<br><b>appreciative</b> [2] - 3:4, 37:20<br><b>approach</b> [1] - 12:7<br><b>appropriate</b> [1] - 24:9<br><b>approval</b> [1] - 19:10<br><b>approved</b> [4] - 17:6, 21:8, 36:17, 39:13<br><b>APTC's</b> [1] - 19:5<br><b>areas</b> [2] - 40:10, 40:16<br><b>assistance</b> [1] - 27:1<br><b>assuming</b> [1] - 15:14<br><b>assumption</b> [1] - 19:11<br><b>attachment</b> [2] - 24:22, 25:1<br><b>attempt</b> [1] - 16:6<br><b>attempting</b> [1] - 31:21<br><b>attorney</b> [1] - 30:12<br><b>attract</b> [1] - 21:3<br><b>attracting</b> [1] - 21:25<br><b>authority</b> [1] - 35:25<br><b>automatically</b> [2] - 23:14, 24:9<br><b>available</b> [8] - 5:4, 10:22, 19:25, 35:2, 36:3, 39:25, 40:2, 43:14<br><b>Avenue</b> [1] - 1:7<br><b>average</b> [2] - 13:17, 38:2<br><b>aware</b> [1] - 9:3 | 1:12<br><b>behaving</b> [1] - 12:22<br><b>belief</b> [1] - 11:3<br><b>below</b> [1] - 13:15<br><b>benefit</b> [4] - 12:5, 24:24, 31:15, 32:4<br><b>benefits</b> [1] - 10:23<br><b>best</b> [3] - 18:23, 32:6, 36:3<br><b>better</b> [5] - 26:3, 26:6, 37:6, 38:16, 43:22<br><b>between</b> [10] - 8:10, 9:25, 10:1, 10:2, 13:11, 15:4, 17:4, 17:13, 30:19<br><b>big</b> [2] - 18:8, 27:5<br><b>billion</b> [1] - 19:1<br><b>birth</b> [1] - 16:19<br><b>bit</b> [3] - 3:13, 13:6, 31:8<br><b>block</b> [4] - 6:3, 6:4, 6:14, 6:17<br><b>blue</b> [4] - 4:24, 8:12, 19:5, 33:19<br><b>Bluffs</b> [2] - 1:6, 1:7<br><b>bottom</b> [1] - 11:5<br><b>bought</b> [1] - 8:2<br><b>box</b> [2] - 32:9, 32:15<br><b>brackets</b> [1] - 10:3<br><b>brand</b> [1] - 28:10<br><b>briefly</b> [1] - 3:7<br><b>bring</b> [3] - 5:15, 9:10, 29:25<br><b>bronze</b> [4] - 23:15, 24:1, 24:5, 30:16<br><b>bronze-level</b> [2] - 23:15, 24:5<br><b>BUCHHOLZ</b> [1] - 26:24<br><b>Bucholz</b> [2] - 2:3, 25:9<br><b>BUCHOLZ</b> [1] - 25:10<br><b>built</b> [1] - 13:22<br><b>bullet</b> [1] - 11:5<br><b>burden</b> [1] - 21:1<br><b>business</b> [2] - 24:12, 24:13<br><b>buy</b> [3] - 12:16, 23:18, 25:18<br><b>buying</b> [1] - 28:10<br><b>bypass</b> [2] - 21:8, 29:4 |
| <b>1</b>  | <b>60</b> [2] - 22:2, 27:9<br><b>65</b> [1] - 10:1<br><b>65,000</b> [1] - 43:15<br><b>6:25</b> [1] - 45:10   | <b>B</b>   | <b>background</b> [1] - 3:13<br><b>bad</b> [2] - 26:5, 43:19<br><b>banded</b> [1] - 12:7<br><b>base</b> [1] - 22:25<br><b>based</b> [7] - 3:24, 11:24, 14:14, 15:23, 22:21, 33:7, 42:6<br><b>baseline</b> [1] - 19:24<br><b>become</b> [1] - 31:18<br><b>BEFORE</b> [2] - 1:1,   |  |
| <b>100-a-month</b> [2] - 22:4, 22:5<br><b>1332</b> [2] - 19:6, 19:23<br><b>144,000</b> [1] - 4:25<br><b>15</b> [2] - 23:1, 27:13<br><b>173-a-month</b> [2] - 14:7, 14:18<br><b>18,20,28,44</b> [1] - 2:3<br><b>19</b> [1] - 1:8<br><b>199</b> [2] - 14:3, 14:13<br><b>1st</b> [1] - 36:15 | <b>7</b><br><b>72,000</b> [3] - 33:8, 43:11, 43:13   | <b>8</b><br><b>87</b> [1] - 22:8   | <b>C</b><br><b>calendar</b> [1] - 18:22<br><b>capacity</b> [1] - 34:24<br><b>car</b> [1] - 28:11<br><b>care</b> [6] - 4:12, 4:16, 22:2, 22:12, 25:24<br><b>Care</b> [6] - 4:19, 6:12, 6:13, 9:13, 13:10,   |  |
| <b>2</b>  | <b>A</b><br><b>able</b> [7] - 3:23, 4:15, 8:14, 11:9, 27:9, 32:3, 40:21<br><b>above-entitled</b> [1] - 1:10<br><b>absorb</b> [1] - 39:7<br><b>abstract</b> [1] - 11:22<br><b>abuses</b> [1] - 44:10<br><b>ACA</b> [23] - 3:16, 4:3, 4:5, 4:19, 5:12, 5:13, 5:18, 5:24, 6:2, 6:18, 6:19, 7:23, 8:5, 9:1, 14:10, 14:15, 17:5, 27:23, 30:16, 31:17, 31:23, 34:12, 38:22<br><b>ACA-compliant</b> [4] - 6:18, 6:19, 7:23, 8:5<br><b>accept</b> [1] - 21:14<br><b>acceptable</b> [1] - 39:20<br><b>accepting</b> [1] - 3:10<br><b>access</b> [5] - 3:24, | <b>8</b><br><b>87</b> [1] - 22:8   | <b>background</b> [1] - 3:13<br><b>bad</b> [2] - 26:5, 43:19<br><b>banded</b> [1] - 12:7<br><b>base</b> [1] - 22:25<br><b>based</b> [7] - 3:24, 11:24, 14:14, 15:23, 22:21, 33:7, 42:6<br><b>baseline</b> [1] - 19:24<br><b>become</b> [1] - 31:18<br><b>BEFORE</b> [2] - 1:1,   |  |
| <b>3</b>  | <b>30</b> [1] - 37:4<br><b>30,42</b> [1] - 2:5   | <b>8</b><br><b>87</b> [1] - 22:8   | <b>background</b> [1] - 3:13<br><b>bad</b> [2] - 26:5, 43:19<br><b>banded</b> [1] - 12:7<br><b>base</b> [1] - 22:25<br><b>based</b> [7] - 3:24, 11:24, 14:14, 15:23, 22:21, 33:7, 42:6<br><b>baseline</b> [1] - 19:24<br><b>become</b> [1] - 31:18<br><b>BEFORE</b> [2] - 1:1,   |  |

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|  |   |   |  |   |
|--|---|---|--|---|
| <p>35:25<br/> <b>carrier</b> [15] - 7:25,<br/> 8:20, 9:2, 10:12,<br/> 28:1, 32:5, 33:22,<br/> 37:18, 38:22, 39:2,<br/> 40:13, 40:18, 40:21<br/> <b>carriers</b> [12] - 4:4,<br/> 9:17, 10:10, 10:14,<br/> 10:15, 32:2, 36:19,<br/> 38:19, 39:5, 40:9,<br/> 40:10, 40:16<br/> <b>case</b> [1] - 20:15<br/> <b>catastrophic</b> [3] -<br/> 30:14, 40:11, 43:3<br/> <b>cath</b> [1] - 28:23<br/> <b>causes</b> [1] - 14:21<br/> <b>CEO</b> [1] - 33:23<br/> <b>certain</b> [4] - 23:18,<br/> 24:25, 25:4<br/> <b>certainly</b> [2] - 30:25,<br/> 38:10<br/> <b>CERTIFIED</b> [1] - 1:25<br/> <b>challenge</b> [3] - 12:18,<br/> 39:22, 42:22<br/> <b>challenges</b> [1] - 4:8<br/> <b>chance</b> [1] - 23:17<br/> <b>change</b> [4] - 4:5,<br/> 13:14, 16:7, 34:4<br/> <b>changed</b> [1] - 8:7<br/> <b>changes</b> [3] - 16:3,<br/> 33:11, 34:5<br/> <b>charges</b> [1] - 44:11<br/> <b>charging</b> [1] - 7:11<br/> <b>child</b> [1] - 16:19<br/> <b>chip</b> [4] - 22:1, 22:3,<br/> 22:4<br/> <b>choice</b> [3] - 30:20,<br/> 31:4, 31:7<br/> <b>choose</b> [4] - 25:21,<br/> 26:3, 39:15, 40:1<br/> <b>choosing</b> [1] - 12:1<br/> <b>chronic</b> [2] - 7:1,<br/> 43:20<br/> <b>chunk</b> [1] - 42:3<br/> <b>cigarettes</b> [1] - 25:24<br/> <b>circumstance</b> [7] -<br/> 4:16, 7:5, 13:14,<br/> 13:19, 13:21, 15:15,<br/> 43:17<br/> <b>circumstances</b> [3] -<br/> 3:25, 43:3, 43:20<br/> <b>citizens</b> [2] - 3:23,<br/> 34:4<br/> <b>clarification</b> [1] - 30:6<br/> <b>clarify</b> [3] - 29:12,<br/> 29:20, 29:24<br/> <b>clear</b> [1] - 24:19<br/> <b>clearly</b> [3] - 27:22,<br/> 31:2, 35:13<br/> <b>cliff</b> [1] - 14:23</p> | <p><b>climbing</b> [1] - 7:16<br/> <b>close</b> [1] - 41:8<br/> <b>closed</b> [3] - 6:3, 6:13,<br/> 6:16<br/> <b>COHEN</b> [5] - 20:15,<br/> 29:11, 29:18, 29:23,<br/> 30:5<br/> <b>Cohen</b> [3] - 2:4, 20:12,<br/> 29:11<br/> <b>collapsing</b> [1] - 43:4<br/> <b>color</b> [2] - 4:17<br/> <b>combination</b> [1] - 3:25<br/> <b>coming</b> [6] - 11:1,<br/> 12:13, 12:24, 28:20,<br/> 41:2, 45:7<br/> <b>comment</b> [6] - 28:15,<br/> 30:9, 33:2, 36:6,<br/> 37:2, 45:4<br/> <b>comments</b> [19] - 3:5,<br/> 3:9, 13:6, 20:10,<br/> 24:16, 24:17, 25:8,<br/> 26:21, 26:23, 28:7,<br/> 30:11, 34:8, 35:5,<br/> 35:14, 37:3, 37:10,<br/> 39:9, 41:4, 45:1<br/> <b>commercial</b> [4] - 5:7,<br/> 5:11, 5:12, 42:18<br/> <b>COMMISSIONER</b> [33]<br/> - 1:1, 3:2, 17:10,<br/> 18:14, 18:17, 20:17,<br/> 24:15, 26:20, 27:6,<br/> 27:15, 28:14, 29:7,<br/> 29:16, 29:22, 30:2,<br/> 30:7, 30:25, 32:25,<br/> 34:13, 34:18, 35:8,<br/> 35:23, 36:9, 36:16,<br/> 37:17, 37:20, 37:24,<br/> 38:2, 39:18, 40:15,<br/> 42:8, 43:1, 44:25<br/> <b>commissioner</b> [2] -<br/> 3:3, 22:19<br/> <b>Commissioner</b> [1] -<br/> 1:12<br/> <b>committed</b> [2] - 38:21,<br/> 38:25<br/> <b>committee</b> [2] - 34:10,<br/> 34:11<br/> <b>companies</b> [13] - 7:10,<br/> 9:17, 10:21, 11:10,<br/> 15:25, 22:11, 25:3,<br/> 32:13, 33:13, 33:15,<br/> 34:1, 44:5, 44:18<br/> <b>company</b> [11] - 8:4,<br/> 9:19, 21:14, 22:17,<br/> 23:6, 24:21, 24:25,<br/> 31:24, 33:20, 33:22,<br/> 39:15<br/> <b>comparing</b> [1] - 37:7<br/> <b>comparison</b> [2] - 17:9<br/> <b>compete</b> [1] - 31:25</p> | <p><b>completing</b> [1] - 36:24<br/> <b>compliant</b> [4] - 6:18,<br/> 6:19, 7:23, 8:5<br/> <b>compromise</b> [1] - 5:24<br/> <b>concentrated</b> [1] - 9:2<br/> <b>concentration</b> [1] -<br/> 14:11<br/> <b>concept</b> [1] - 4:19<br/> <b>concepts</b> [1] - 10:17<br/> <b>concern</b> [1] - 8:6<br/> <b>concerned</b> [2] - 9:1,<br/> 20:23<br/> <b>conclude</b> [1] - 45:1<br/> <b>concluded</b> [1] - 45:10<br/> <b>condition</b> [1] - 44:8<br/> <b>conditions</b> [4] - 4:11,<br/> 6:25, 7:1, 43:21<br/> <b>Congress</b> [6] - 10:6,<br/> 10:7, 28:4, 30:8,<br/> 36:8, 42:17<br/> <b>congressional</b> [1] -<br/> 35:9<br/> <b>consider</b> [1] - 42:25<br/> <b>considered</b> [1] - 33:11<br/> <b>considering</b> [1] -<br/> 37:14<br/> <b>consumer</b> [1] - 25:5<br/> <b>consumers</b> [5] - 9:22,<br/> 11:23, 12:22, 24:23,<br/> 31:17<br/> <b>continue</b> [3] - 9:12,<br/> 12:5, 20:19<br/> <b>contribute</b> [2] - 14:8,<br/> 31:18<br/> <b>contribution</b> [2] -<br/> 15:8, 16:3<br/> <b>conversation</b> [2] -<br/> 12:14, 44:3<br/> <b>conversations</b> [2] -<br/> 8:23, 43:23<br/> <b>correct</b> [6] - 28:16,<br/> 29:15, 29:22, 30:2,<br/> 30:4, 37:23<br/> <b>cost</b> [5] - 11:19, 14:4,<br/> 17:17, 17:19, 29:13<br/> <b>costs</b> [10] - 7:6, 14:11,<br/> 17:19, 29:5, 42:23,<br/> 43:13, 43:17, 44:9,<br/> 44:11, 44:22<br/> <b>Council</b> [2] - 1:6, 1:7<br/> <b>count</b> [2] - 41:21,<br/> 41:22<br/> <b>counties</b> [1] - 40:9<br/> <b>country</b> [3] - 3:17,<br/> 34:2, 44:20<br/> <b>couple</b> [8] - 13:18,<br/> 14:1, 14:5, 14:14,<br/> 15:6, 15:9, 17:10,<br/> 30:18<br/> <b>Coveny</b> [1] - 8:2</p> | <p><b>cover</b> [5] - 10:22,<br/> 24:11, 42:21, 44:5,<br/> 44:7<br/> <b>coverage</b> [13] - 3:24,<br/> 5:2, 5:4, 5:16, 5:17,<br/> 21:23, 32:10, 32:11,<br/> 33:5, 39:20, 39:21,<br/> 39:25<br/> <b>covered</b> [10] - 5:1, 8:3,<br/> 20:5, 23:23, 23:24,<br/> 24:7, 32:23, 42:23,<br/> 44:19, 44:20<br/> <b>covering</b> [5] - 7:25,<br/> 14:19, 15:2, 21:19,<br/> 22:11<br/> <b>covers</b> [1] - 23:1<br/> <b>cratering</b> [1] - 42:12<br/> <b>create</b> [2] - 12:5, 24:5<br/> <b>created</b> [1] - 34:10<br/> <b>creates</b> [1] - 23:12<br/> <b>credit</b> [1] - 13:22<br/> <b>credits</b> [7] - 10:25,<br/> 11:2, 16:5, 19:2,<br/> 19:20, 19:24, 20:2<br/> <b>crisis</b> [1] - 36:2<br/> <b>criticism</b> [1] - 27:25<br/> <b>current</b> [11] - 7:21,<br/> 10:23, 13:19, 14:10,<br/> 16:22, 17:5, 27:23,<br/> 37:17, 38:6, 38:7,<br/> 38:22<br/> <b>Curtis</b> [2] - 2:5, 35:15<br/> <b>CURTIS</b> [7] - 35:16,<br/> 36:7, 36:13, 37:13,<br/> 37:19, 37:22, 37:25<br/> <b>customer</b> [1] - 25:4<br/> <b>cut</b> [1] - 21:15</p> | <p>9:23<br/> <b>demonstrate</b> [2] -<br/> 4:18, 7:24<br/> <b>denying</b> [1] - 6:25<br/> <b>depart</b> [2] - 42:10,<br/> 42:11<br/> <b>departing</b> [1] - 7:20<br/> <b>department</b> [1] - 15:22<br/> <b>departure</b> [1] - 9:6<br/> <b>describe</b> [1] - 13:8<br/> <b>described</b> [1] - 5:22<br/> <b>designed</b> [3] - 10:18,<br/> 36:2, 43:9<br/> <b>desire</b> [2] - 34:3,<br/> 38:20<br/> <b>DIANE</b> [7] - 35:16,<br/> 36:7, 36:13, 37:13,<br/> 37:19, 37:22, 37:25<br/> <b>Diane</b> [2] - 2:5, 35:15<br/> <b>difference</b> [7] - 7:24,<br/> 14:20, 15:2, 15:4,<br/> 15:6, 15:7, 17:3<br/> <b>differences</b> [1] - 27:22<br/> <b>different</b> [4] - 6:19,<br/> 17:8, 28:9, 40:19<br/> <b>differently</b> [1] - 11:21<br/> <b>differing</b> [1] - 17:1<br/> <b>difficult</b> [1] - 31:24<br/> <b>discussed</b> [2] - 10:8,<br/> 10:17<br/> <b>discussion</b> [2] - 3:15,<br/> 38:16<br/> <b>discussions</b> [1] - 40:4<br/> <b>distinction</b> [2] - 8:10,<br/> 13:11<br/> <b>diverting</b> [1] - 44:12<br/> <b>divided</b> [1] - 24:2<br/> <b>Doctor</b> [1] - 25:7<br/> <b>doctor</b> [2] - 27:2,<br/> 30:21<br/> <b>doggone</b> [1] - 41:8<br/> <b>dollar</b> [1] - 15:6<br/> <b>dollars</b> [3] - 24:2,<br/> 28:19, 28:20<br/> <b>done</b> [2] - 9:7, 36:20<br/> <b>Doug</b> [1] - 3:3<br/> <b>DOUG</b> [1] - 1:12<br/> <b>down</b> [4] - 29:25,<br/> 31:13, 44:9, 44:10<br/> <b>DR</b> [9] - 17:7, 18:10,<br/> 18:16, 20:21, 22:14,<br/> 22:18, 28:18, 29:6,<br/> 44:2<br/> <b>Dr</b> [2] - 2:3, 24:16<br/> <b>draft</b> [1] - 18:19<br/> <b>dramatic</b> [5] - 10:1,<br/> 13:14, 14:22, 15:5,<br/> 15:15<br/> <b>dramatically</b> [1] - 33:9<br/> <b>drink</b> [1] - 25:23</p> |
| <b>D</b>   |   |   |  |   |
| <p><b>days</b> [1] - 37:5<br/> <b>deal</b> [5] - 7:9, 12:12,<br/> 36:2, 43:2, 43:18<br/> <b>dealing</b> [1] - 33:15<br/> <b>decide</b> [1] - 37:15<br/> <b>decided</b> [5] - 8:7,<br/> 8:17, 15:22, 17:14,<br/> 32:21<br/> <b>decision</b> [3] - 32:5,<br/> 36:10, 37:11<br/> <b>decisions</b> [1] - 6:24<br/> <b>declined</b> [1] - 5:11<br/> <b>decreases</b> [1] - 10:2<br/> <b>deductible</b> [3] - 28:13,<br/> 28:16, 41:17<br/> <b>deductibles</b> [1] -<br/> 28:17<br/> <b>define</b> [1] - 24:6<br/> <b>delegation</b> [1] - 35:9<br/> <b>demographics</b> [1] -</p>   |   |   |  |   |

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Clive, IA 50325  
(515) 243-6596

|   |   |  |   |  |
|---|---|--|---|--|
| <p><b>drop</b> [1] - 42:5</p> <p><b>during</b> [1] - 37:5</p>   | <p><b>eventually</b> [1] - 44:15</p> <p><b>exactly</b> [4] - 8:21, 17:14, 34:14, 40:24</p> <p><b>example</b> [2] - 14:1, 16:1</p> <p><b>exceed</b> [1] - 37:4</p> <p><b>exceeded</b> [1] - 24:25</p> <p><b>exceedingly</b> [1] - 17:19</p> <p><b>except</b> [1] - 24:22</p> <p><b>exchange</b> [4] - 8:11, 8:12, 8:13, 8:16</p> <p><b>exercise</b> [1] - 25:22</p> <p><b>exist</b> [1] - 44:5</p> <p><b>expanding</b> [2] - 5:2, 5:3</p> <p><b>expansion</b> [3] - 4:23, 5:7, 5:14</p> <p><b>expect</b> [1] - 19:20</p> <p><b>expenses</b> [1] - 24:25</p> <p><b>expensive</b> [2] - 4:12, 7:1</p> <p><b>experience</b> [3] - 4:8, 15:23, 17:25</p> <p><b>experiences</b> [1] - 17:1</p> <p><b>experiencing</b> [1] - 34:15</p> <p><b>explain</b> [4] - 9:7, 16:2, 18:18, 18:23</p> <p><b>expressed</b> [1] - 38:20</p> | <p>17:24, 38:23</p> <p><b>filing</b> [2] - 38:6, 38:9</p> <p><b>final</b> [2] - 18:6, 37:3</p> <p><b>finally</b> [1] - 34:9</p> <p><b>fine</b> [1] - 22:6</p> <p><b>fire</b> [1] - 12:18</p> <p><b>first</b> [2] - 8:4, 17:11</p> <p><b>fits</b> [1] - 32:6</p> <p><b>fixed</b> [6] - 16:2, 16:5, 31:1, 31:3, 31:12, 31:14</p> <p><b>flattered</b> [1] - 25:13</p> <p><b>fleeing</b> [1] - 9:17</p> <p><b>flowing</b> [2] - 19:5, 19:25</p> <p><b>folks</b> [5] - 6:5, 11:19, 12:1, 30:12, 42:10</p> <p><b>fork</b> [1] - 9:14</p> <p><b>form</b> [2] - 11:2, 12:3</p> <p><b>fortunate</b> [1] - 42:1</p> <p><b>forward</b> [9] - 3:5, 15:14, 20:24, 27:19, 28:1, 28:5, 33:16, 38:24, 39:8</p> <p><b>frame</b> [1] - 36:18</p> <p><b>framework</b> [2] - 14:10, 14:15</p> <p><b>frankly</b> [4] - 5:6, 6:16, 7:2, 7:19</p> <p><b>Frankly</b> [1] - 5:10</p> <p><b>free</b> [1] - 5:3</p> <p><b>front</b> [1] - 13:5</p> <p><b>full</b> [1] - 30:16</p> <p><b>functioned</b> [1] - 4:6</p> <p><b>funded</b> [2] - 4:15, 43:24</p> <p><b>funding</b> [7] - 11:1, 11:8, 17:13, 18:18, 18:21, 19:7</p> | <p>37:12, 38:19, 40:11</p> <p><b>governor</b> [1] - 32:11</p> <p><b>grandfathered</b> [4] - 5:22, 5:23, 6:5, 6:14</p> <p><b>grandmothered</b> [2] - 6:10, 6:15</p> <p><b>green</b> [1] - 6:7</p> <p><b>grossly</b> [1] - 17:8</p> <p><b>group</b> [6] - 6:5, 18:16, 23:8, 23:9, 23:12, 33:5</p> <p><b>groups</b> [1] - 23:25</p> <p><b>guaranteed</b> [1] - 12:9</p> <p><b>guess</b> [7] - 25:4, 25:10, 25:13, 29:24, 32:7, 33:24, 38:8</p> <p><b>Gunderson</b> [2] - 10:11, 19:18</p>  | <p>43:2</p> <p><b>historically</b> [2] - 4:14, 11:7</p> <p><b>history</b> [1] - 18:3</p> <p><b>hold</b> [2] - 22:11, 22:16</p> <p><b>home</b> [1] - 12:15</p> <p><b>hope</b> [1] - 34:18</p> <p><b>hospital</b> [1] - 13:2</p> <p><b>hosting</b> [1] - 3:3</p> <p><b>House</b> [1] - 21:6</p> <p><b>house</b> [3] - 12:17, 41:21</p> <p><b>household</b> [3] - 14:2, 14:24, 30:3</p> <p><b>huge</b> [2] - 18:10, 42:3</p> <p><b>Hurst</b> [4] - 2:3, 20:20, 20:21, 24:16</p> <p><b>HURST</b> [9] - 17:7, 18:10, 18:16, 20:21, 22:14, 22:18, 28:18, 29:6, 44:2</p> <p><b>husband</b> [2] - 27:8, 29:3</p>   |
| <p style="text-align: center;"><b>E</b></p>   | <p style="text-align: center;"><b>F</b></p>   | <p style="text-align: center;"><b>G</b></p>  | <p style="text-align: center;"><b>H</b></p>   | <p style="text-align: center;"><b>I</b></p>  |
| <p><b>early</b> [1] - 7:9</p> <p><b>eat</b> [1] - 25:23</p> <p><b>economic</b> [4] - 14:23, 36:24, 37:5, 42:9</p> <p><b>edge</b> [1] - 14:23</p> <p><b>effect</b> [2] - 5:14, 11:18</p> <p><b>efficient</b> [1] - 19:9</p> <p><b>effort</b> [1] - 10:24</p> <p><b>either</b> [3] - 9:11, 22:3, 32:18</p> <p><b>elected</b> [1] - 32:25</p> <p><b>eliminated</b> [1] - 43:2</p> <p><b>elsewhere</b> [1] - 5:25</p> <p><b>employee</b> [1] - 22:21</p> <p><b>employee-based</b> [1] - 22:21</p> <p><b>employees</b> [1] - 32:24</p> <p><b>employer</b> [3] - 3:24, 22:25, 33:7</p> <p><b>employer-based</b> [2] - 3:24, 33:7</p> <p><b>encourage</b> [3] - 34:4, 37:1, 37:9</p> <p><b>end</b> [3] - 5:5, 14:17, 16:23</p> <p><b>engaged</b> [1] - 34:5</p> <p><b>enjoy</b> [1] - 27:12</p> <p><b>enroll</b> [1] - 21:16</p> <p><b>enrolled</b> [2] - 23:14, 24:9</p> <p><b>enrollment</b> [3] - 12:23, 13:3, 36:14</p> <p><b>enrolls</b> [1] - 25:5</p> <p><b>entice</b> [1] - 7:17</p> <p><b>entire</b> [1] - 9:1</p> <p><b>entitled</b> [1] - 1:10</p> <p><b>environment</b> [1] - 34:25</p> <p><b>especially</b> [2] - 9:22, 41:16</p> <p><b>essence</b> [1] - 14:4</p> <p><b>essential</b> [1] - 10:23</p> <p><b>essentially</b> [1] - 5:3</p> <p><b>establish</b> [1] - 19:23</p> <p><b>estimate</b> [4] - 15:18, 18:24, 18:25, 19:15</p> <p><b>estimated</b> [3] - 19:19, 29:14, 29:25</p> <p><b>estimates</b> [4] - 13:8, 13:19, 15:21, 39:13</p> <p><b>evaluate</b> [3] - 11:23, 39:5</p> <p><b>evaluating</b> [1] - 11:23</p> <p><b>event</b> [3] - 3:4, 30:14, 43:8</p> | <p><b>face</b> [1] - 39:21</p> <p><b>facing</b> [4] - 17:17, 40:25, 41:1</p> <p><b>fact</b> [5] - 6:16, 9:4, 13:9, 17:24, 24:22</p> <p><b>fair</b> [1] - 23:18</p> <p><b>fall</b> [2] - 13:15, 24:20</p> <p><b>families</b> [2] - 38:11, 38:16</p> <p><b>family</b> [6] - 15:8, 15:9, 16:16, 16:21, 20:22, 26:25</p> <p><b>farm</b> [1] - 5:19</p> <p><b>fault</b> [1] - 26:6</p> <p><b>fear</b> [1] - 27:24</p> <p><b>federal</b> [15] - 11:14, 14:3, 20:3, 24:4, 26:22, 32:18, 35:7, 35:12, 35:17, 35:18, 35:24, 36:21, 37:11, 38:18, 40:11</p> <p><b>federally</b> [2] - 21:8, 39:1</p> <p><b>feds</b> [1] - 32:19</p> <p><b>fewer</b> [1] - 5:13</p> <p><b>figure</b> [1] - 38:12</p> <p><b>filed</b> [4] - 15:25, 17:23,</p>   | <p>17:24, 38:23</p> <p><b>gamble</b> [1] - 23:4</p> <p><b>game</b> [1] - 34:1</p> <p><b>general</b> [1] - 28:21</p> <p><b>generally</b> [4] - 4:15, 25:1, 43:6, 43:24</p> <p><b>given</b> [1] - 36:9</p> <p><b>GLEN</b> [1] - 17:7</p> <p><b>Glenn</b> [3] - 2:3, 20:20, 20:21</p> <p><b>GLENN</b> [8] - 18:10, 18:16, 20:21, 22:14, 22:18, 28:18, 29:6, 44:2</p> <p><b>goal</b> [1] - 21:2</p> <p><b>gonna</b> [4] - 23:5, 23:6, 41:3</p> <p><b>government</b> [6] - 35:18, 35:24, 36:21,</p>   | <p><b>half</b> [2] - 33:5, 41:20</p> <p><b>hands</b> [2] - 35:13, 45:5</p> <p><b>happy</b> [1] - 29:8</p> <p><b>hard</b> [2] - 28:8, 40:23</p> <p><b>hardship</b> [2] - 23:20, 23:21</p> <p><b>Health</b> [1] - 36:11</p> <p><b>health</b> [9] - 4:11, 10:23, 21:16, 25:20, 25:24, 26:3, 26:11, 41:16, 43:19</p> <p><b>healthcare</b> [8] - 21:18, 28:22, 44:9, 44:14, 44:16, 44:21</p> <p><b>healthy</b> [10] - 7:16, 7:19, 9:21, 11:19, 21:3, 21:17, 21:25, 23:4, 42:11, 43:6</p> <p><b>hear</b> [4] - 8:15, 24:17, 28:6</p> <p><b>Hearing</b> [1] - 45:10</p> <p><b>hearing</b> [4] - 1:10, 9:10, 43:22, 45:2</p> <p><b>heart</b> [1] - 28:23</p> <p><b>help</b> [2] - 33:17, 44:5</p> <p><b>helping</b> [1] - 35:4</p> <p><b>high</b> [15] - 3:18, 4:6, 4:10, 4:14, 6:22, 7:5, 11:7, 14:11, 17:17, 17:19, 21:13, 24:19, 29:23, 43:17</p> <p><b>high-risk</b> [5] - 4:6, 4:10, 4:14, 6:22, 11:7</p> <p><b>higher</b> [3] - 18:1, 19:21, 42:20</p> <p><b>HIPIOWA</b> [5] - 11:15, 30:15, 42:25, 43:1,</p> | <p><b>identify</b> [2] - 29:10, 39:10</p> <p><b>imagine</b> [1] - 7:14</p> <p><b>impact</b> [4] - 16:16, 16:22, 37:11, 40:5</p> <p><b>impacted</b> [1] - 33:9</p> <p><b>implement</b> [1] - 21:9</p> <p><b>implementation</b> [1] - 6:12</p> <p><b>implemented</b> [1] - 36:14</p> <p><b>important</b> [6] - 3:12, 11:5, 17:11, 17:25, 18:6, 40:5</p> <p><b>impossible</b> [2] - 22:13, 22:15</p> <p><b>IN</b> [1] - 1:3</p> <p><b>inception</b> [1] - 12:10</p> <p><b>include</b> [2] - 28:13, 28:16</p> <p><b>income</b> [16] - 5:5, 12:6, 13:24, 14:2, 14:6, 14:13, 15:3, 15:8, 15:9, 16:3, 16:7, 20:2, 31:18, 41:21, 41:22, 41:23</p> <p><b>incomes</b> [1] - 14:24</p> <p><b>increase</b> [1] - 14:25</p> <p><b>increases</b> [5] - 7:10, 7:13, 16:8, 24:7</p> <p><b>increasing</b> [3] - 9:18, 9:19, 9:25</p> <p><b>Indiana</b> [1] - 40:25</p> <p><b>individual</b> [20] - 7:2,</p> |
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|   |  |  |  |   |
|---|--|--|--|---|
| 7:7, 8:1, 9:24, 14:17, 16:12, 22:23, 22:24, 24:23, 27:16, 27:17, 31:6, 33:10, 34:22, 34:23, 35:1, 35:3, 40:2, 41:8, 42:21   | <b>issue</b> [11] - 9:3, 9:11, 11:15, 11:16, 12:10, 12:13, 13:2, 19:10, 28:24, 31:21, 33:1                   | <b>likewise</b> [1] - 16:22  | 39:3, 39:16, 40:3, 42:12, 42:14, 42:18, 42:21, 43:4  | <b>Mnuchin</b> [1] - 36:12  |
| <b>individuals</b> [18] - 3:18, 4:11, 5:1, 6:4, 6:8, 6:21, 7:5, 8:1, 8:19, 10:2, 11:6, 11:17, 12:5, 14:11, 17:18, 33:6, 34:22, 42:20  | <b>issues</b> [8] - 11:4, 12:8, 30:19, 31:3, 35:12, 40:25, 41:1  | <b>limited</b> [1] - 13:3  | <b>Marti</b> [2] - 2:5, 30:10  | <b>moment</b> [1] - 37:3  |
| <b>Individuals</b> [1] - 7:15   |  | <b>list</b> [3] - 20:8, 20:19, 40:17   | <b>MARTI</b> [6] - 30:10, 32:7, 34:9, 34:17, 35:6, 42:24   | <b>money</b> [6] - 19:8, 20:4, 23:11, 28:9, 32:9, 41:15   |
| <b>information</b> [1] - 35:11  | <b>J</b>   | <b>listening</b> [1] - 42:17   | <b>math</b> [1] - 41:19  | <b>morning</b> [1] - 34:21  |
| <b>innovation</b> [1] - 36:1  | <b>job</b> [2] - 21:14, 37:6   | <b>literally</b> [1] - 43:12   | <b>matter</b> [1] - 1:10   | <b>most</b> [4] - 4:4, 10:15, 11:5, 17:11   |
| <b>insist</b> [1] - 39:19   | <b>Joy</b> [2] - 2:4, 27:7   | <b>lives</b> [11] - 21:19, 21:24, 22:12, 23:4, 23:7, 23:23, 23:24, 24:7, 24:11, 44:6, 44:19  | <b>maximum</b> [3] - 14:5, 14:7, 41:18   | <b>mostly</b> [1] - 4:9   |
| <b>instead</b> [1] - 32:12  | <b>JOY</b> [3] - 27:8, 28:8, 29:3  | <b>location</b> [1] - 40:14  | <b>mean</b> [16] - 8:22, 17:19, 18:14, 26:14, 27:4, 31:1, 34:14, 38:8, 39:2, 39:7, 39:20, 39:24, 40:4, 40:17, 40:23, 43:10 | <b>move</b> [6] - 3:5, 11:11, 15:14, 17:18, 27:19, 38:24  |
| <b>insurable</b> [2] - 32:21, 32:22   | <b>July</b> [1] - 1:8  | <b>look</b> [8] - 5:12, 8:9, 9:23, 16:16, 17:15, 38:23, 39:3, 39:13  | <b>means</b> [4] - 16:20, 18:21, 27:11, 33:20  | <b>moved</b> [1] - 6:18   |
| <b>INSURANCE</b> [1] - 1:1  | <b>jump</b> [1] - 16:4   | <b>losing</b> [2] - 21:22, 21:24   | <b>Measure</b> [10] - 3:11, 10:18, 12:9, 17:6, 17:12, 27:20, 28:6, 31:22, 32:1, 38:15                                      | <b>MOYNA</b> [1] - 1:25   |
| <b>insurance</b> [35] - 3:19, 3:24, 7:3, 7:10, 11:10, 12:16, 12:17, 12:24, 15:12, 21:14, 21:16, 22:9, 22:11, 22:18, 23:5, 23:10, 23:12, 24:21, 24:24, 25:3, 25:20, 26:11, 27:10, 29:1, 30:15, 32:9, 32:13, 33:13, 33:21, 39:14, 41:16, 43:9, 43:14, 44:5, 44:18 | <b>justifying</b> [1] - 17:7   | <b>loss</b> [1] - 15:15  | <b>MEASURE</b> [1] - 1:4   | <b>MR</b> [1] - 41:6  |
| <b>insured</b> [1] - 38:13  |  | <b>losses</b> [5] - 8:25, 9:2, 19:13, 39:4, 39:7   | <b>mechanism</b> [1] - 11:9  | <b>MS</b> [25] - 20:15, 25:10, 26:24, 27:8, 28:8, 29:3, 29:11, 29:18, 29:23, 30:5, 30:10, 32:7, 34:9, 34:17, 35:6, 35:16, 36:7, 36:13, 37:13, 37:19, 37:22, 37:25, 39:12, 40:7, 42:24 |
| <b>insurers</b> [1] - 17:16   | <b>L</b>   | <b>low</b> [4] - 3:20, 3:22, 4:1, 24:8   | <b>mechanisms</b> [1] - 11:14  | <b>must</b> [4] - 9:20, 22:22, 23:25  |
| <b>intend</b> [2] - 30:11, 38:25  | <b>lacked</b> [1] - 21:5   | <b>lower</b> [7] - 12:6, 14:12, 14:17, 31:5, 31:12, 31:25, 32:4  | <b>Medica</b> [13] - 8:21, 8:23, 10:11, 10:13, 10:16, 17:23, 19:18, 19:20, 30:19, 33:21, 37:19, 37:21, 39:14               | <b>mutual</b> [2] - 33:19, 33:25  |
| <b>intended</b> [1] - 37:3  | <b>lady</b> [1] - 44:9   | <b>lowest</b> [6] - 3:17, 5:5, 9:4, 9:5, 19:16   | <b>Medica's</b> [1] - 18:1   | <b>N</b>  |
| <b>intent</b> [2] - 3:8, 16:8   | <b>large</b> [8] - 3:19, 5:19, 6:7, 7:25, 9:5, 20:3, 24:25, 41:16  |  | <b>Medicaid</b> [7] - 4:23, 32:12, 40:21   | <b>name</b> [2] - 30:10, 41:6   |
| <b>interested</b> [1] - 10:15   | <b>last</b> [2] - 26:9, 42:5   | <b>M</b>   | <b>medical</b> [4] - 28:24, 30:14, 30:20, 44:8   | <b>Nancy</b> [3] - 2:4, 20:12, 29:11  |
| <b>interesting</b> [1] - 16:15  | <b>law</b> [5] - 9:13, 10:23, 26:22, 37:17, 38:6   | <b>ma'am</b> [1] - 39:10   | <b>Medicare</b> [2] - 32:12, 44:20   | <b>NANCY</b> [5] - 20:15, 29:11, 29:18, 29:23, 30:5   |
| <b>introduce</b> [1] - 3:2  | <b>laws</b> [1] - 34:4   | <b>major</b> [1] - 28:24   | <b>meet</b> [1] - 23:21  | <b>national</b> [1] - 9:16  |
| <b>investors</b> [1] - 33:15  | <b>least</b> [1] - 23:15   | <b>majority</b> [1] - 43:12  | <b>meeting</b> [2] - 34:21, 34:23  | <b>nationwide</b> [1] - 40:13   |
| <b>involved</b> [2] - 20:4, 34:5  | <b>leave</b> [3] - 8:17, 12:25, 20:6   | <b>management</b> [1] - 36:2   | <b>Michelle</b> [2] - 2:3, 25:9  | <b>nearly</b> [1] - 9:5   |
| <b>involves</b> [2] - 16:2, 17:12   | <b>leaves</b> [1] - 9:21   | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  | <b>MICHELLE</b> [2] - 25:10, 26:24   | <b>need</b> [14] - 4:12, 27:4, 27:16, 27:17, 30:8, 32:15, 33:13, 39:24, 40:2, 42:17, 42:23, 44:13, 44:14, 44:16   |
| <b>IOWA</b> [1] - 1:1   | <b>leaving</b> [3] - 9:22, 12:13, 19:16  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, | <b>million</b> [5] - 17:14, 19:3, 19:13, 19:19, 33:4   | <b>needed</b> [2] - 9:7, 11:16  |
| <b>Iowa</b> [15] - 1:7, 3:12, 3:14, 3:16, 4:21, 5:25, 7:4, 10:5, 10:9, 14:25, 20:22, 21:7, 24:11, 35:21, 37:7   | <b>left</b> [1] - 42:13  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  | <b>mind</b> [1] - 43:11  | <b>needing</b> [1] - 10:21  |
| <b>IOWA'S</b> [1] - 1:3   | <b>legislative</b> [1] - 35:12   | <b>manner</b> [2] - 19:8, 19:9   | <b>Minden</b> [1] - 20:22  | <b>needs</b> [5] - 27:11, 32:6, 35:1, 40:2, 42:22   |
| <b>Iowans</b> [4] - 4:13, 4:25, 5:6, 23:4   | <b>legislature</b> [3] - 32:11, 32:24, 35:7  | <b>majority</b> [1] - 43:12  | <b>minimize</b> [1] - 38:9   | <b>Nerenstone</b> [2] - 2:5, 30:11  |
| <b>irresponsible</b> [1] - 32:23  | <b>level</b> [14] - 3:15, 5:8, 13:15, 13:16, 14:3, 14:13, 21:9, 23:15, 24:5, 24:6, 32:19, 32:20, 35:12, 36:1 | <b>management</b> [1] - 36:2   | <b>Minnesota</b> [1] - 33:22   | <b>NERENSTONE</b> [6] - 30:10, 32:7, 34:9, 34:17, 35:6, 42:24   |
|   | <b>level-set</b> [1] - 3:15  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  | <b>Misselt</b> [4] - 2:6, 2:6, 39:12, 41:6   | <b>network</b> [5] - 31:10, 31:20, 31:24, 32:6  |
|   | <b>levelize</b> [2] - 16:8, 19:17  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, | <b>MISSELT</b> [3] - 39:12, 40:7, 41:6   | <b>Nevada</b> [1] - 40:24   |
|   | <b>levelizing</b> [1] - 18:8   | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  | <b>Missouri</b> [1] - 40:20  | <b>never</b> [1] - 43:1   |
|   | <b>levels</b> [1] - 5:5  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   | <b>Library</b> [1] - 1:6   | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   | <b>life</b> [2] - 25:25, 26:6  | <b>majority</b> [1] - 43:12  |  |   |
|   | <b>likely</b> [2] - 8:20, 31:20  | <b>management</b> [1] - 36:2   |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16, 4:4, 5:7, 5:11, 5:12, 6:18, 6:20, 7:2, 7:7, 7:21, 7:23, 8:1, 8:6, 8:10, 9:1, 9:17, 9:24, 10:19, 12:19, 13:12, 13:24, 15:1, 15:16, 15:19, 16:13, 16:24, 17:18, 19:1, 19:9, 19:12, 19:14, 19:17, 19:18, 23:1, 23:2, 23:25, 27:16, 27:17, 27:23, 31:13, 32:3, 33:10, 34:7, 34:12, 35:1, 37:16, 38:5, |  |   |
|   |  | <b>mandate</b> [10] - 7:19, 11:17, 22:7, 22:8, 22:9, 23:10, 24:2, 24:4, 26:22  |  |   |
|   |  | <b>manner</b> [2] - 19:8, 19:9   |  |   |
|   |  | <b>market</b> [55] - 3:16,   |  |   |

|   |  |   |  |  |
|---|--|---|--|--|
| <p><b>new</b> [1] - 28:11<br/> <b>next</b> [6] - 16:10, 16:14, 16:20, 27:24, 29:13, 39:16<br/> <b>nice</b> [2] - 28:11, 44:9<br/> <b>none</b> [1] - 28:18<br/> <b>nonprofit</b> [2] - 33:21, 33:25<br/> <b>nonprofits</b> [1] - 33:25<br/> <b>nothing</b> [1] - 28:11<br/> <b>November</b> [1] - 36:14<br/> <b>number</b> [10] - 3:18, 4:3, 5:10, 6:7, 6:15, 8:18, 15:18, 16:25, 24:3, 40:20<br/> <b>numbers</b> [10] - 3:21, 4:2, 7:4, 9:25, 13:4, 13:7, 13:20, 15:20, 15:21, 18:24</p>  | <p><b>opinion</b> [1] - 27:22<br/> <b>opportunities</b> [1] - 12:23<br/> <b>opportunity</b> [1] - 45:4<br/> <b>opposed</b> [4] - 21:6, 21:11, 21:12, 25:2<br/> <b>option</b> [2] - 17:25, 44:17<br/> <b>orange</b> [1] - 6:20<br/> <b>order</b> [3] - 11:15, 19:9, 31:25<br/> <b>out-of-pocket</b> [3] - 28:20, 29:1, 41:18<br/> <b>outside</b> [4] - 11:20, 15:16, 32:8, 32:15<br/> <b>overall</b> [1] - 32:7<br/> <b>overview</b> [1] - 3:11<br/> <b>owned</b> [1] - 33:20<br/> <b>ownership</b> [1] - 12:15</p>   | <p>26:7, 26:9, 26:10, 26:16, 28:10, 28:25, 32:12, 32:23, 33:23, 41:7, 44:6<br/> <b>payer</b> [3] - 22:21, 30:16, 44:23<br/> <b>payers</b> [2] - 20:25, 24:11<br/> <b>paying</b> [9] - 11:24, 12:25, 21:21, 28:20, 28:25, 30:16, 32:13, 32:16, 41:9<br/> <b>payment</b> [4] - 24:10, 29:19, 29:21, 41:21<br/> <b>payments</b> [1] - 18:12<br/> <b>pays</b> [1] - 14:5<br/> <b>penalty</b> [1] - 26:8<br/> <b>people</b> [81] - 3:23, 4:7, 4:10, 5:4, 5:10, 5:13, 5:15, 5:16, 5:21, 5:24, 6:1, 6:4, 6:17, 6:23, 6:25, 7:15, 7:20, 8:3, 8:10, 8:14, 9:24, 9:25, 10:22, 11:11, 11:19, 11:21, 12:13, 12:16, 13:23, 14:9, 14:25, 15:15, 15:17, 15:18, 16:10, 17:1, 18:6, 18:12, 20:8, 21:15, 21:17, 22:1, 22:2, 22:8, 22:12, 23:3, 23:9, 23:10, 23:13, 23:16, 23:17, 23:19, 23:20, 23:22, 24:3, 25:14, 26:1, 26:4, 26:5, 26:10, 26:25, 31:10, 31:13, 33:4, 33:20, 34:11, 34:14, 34:19, 38:3, 38:4, 40:1, 40:13, 42:6, 42:11, 42:13, 42:16, 43:3, 43:6, 43:13, 43:19, 43:20<br/> <b>percent</b> [13] - 13:15, 13:16, 14:3, 14:13, 14:14, 22:8, 23:1, 23:2, 37:23, 38:1, 38:3, 38:4<br/> <b>percentage</b> [4] - 13:25, 14:6, 15:8, 31:18<br/> <b>perfect</b> [2] - 27:20, 27:21<br/> <b>period</b> [4] - 36:6, 36:14, 37:2, 37:4<br/> <b>permission</b> [6] - 36:5, 36:6, 36:7, 36:23, 38:18, 38:19<br/> <b>permit</b> [1] - 35:25</p> | <p><b>persistent</b> [3] - 4:11, 7:1, 43:17<br/> <b>personal</b> [1] - 30:13<br/> <b>perspective</b> [1] - 11:20<br/> <b>persuade</b> [1] - 40:21<br/> <b>persuading</b> [1] - 11:18<br/> <b>physician</b> [1] - 20:22<br/> <b>physician's</b> [1] - 28:21<br/> <b>pick</b> [2] - 31:20, 32:2<br/> <b>picked</b> [1] - 16:17<br/> <b>picking</b> [1] - 17:3<br/> <b>piece</b> [5] - 17:22, 18:9, 24:20, 25:2<br/> <b>place</b> [5] - 11:14, 18:23, 27:24, 28:4, 39:24<br/> <b>placed</b> [1] - 6:23<br/> <b>plan</b> [11] - 6:1, 6:3, 10:19, 14:4, 22:21, 24:1, 25:5, 28:17, 30:17, 33:19, 39:17<br/> <b>plans</b> [12] - 3:25, 5:22, 5:23, 6:8, 6:9, 6:10, 6:15, 6:18, 22:23, 22:24, 40:11<br/> <b>play</b> [3] - 17:11, 17:12, 40:24<br/> <b>plenty</b> [2] - 20:7, 20:18<br/> <b>pocket</b> [3] - 28:20, 29:1, 41:18<br/> <b>point</b> [6] - 9:9, 19:6, 20:16, 24:18, 24:23, 42:2<br/> <b>points</b> [2] - 24:18, 25:1<br/> <b>policy</b> [1] - 6:24<br/> <b>pool</b> [11] - 4:6, 4:10, 4:14, 4:20, 6:22, 11:7, 11:12, 21:13, 22:22, 23:12, 43:13<br/> <b>pop</b> [1] - 25:23<br/> <b>population</b> [3] - 5:21, 9:21, 33:5<br/> <b>portion</b> [2] - 18:11<br/> <b>position</b> [2] - 8:18, 25:3<br/> <b>possible</b> [1] - 44:7<br/> <b>possibly</b> [1] - 8:20<br/> <b>poverty</b> [3] - 13:15, 13:16, 14:3<br/> <b>practice</b> [1] - 20:22<br/> <b>preexisting</b> [1] - 6:25<br/> <b>premium</b> [17] - 8:14, 10:24, 11:2, 13:1, 14:7, 14:12, 14:14, 15:10, 16:5, 19:1, 19:2, 21:3, 21:17, 29:19, 29:21, 30:3, 38:1</p> | <p><b>premiums</b> [4] - 15:24, 16:23, 17:8, 21:22<br/> <b>present</b> [1] - 13:1<br/> <b>presentation</b> [1] - 34:6<br/> <b>presents</b> [1] - 38:10<br/> <b>pressure</b> [1] - 24:11<br/> <b>pretty</b> [5] - 4:6, 4:9, 13:13, 41:8<br/> <b>previously</b> [1] - 8:2<br/> <b>price</b> [1] - 11:24<br/> <b>Price</b> [1] - 36:11<br/> <b>priced</b> [1] - 5:6<br/> <b>primarily</b> [1] - 6:23<br/> <b>private</b> [2] - 22:17, 32:13<br/> <b>probed</b> [1] - 27:2<br/> <b>problem</b> [10] - 10:6, 25:6, 33:12, 33:17, 34:7, 38:14, 39:3, 44:12, 44:13<br/> <b>problems</b> [2] - 13:9, 38:10<br/> <b>process</b> [8] - 3:6, 7:8, 18:20, 19:6, 19:10, 19:23, 20:4, 36:1<br/> <b>prodded</b> [1] - 27:3<br/> <b>professional</b> [2] - 34:23, 34:24<br/> <b>profit</b> [1] - 32:16<br/> <b>program</b> [8] - 21:24, 23:12, 23:15, 23:17, 25:15, 25:16, 35:22, 41:12<br/> <b>project</b> [1] - 45:8<br/> <b>property</b> [1] - 25:17<br/> <b>proposal</b> [9] - 12:3, 16:2, 18:19, 20:23, 21:5, 29:13, 29:20, 29:24, 43:25<br/> <b>propose</b> [2] - 22:10, 22:20<br/> <b>proposed</b> [1] - 12:12<br/> <b>protected</b> [1] - 43:7<br/> <b>provide</b> [4] - 3:5, 4:13, 10:9, 24:1<br/> <b>provider</b> [2] - 21:18, 30:20<br/> <b>provides</b> [1] - 22:21<br/> <b>provisions</b> [1] - 40:12<br/> <b>Public</b> [1] - 1:6<br/> <b>public</b> [3] - 1:10, 9:11, 35:5<br/> <b>publicly</b> [2] - 33:14, 38:21<br/> <b>purchasing</b> [1] - 5:15<br/> <b>purpose</b> [4] - 9:10, 32:9, 34:6, 35:5<br/> <b>purposes</b> [1] - 19:18<br/> <b>put</b> [8] - 7:4, 8:17,</p> |
| <b>O</b>  | <b>P</b>   |   |  |  |
| <p><b>observation</b> [1] - 18:4<br/> <b>occurred</b> [1] - 4:5<br/> <b>occurring</b> [1] - 17:5<br/> <b>offer</b> [9] - 20:10, 20:13, 22:23, 23:17, 24:1, 33:3, 33:24, 37:10, 45:4<br/> <b>offering</b> [1] - 45:8<br/> <b>office</b> [3] - 21:21, 28:21, 29:1<br/> <b>Ohio</b> [1] - 40:25<br/> <b>old</b> [1] - 35:2<br/> <b>Omaha</b> [1] - 30:22<br/> <b>Ommen</b> [1] - 3:3<br/> <b>OMMEN</b> [33] - 1:12, 3:2, 17:10, 18:14, 18:17, 20:17, 24:15, 26:20, 27:6, 27:15, 28:14, 29:7, 29:16, 29:22, 30:2, 30:7, 30:25, 32:25, 34:13, 34:18, 35:8, 35:23, 36:9, 36:16, 37:17, 37:20, 37:24, 38:2, 39:18, 40:15, 42:8, 43:1, 44:25<br/> <b>once</b> [1] - 41:2<br/> <b>one</b> [24] - 3:16, 6:24, 8:20, 9:2, 9:13, 11:5, 12:8, 13:9, 16:14, 16:18, 19:22, 20:16, 23:8, 27:11, 27:15, 30:18, 31:1, 31:3, 31:16, 34:22, 37:18, 41:13, 44:15<br/> <b>online</b> [2] - 37:1, 37:9<br/> <b>operate</b> [2] - 9:12, 34:25</p> | <p><b>p.m</b> [2] - 1:10, 45:10<br/> <b>packages</b> [1] - 24:5<br/> <b>PAGE</b> [1] - 2:2<br/> <b>pardon</b> [1] - 37:24<br/> <b>parents</b> [1] - 16:17<br/> <b>part</b> [13] - 3:19, 5:23, 7:8, 11:8, 16:11, 18:8, 23:15, 31:7, 33:12, 34:2, 36:6, 39:3, 43:24<br/> <b>participate</b> [10] - 4:22, 7:18, 12:11, 22:22, 22:23, 25:14, 25:16, 38:20, 38:21, 40:1<br/> <b>participating</b> [2] - 33:16, 33:21<br/> <b>participation</b> [1] - 10:2<br/> <b>particular</b> [3] - 11:11, 11:20, 25:5<br/> <b>Pass</b> [1] - 18:21<br/> <b>pass</b> [6] - 10:25, 11:3, 11:8, 17:12, 18:18, 19:7<br/> <b>Pass-through</b> [1] - 18:21<br/> <b>pass-through</b> [5] - 10:25, 11:3, 11:8, 18:18, 19:7<br/> <b>passage</b> [2] - 5:11, 6:11<br/> <b>passed</b> [1] - 21:5<br/> <b>passing</b> [1] - 5:24<br/> <b>past</b> [1] - 21:10<br/> <b>patients</b> [1] - 21:20<br/> <b>pay</b> [19] - 21:17, 22:6, 22:7, 22:9, 23:10, 23:19, 24:3, 25:17,</p> |   |  |  |

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|  |  |  |   |   |
|--|--|--|---|---|
| 13:5, 23:2, 27:23,<br>28:4, 28:5, 28:8<br><b>puts</b> [5] - 14:2, 21:1,<br>21:24, 24:10, 41:17<br><b>putting</b> [2] - 20:24,<br>42:20   | 24:2<br><b>receiving</b> [2] - 3:9,<br>8:19<br><b>recently</b> [1] - 3:21<br><b>recognize</b> [1] - 31:2<br><b>recognizing</b> [1] - 14:9<br><b>record</b> [3] - 29:9,<br>29:10, 45:6<br><b>red</b> [1] - 8:12<br><b>redirect</b> [1] - 10:24<br><b>redirected</b> [1] - 11:3<br><b>redistribution</b> [1] -<br>20:1<br><b>reduce</b> [1] - 16:6<br><b>reduced</b> [1] - 5:8<br><b>reducing</b> [1] - 6:15<br><b>reflecting</b> [1] - 17:20<br><b>reflective</b> [1] - 11:25<br><b>reflects</b> [2] - 13:25,<br>27:17<br><b>region</b> [1] - 9:6<br><b>regional</b> [1] - 33:22<br><b>regulate</b> [1] - 22:20<br><b>regulation</b> [1] - 23:2<br><b>regulations</b> [1] - 22:19<br><b>regulator</b> [2] - 7:3,<br>35:13<br><b>regulators</b> [1] - 15:12<br><b>reimbursement</b> [1] -<br>24:5<br><b>reinsurance</b> [8] - 11:9,<br>17:15, 18:8, 20:1,<br>21:12, 24:20, 25:2,<br>43:23<br><b>reinsured</b> [1] - 18:16<br><b>relieve</b> [1] - 11:10<br><b>remain</b> [1] - 39:15<br><b>repeat</b> [1] - 42:16<br><b>rephrase</b> [1] - 40:7<br><b>REPORTER</b> [1] - 1:25<br><b>representative</b> [2] -<br>13:20, 15:24<br><b>Representatives</b> [1] -<br>21:6<br><b>represented</b> [3] - 4:24,<br>6:20, 8:12<br><b>represents</b> [1] - 6:7<br><b>Republicans</b> [1] -<br>26:15<br><b>request</b> [1] - 35:19<br><b>required</b> [2] - 25:18,<br>25:22<br><b>requirement</b> [2] -<br>12:9, 23:20<br><b>reset</b> [1] - 42:18<br><b>responsibility</b> [5] -<br>16:11, 20:25, 23:6,<br>24:10, 24:21<br><b>responsible</b> [2] - | 22:11, 22:17<br><b>rest</b> [1] - 12:18<br><b>resulted</b> [2] - 4:1,<br>19:13<br><b>resurrecting</b> [1] -<br>42:25<br><b>retire</b> [1] - 27:9<br><b>retirement</b> [2] - 27:12,<br>28:9<br><b>review</b> [1] - 37:9<br><b>richer</b> [2] - 31:20,<br>32:17<br><b>rid</b> [1] - 26:15<br><b>risk</b> [17] - 4:6, 4:10,<br>4:14, 4:20, 6:22,<br>11:7, 11:20, 11:25,<br>17:16, 17:21, 21:13,<br>21:15, 21:24, 24:19,<br>27:18, 33:6, 42:20<br><b>river</b> [1] - 30:22<br><b>road</b> [1] - 9:15<br><b>rough</b> [1] - 41:19<br><b>rules</b> [1] - 42:17<br><b>run</b> [1] - 37:4  | 29:2, 31:4<br><b>sent</b> [1] - 27:3<br><b>serious</b> [1] - 43:7<br><b>serve</b> [1] - 34:24<br><b>set</b> [2] - 3:15, 11:9<br><b>several</b> [1] - 11:4<br><b>severe</b> [1] - 28:3<br><b>shape</b> [1] - 35:4<br><b>share</b> [1] - 34:20<br><b>shared</b> [3] - 24:10,<br>33:6, 44:10<br><b>shareholders</b> [1] -<br>32:17<br><b>shore</b> [1] - 39:6<br><b>short</b> [2] - 10:20, 39:6<br><b>SHORTHAND</b> [1] -<br>1:25<br><b>shoulders</b> [1] - 21:1<br><b>show</b> [1] - 16:2<br><b>sick</b> [2] - 21:15, 42:13<br><b>sign</b> [1] - 20:8<br><b>sign-up</b> [1] - 20:8<br><b>signed</b> [2] - 20:9,<br>20:15<br><b>significant</b> [3] - 16:25,<br>29:25, 40:5<br><b>significantly</b> [1] - 4:4<br><b>signing</b> [1] - 25:11<br><b>silver</b> [2] - 14:4, 28:17<br><b>simply</b> [1] - 5:2<br><b>single</b> [2] - 4:20, 44:23<br><b>single-risk</b> [1] - 4:20<br><b>sitting</b> [1] - 38:11<br><b>situation</b> [1] - 42:24<br><b>six</b> [1] - 12:7<br><b>six-banded</b> [1] - 12:7<br><b>skyrocketing</b> [1] -<br>44:11<br><b>slide</b> [4] - 4:18, 4:24,<br>6:7, 21:10<br><b>slight</b> [1] - 15:4<br><b>slightly</b> [1] - 9:25<br><b>small</b> [1] - 10:12<br><b>smoke</b> [1] - 25:23<br><b>sold</b> [1] - 40:12<br><b>solution</b> [1] - 16:12<br><b>solve</b> [3] - 33:8, 33:12,<br>33:17<br><b>someone</b> [1] - 26:25<br><b>somewhere</b> [1] -<br>18:12<br><b>sort</b> [2] - 3:15, 40:12<br><b>sounds</b> [2] - 21:4,<br>44:3<br><b>southern</b> [1] - 5:20<br><b>SPEAKER</b> [5] - 2:2,<br>22:13, 22:16, 28:12,<br>44:23<br><b>special</b> [2] - 12:23, | 13:3<br><b>specialists</b> [1] - 30:22<br><b>specifically</b> [1] - 15:17<br><b>spectrum</b> [1] - 12:6<br><b>spend</b> [2] - 28:19,<br>28:22<br><b>spread</b> [2] - 7:6, 25:1<br><b>stabilize</b> [1] - 10:19<br><b>stable</b> [1] - 6:3<br><b>stand</b> [1] - 10:21<br><b>standard</b> [2] - 10:19,<br>23:21<br><b>start</b> [6] - 11:22,<br>13:17, 16:16, 20:11,<br>35:21, 41:2<br><b>started</b> [3] - 10:4,<br>18:20, 42:19<br><b>State</b> [2] - 21:7, 35:21<br><b>state</b> [24] - 3:18, 5:9,<br>7:25, 8:24, 9:5, 9:11,<br>10:12, 15:24, 16:9,<br>16:25, 18:3, 21:9,<br>22:22, 24:3, 25:6,<br>32:20, 32:24, 33:4,<br>35:13, 36:1, 36:22,<br>42:25<br><b>states</b> [9] - 5:19, 5:20,<br>17:1, 40:8, 40:15,<br>40:18, 40:19, 40:20,<br>41:1<br><b>stay</b> [2] - 8:24, 24:23<br><b>stayed</b> [1] - 34:1<br><b>stent</b> [1] - 29:4<br><b>step</b> [1] - 38:24<br><b>stepped</b> [2] - 28:1,<br>33:16<br><b>stepping</b> [1] - 14:23<br><b>still</b> [13] - 16:4, 16:7,<br>24:20, 29:23, 31:2,<br>33:16, 36:21, 36:25,<br>37:18, 39:1, 43:2,<br>43:4<br><b>stinking</b> [1] - 25:22<br><b>stop</b> [1] - 12:25<br><b>STOPGAP</b> [1] - 1:3<br><b>Stopgap</b> [10] - 3:11,<br>10:18, 12:8, 17:5,<br>17:12, 27:20, 28:5,<br>31:22, 32:1, 38:15<br><b>stopgap</b> [2] - 29:20,<br>30:8<br><b>story</b> [1] - 30:13<br><b>stressed</b> [1] - 42:19<br><b>structure</b> [3] - 13:10,<br>13:22, 16:24<br><b>struggling</b> [1] - 40:16<br><b>submit</b> [1] - 30:11<br><b>subsequently</b> [1] -<br>39:15<br><b>subsidies</b> [5] - 8:15, |
| <b>Q</b>   |  |  |   |   |
| <b>quadruple</b> [1] - 29:4<br><b>qualify</b> [3] - 22:5,<br>41:25, 42:1<br><b>questions</b> [9] - 3:10,<br>20:7, 20:10, 20:18,<br>30:18, 38:7, 39:9,<br>41:5, 44:1<br><b>quick</b> [1] - 3:11<br><b>quickly</b> [1] - 7:22<br><b>quite</b> [1] - 8:18   |  |  |   |   |
| <b>R</b>   |  |  |   |   |
| <b>raise</b> [1] - 37:25<br><b>ranks</b> [2] - 4:25, 5:16<br><b>ratchet</b> [2] - 44:9,<br>44:10<br><b>rate</b> [15] - 3:20, 4:1,<br>7:9, 7:12, 17:4,<br>17:20, 23:18, 24:1,<br>31:5, 31:11, 31:14,<br>31:19, 32:4<br><b>rated</b> [1] - 19:16<br><b>rates</b> [13] - 3:17, 7:11,<br>7:16, 9:5, 9:18, 9:19,<br>18:1, 18:2, 18:6,<br>19:16, 31:25, 41:2,<br>42:15<br><b>rather</b> [1] - 7:22<br><b>RE</b> [1] - 1:3<br><b>reaction</b> [1] - 41:3<br><b>ready</b> [1] - 45:1<br><b>real</b> [4] - 3:7, 3:10,<br>12:18, 14:21<br><b>really</b> [29] - 3:22, 4:1,<br>4:20, 5:4, 5:23, 7:17,<br>8:7, 8:21, 9:9, 9:10,<br>10:9, 11:6, 13:2,<br>17:17, 17:23, 17:25,<br>18:23, 20:25, 21:2,<br>22:10, 24:19, 25:7,<br>25:11, 26:4, 26:23,<br>39:21, 40:23, 41:7,<br>41:24<br><b>reason</b> [6] - 8:9, 9:20,<br>21:11, 28:5, 31:3,<br>32:22<br><b>reasons</b> [2] - 27:16,<br>31:1<br><b>receive</b> [2] - 24:17,<br>37:5<br><b>received</b> [2] - 19:2, |  |  |   |   |
|  |  | <b>S</b>   |   |   |
|  |  | <b>save</b> [1] - 44:22<br><b>saw</b> [5] - 3:20, 9:23,<br>10:12, 12:21, 31:9<br><b>scam</b> [1] - 27:5<br><b>schedule</b> [1] - 16:5<br><b>SCHWARTING</b> [3] -<br>27:8, 28:8, 29:3<br><b>Schwarting</b> [2] - 2:4,<br>27:7<br><b>Secretary</b> [3] - 36:10,<br>36:11, 36:12<br><b>secretary</b> [1] - 36:12<br><b>see</b> [32] - 3:11, 7:22,<br>11:4, 12:21, 13:6,<br>13:9, 13:13, 13:18,<br>13:20, 14:24, 15:3,<br>15:13, 15:15, 15:22,<br>16:6, 16:22, 17:2,<br>18:7, 19:7, 21:9,<br>21:25, 28:3, 31:14,<br>31:16, 34:7, 35:18,<br>39:4, 41:2, 41:3,<br>42:9, 42:10, 43:8<br><b>seeing</b> [6] - 7:12, 7:19,<br>9:25, 10:1, 11:17,<br>45:5<br><b>segment</b> [2] - 13:23,<br>15:1<br><b>selection</b> [1] - 7:15<br><b>selections</b> [1] - 28:3<br><b>selective</b> [1] - 24:24<br><b>senators</b> [1] - 35:10<br><b>sense</b> [3] - 28:18, |   |   |
|  |  |  |   |   |

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|  |  |  |
|--|--|--|
| 8:16, 8:19, 12:4, 42:2<br><b>subsidized</b> [4] - 13:12, 13:23, 14:25, 15:16<br><b>subsidy</b> [3] - 31:2, 31:3, 31:12<br><b>substantial</b> [2] - 15:18, 19:13<br><b>suggest</b> [1] - 27:21<br><b>suggestion</b> [1] - 12:11<br><b>suggests</b> [1] - 23:16<br><b>support</b> [3] - 19:1, 19:3, 19:4<br><b>supported</b> [1] - 18:25<br><b>surgery</b> [1] - 12:24<br><b>Susan</b> [2] - 2:6, 39:12<br><b>SUSAN</b> [2] - 39:12, 40:7<br><b>system</b> [7] - 12:16, 12:20, 21:3, 21:11, 24:8, 33:7, 43:22  | <b>Todd</b> [2] - 2:6, 41:6<br><b>TODD</b> [1] - 41:6<br><b>tool</b> [1] - 36:3<br><b>traded</b> [1] - 33:14<br><b>transitional</b> [1] - 6:8<br><b>Treasury</b> [1] - 36:12<br><b>treatments</b> [1] - 4:12<br><b>tried</b> [2] - 7:9, 21:7<br><b>truly</b> [1] - 3:4<br><b>try</b> [6] - 16:8, 16:11, 33:17, 34:3, 34:6, 36:19<br><b>trying</b> [9] - 7:6, 18:7, 21:2, 25:3, 26:15, 27:18, 38:12, 40:19, 43:7<br><b>turn</b> [2] - 19:25, 45:3<br><b>twins</b> [1] - 16:17<br><b>two</b> [5] - 10:15, 16:17, 17:8, 26:9, 27:9<br><b>type</b> [2] - 21:11, 21:23  | <b>utilizers</b> [1] - 24:8  |
| <b>T</b>   | <b>U</b>   | <b>V</b>   |
| <b>tabbed</b> [1] - 6:9<br><b>table</b> [1] - 38:12<br><b>tapped</b> [1] - 41:10<br><b>tax</b> [10] - 10:24, 11:2, 13:22, 19:2, 19:19, 19:24, 20:2, 41:22, 41:23<br><b>taxes</b> [2] - 25:17, 41:22<br><b>taxpayers</b> [5] - 14:19, 15:2, 17:2, 17:3, 21:1<br><b>term</b> [3] - 39:6<br><b>terms</b> [5] - 12:15, 18:7, 24:13, 28:19, 38:18<br><b>test</b> [2] - 27:3, 27:4<br><b>text</b> [1] - 6:2<br><b>THE</b> [1] - 1:1<br><b>themselves</b> [1] - 43:7<br><b>therefore</b> [1] - 31:19<br><b>they've</b> [3] - 21:23, 38:25, 44:6<br><b>thinking</b> [2] - 13:7, 32:8<br><b>thoughts</b> [1] - 45:8<br><b>thousand</b> [1] - 15:6<br><b>three</b> [1] - 33:4<br><b>throughout</b> [1] - 19:14<br><b>thrown</b> [1] - 30:15<br><b>tiered</b> [1] - 31:10<br><b>tighter</b> [1] - 31:24<br><b>tilted</b> [1] - 27:14<br><b>today</b> [4] - 5:13, 34:6, 37:2, 37:7 | <b>ultimately</b> [1] - 36:10<br><b>unable</b> [1] - 5:15<br><b>unbelievable</b> [1] - 27:5<br><b>uncertainty</b> [2] - 11:10, 39:1<br><b>under</b> [21] - 4:5, 4:18, 5:18, 9:12, 10:23, 13:10, 13:18, 13:21, 14:10, 14:15, 17:5, 19:23, 29:13, 29:20, 30:16, 31:16, 31:23, 35:24, 37:17, 38:6, 38:22<br><b>underwrite</b> [1] - 11:19<br><b>unemployment</b> [2] - 3:20, 3:21<br><b>unfavorable</b> [1] - 39:14<br><b>UNIDENTIFIED</b> [4] - 22:13, 22:16, 28:12, 44:23<br><b>uninsured</b> [3] - 3:17, 4:1, 5:8<br><b>unique</b> [1] - 5:19<br><b>unless</b> [2] - 16:23, 28:23<br><b>unsubsidized</b> [1] - 16:24<br><b>up</b> [14] - 7:4, 10:21, 11:9, 12:25, 16:24, 17:3, 17:20, 20:8, 20:9, 25:11, 33:22, 37:23, 41:11, 44:3<br><b>upset</b> [1] - 21:21<br><b>useful</b> [1] - 3:15 | <b>vast</b> [1] - 43:12<br><b>versus</b> [2] - 37:8, 44:8<br><b>view</b> [6] - 7:16, 7:17, 11:25, 24:18, 27:18, 36:4<br><b>vote</b> [1] - 33:1<br><b>voted</b> [1] - 35:20   |
|  |  | <b>W</b>   |
|  |  | <b>waiver</b> [11] - 9:11, 12:12, 19:12, 35:17, 35:19, 35:21, 36:1, 37:8, 37:14<br><b>ways</b> [1] - 40:19<br><b>Wednesday</b> [1] - 1:8<br><b>weigh</b> [1] - 32:4<br><b>Wellmark</b> [7] - 8:4, 10:13, 10:16, 19:19, 33:19, 37:13, 38:21<br><b>willing</b> [3] - 28:1, 31:6, 31:7<br><b>Willow</b> [1] - 1:7<br><b>wish</b> [1] - 20:13<br><b>world</b> [1] - 37:7<br><b>worried</b> [1] - 21:22<br><b>worse</b> [3] - 16:10, 27:24, 28:4<br><b>wrapping</b> [1] - 44:3<br><b>write</b> [3] - 8:8, 8:24, 40:22<br><b>writing</b> [1] - 8:5 |
|  |  | <b>Y</b>   |
|  |  | <b>year</b> [12] - 16:11, 16:20, 18:22, 27:24, 28:11, 29:13, 30:19, 35:2, 38:11, 39:16, 42:5<br><b>year-old</b> [1] - 35:2<br><b>years</b> [3] - 7:9, 26:9, 27:9<br><b>young</b> [8] - 7:19, 11:18, 12:1, 21:3, 21:25, 25:14, 25:15, 42:10<br><b>younger</b> [1] - 10:3<br><b>yourself</b> [3] - 13:16, 29:10, 39:11   |

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