BEFORE THE IOWA INSURANCE COMMISSIONER

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IN RE: IOWA'S STOPGAP :
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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

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[redacted] - CERTIFIED SHORTHAND REPORTER

I N D E X

P R O C E E D I N G S

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

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

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

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

really resulted in us having low uninsured rate numbers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

happening is young folks were choosing to not do that.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Now, the companies have not yet filed these,

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. GLENN [redacted]: This reinsured group.

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

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

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

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

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

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

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

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

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

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

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

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

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

Glenn [redacted].

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

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

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

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

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

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

I don't see this attracting young, healthy

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

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

AN UNIDENTIFIED SPEAKER: That's impossible.

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

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

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

And you can base that on an employer who

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

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

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

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

So all of the groups on the market must

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

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

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

Thank you.

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

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

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

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

Michelle [redacted].

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

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

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

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

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

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

COMMISSIONER OMMEN: Thank you for those comments.

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

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

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

COMMISSIONER OMMEN: Thank you very much.

Joy [redacted].

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

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

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

That is not in any way a criticism of the

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

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

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

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

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

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

You are paying more than you would pay

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

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

DR. GLENN [redacted]: Right.

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

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

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

COMMISSIONER OMMEN: Okay. Again, where is this?

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

COMMISSIONER OMMEN: That is correct.

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

amount.

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

MS. NANCY [redacted]: That was just a clarification.

COMMISSIONER OMMEN: And, again, that's why I said, this is stopgap. We do need Congress to act.

Yes. There's another question or comment.

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

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

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

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

COMMISSIONER OMMEN: Certainly. Yes. I

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

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

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

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

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

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

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

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

COMMISSIONER OMMEN: Again, I'm not elected.

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

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

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

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

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

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

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

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

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

MS. MARTI [redacted]: Right.

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

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

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

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

MS. MARTI [redacted]: So are you talking to the federal legislature?

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

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

Again, thank you for those comments.

Diane [redacted]. Yes.

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

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

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

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

MS. DIANE [redacted]: And who gives permission, Congress?

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

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

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

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

encourage you to go online.

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

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

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

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

MS. DIANE [redacted]: Medica.

COMMISSIONER OMMEN: We're very appreciative of Medica.

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

COMMISSIONER OMMEN: Pardon?

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

their premium 43 percent?

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

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

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

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

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

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

Any further questions or comments?

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

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

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

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

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

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

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

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

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

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

All right. Any further comments or questions?

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

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

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

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

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

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

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

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

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

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

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

Other questions?

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

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

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

UNIDENTIFIED SPEAKER: Amen. Single payer is the answer.

COMMISSIONER OMMEN: Again, I appreciate

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

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

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

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

C E R T I F I C A T E

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

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

Dated at Des Moines, Iowa, this 7th day of August, 2017.

[redacted]
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