KIM REYNOLDS
GOVERNOR

OFFICE OF THE GOVERNOR

ADAM GREGG
LT GOVERNOR

June 16, 2021

The Honorable Paul Pate
Secretary of State of Iowa
State Capitol
Des Moines, Iowa 50319

Dear Mr. Secretary,

I hereby transmit:

House File 838, an Act relating to various matters under the purview of the Insurance Division of the Department of Commerce, providing fees, making an appropriation, and resolving inconsistencies.

The above House File is hereby approved on this date.

Sincerely,

Kim Reynolds
Governor of Iowa

cc: Secretary of the Senate
Clerk of the House

House File 838

AN ACT

RELATING TO VARIOUS MATTERS UNDER THE PURVIEW OF THE INSURANCE DIVISION OF THE DEPARTMENT OF COMMERCE, PROVIDING FEES, MAKING AN APPROPRIATION, AND RESOLVING INCONSISTENCIES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

INSURANCE

Section 1. Section 507A.4, subsection 9, Code 2021, is amended by striking the subsection and inserting in lieu thereof the following:

9. Transactions involving a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002, paragraph 40, or a multiple employer welfare arrangement formed as an association health plan pursuant to 29 C.F.R. pt. 2510 that complies with chapter 513D.

Sec. 2. Section 507B.7, Code 2021, is amended to read as follows:

507B.7 ~~Cease and desist orders~~ Orders and penalties.

1. If, after hearing, the commissioner determines that a person has engaged in an unfair method of competition or an unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings, an order requiring such person to cease and desist from engaging in such method of competition, act,

or practice, and the commissioner may at the commissioner's discretion order any one or more of the following:

a. Payment of a civil penalty of not more than one thousand dollars for each act or violation of this subtitle, but not to exceed an aggregate of ten thousand dollars, unless the person knew or reasonably should have known the person was in violation of this subtitle, in which case the penalty shall be not more than five thousand dollars for each act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any one six-month period. If the commissioner finds that a violation of this subtitle was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a penalty to the employer or insurer.

b. Suspension or revocation of the license of a person as defined in section 507B.2, subsection 1, if the person knew or reasonably should have known the person was in violation of this subtitle.

c. Payment of interest at the rate of ten percent per annum if the commissioner finds that the insurer failed to pay interest as required under section 507B.4, subsection 3, paragraph *"p"*.

2. Until the expiration of the time allowed under section 507B.8 for filing a petition for review if no such petition has been duly filed within such time, or, if a petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the district court, the commissioner may at any time, upon such notice and in such manner as the commissioner may deem proper, modify or set aside in whole or in part any order issued by the commissioner under this section.

3. After the expiration of the time allowed for filing such a petition for review if no such petition has been duly filed within such time, the commissioner may at any time, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by the commissioner under this section, whenever in the commissioner's opinion conditions of fact or of law have so changed as to require such action, or if the public interest shall so

require.

4. Any person who violates ~~a cease and desist~~ an order of the commissioner, and while such order is in effect, may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to any one or more of the following:

a. A monetary penalty of not more than ten thousand dollars for each and every act or violation. A penalty collected under this lettered paragraph shall be deposited as provided in section 505.7.

b. Suspension or revocation of such person's license.

Sec. 3. Section 507E.2A, subsection 2, Code 2021, is amended to read as follows:

2. "*Insurer*" ~~includes an insurer~~ means any corporation, association, partnership, or individual engaged in the business of insurance, including but not limited to a corporation, association, partnership, or individual that issues a policy of workers' compensation, a self-insured business for purposes of workers' compensation liability, or a group or self-insured plan as described in section 87.4. "*Insurer*" does not include a person required to be licensed to sell, solicit, or negotiate insurance pursuant to chapter 522B.

Sec. 4. Section 507E.8, Code 2021, is amended to read as follows:

507E.8 Law enforcement authority.

1. An individual employed by the division and designated as a peace officer shall be considered a law enforcement officer as that term is defined in section 80B.3, and shall exercise the powers of a law enforcement officer as follows:

a. For purposes of an arrest resulting from a criminal violation of any provision of the Code subject to the jurisdiction of the commissioner established as a result of an investigation pursuant to this chapter~~, an insurance fraud bureau investigator shall have the authority and status of a law enforcement officer pursuant to section 80B.3, subsection 3~~.

b. While conducting an investigation or engaged in an assignment authorized by this chapter or ordered by the commissioner.

c. To protect life if a public offense is committed in the presence of the peace officer.

d. While providing assistance to a law enforcement agency or another law enforcement officer.

e. While providing assistance at the request of a member of the public.

2. ~~The laws~~ Laws applicable to an arrest of an individual by a law enforcement officer of the state shall apply to an ~~insurance fraud bureau investigator~~ individual employed by the division and designated as a peace officer. An ~~insurance fraud bureau investigator~~ individual employed by the division and designated as a peace officer shall have the power to execute arrest warrants and search warrants, serve subpoenas issued for the examination, investigation, and trial of all offenses identified through the course of an investigation conducted pursuant to this section, and arrest upon probable cause without warrant a person found in the act of committing a violation of ~~a provision of~~ this chapter or a law of this state.

Sec. 5. Section 508.38, subsection 3, paragraph b, subparagraph (1), subparagraph division (c), Code 2021, is amended to read as follows:

(c) The resulting interest guarantee shall not be less than ~~one~~ fifteen hundredths percent.

Sec. 6. Section 508E.2, subsection 14, Code 2021, is amended to read as follows:

14. *"Viatical settlement broker"* means a person, including a life insurance producer ~~as provided for in section 508E.3~~, who, working exclusively on behalf of a viator and for a fee, commission, or other valuable consideration, offers or attempts to negotiate viatical settlement contracts between a viator and one or more viatical settlement providers or one or more viatical settlement brokers. Notwithstanding the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator, and not the insurer or the viatical settlement provider, and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. *"Viatical settlement broker"* does not include an attorney,

certified public accountant, or a financial planner accredited by a nationally recognized accreditation agency who is retained to represent the viator and whose compensation is not paid directly or indirectly by the viatical settlement provider or purchaser.

Sec. 7. Section 509.1, subsection 9, Code 2021, is amended to read as follows:

9. A policy of group health insurance coverage issued to ~~an associated health plan~~ a multiple employer welfare arrangement pursuant to ~~section 513D.1~~ chapter 513D that is subject to regulation by the commissioner.

Sec. 8. Section 509.19, subsection 2, paragraph d, Code 2021, is amended to read as follows:

d. A multiple employer welfare arrangement, as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002~~(40)~~, paragraph 40, or a multiple employer welfare arrangement formed as an association health plan pursuant to 29 C.F.R. pt. 2510, that meets the requirements of ~~section 507A.4, subsection 9, paragraph "a"~~ chapter 513D.

Sec. 9. Section 510.21, Code 2021, is amended to read as follows:

510.21 ~~Certificate of registration required~~ Certificates — registration and renewal.

A person shall not act as or represent oneself to be a third-party administrator in this state, other than an adjuster licensed in this state for the kinds of business for which the person is acting as a third-party administrator, unless the person holds a current certificate of registration as a third-party administrator issued by the commissioner of insurance. A certificate of registration as a third-party administrator ~~is renewable~~ shall be renewed every three years. Failure to hold a current certificate ~~subjects the~~ of registration shall subject a third-party administrator to the sanctions set out in section 507B.7. ~~The~~ An application for a certificate of registration shall be accompanied by a filing fee of one hundred dollars. A certificate of registration shall be issued by the commissioner to a third-party administrator unless the commissioner~~, after due notice and~~

~~hearing,~~ determines that the third-party administrator is not competent, trustworthy, financially responsible, ~~or~~ of good personal and business reputation, or has had ~~a previous~~ an application for an insurance license denied for cause within the preceding five years.

~~An application for registration shall be accompanied by a filing fee of one hundred dollars. After notice and hearing, the commissioner may impose any or all of the sanctions set out in section 507B.7, upon finding that either the third-party administrator violated any of the requirements of sections 510.12 through 510.20 and this section, or the third-party administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.~~ If the commissioner denies an application for registration or renewal, a written notice that specifies the reasons for the denial or nonrenewal shall be provided to the applicant. Pursuant to chapter 17A, upon the applicant's request, the commissioner shall grant the applicant a hearing on the denial or nonrenewal.

Sec. 10. Section 510.23, Code 2021, is amended by striking the section and inserting in lieu thereof the following:

510.23 Violations and penalties.

1. If, after hearing, the commissioner determines that a third-party administrator has violated this chapter, or chapter 507B, the commissioner may order any one or more of the sanctions or penalties set out in section 507B.7.

2. If, after hearing, the commissioner determines that a person has aided and abetted a third-party administrator in commission of a violation of this chapter, or chapter 507B, the commissioner may order any one or more of the sanctions or penalties set out in section 507B.7.

3. If, after hearing, the commissioner determines that a third-party administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation, the commissioner may order any one or more of the sanctions and penalties set out in section 507B.7.

Sec. 11. Section 513D.1, Code 2021, is amended by striking the section and inserting in lieu thereof the following:

513D.1 Multiple employer welfare arrangements and association

health plans.

1. As used in this chapter, unless the context otherwise requires:

a. "Association health plan" or *"AHP"* means a multiple employer welfare arrangement formed as an association health plan pursuant to 29 C.F.R. pt. 2510.

b. "Commissioner" means the commissioner of insurance.

c. "Multiple employer welfare arrangement" or *"MEWA"* means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. §1002, paragraph 40.

2. An AHP or MEWA that offers a plan to, or maintains a group health plan for, any resident of this state shall be subject to the jurisdiction of the commissioner and shall comply with all of the following requirements:

a. The AHP or MEWA must be administered by an insurer authorized to do the business of insurance in this state or an authorized third-party administrator that holds a current certificate of registration pursuant to section 510.21.

b. The AHP or MEWA must be established by a trade, industry, or professional association of employers that has a constitution or bylaws, is organized and maintained in good faith, and has membership stability as defined by rules adopted by the commissioner.

c. The AHP or MEWA must register with the commissioner and obtain and maintain a certificate of registration issued by the commissioner.

d. The AHP or MEWA shall comply with all rules and solvency standards established by rules adopted by the commissioner.

3. An AHP or MEWA that does not meet the solvency standards pursuant to subsection 2, paragraph *"d"*, shall be subject to chapter 507C.

4. An AHP or MEWA that meets all of the requirements of subsection 2 shall not be considered any of the following:

a. An insurance company or association of whatever kind or character under section 432.1.

b. A member of the Iowa individual health benefit reinsurance association pursuant to section 513C.10, subsection 1.

c. A member insurer of the Iowa life and health insurance guaranty association pursuant to section 508C.5.

5. An AHP or MEWA that is registered with the commissioner pursuant to subsection 2, paragraph *"c"*, shall annually file with the commissioner on or before March 1 a copy of the report required to be filed by the AHP or MEWA with the United States department of labor pursuant to 29 C.F.R. §2520.101-2.

6. An AHP or MEWA that is registered with the commissioner pursuant to subsection 2, paragraph *"c"*, shall annually file with the commissioner a report on or before March 1 for the preceding calendar year. The annual report shall contain the information and be in a form and manner as prescribed by the commissioner.

7. A foreign or domestic AHP or MEWA doing business in the state shall pay fees as prescribed by the commissioner unless otherwise provided by law.

8. A MEWA that is recognized as tax-exempt under Internal Revenue Code section 501(c)(9) and that is registered with the commissioner prior to January 1, 2018, shall not be considered an AHP unless the MEWA affirmatively elects to be treated as an AHP.

Sec. 12. Section 513D.2, subsection 1, Code 2021, is amended to read as follows:

1. The commissioner of insurance shall adopt rules~~,~~ as necessary~~,~~ pursuant to chapter 17A to administer this chapter.

Sec. 13. Section 514G.103, subsection 10, Code 2021, is amended to read as follows:

10. *"Independent review ~~entity~~ organization"* means a review ~~entity~~ organization certified by the commissioner pursuant to section 514G.110, subsection 4.

Sec. 14. Section 514G.110, subsections 4, 5, 6, 7, 8, and 9, Code 2021, are amended to read as follows:

4. *Qualifications of independent review ~~entities~~ organizations.* The commissioner shall maintain a list of qualified independent review ~~entities~~ organizations that are certified by the commissioner. Independent review ~~entities~~ organizations shall be recertified by the commissioner every two years in order to remain on the list. In order to be certified, an independent review ~~entity~~ organization shall meet

all of the following criteria:

a. Have on staff, or contract with, a qualified, licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment who can conduct an independent review.

(1) In order to be qualified, a licensed health care professional who is a physician shall hold a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

(2) In order to be qualified, a licensed health care professional who is not a physician shall hold a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

b. Ensure that any licensed health care professional who conducts an independent review has no history of disciplinary actions or sanctions, including but not limited to the loss of staff privileges or any participation restrictions taken or pending by any hospital or state or federal government regulatory agency.

c. Ensure that the independent review ~~entity~~ organization or any of its employees, agents, or licensed health care professionals utilized does not receive compensation of any type that is dependent on the outcome of a review.

d. Ensure that the independent review ~~entity~~ organization or any of its employees, agents, or licensed health care professionals utilized are not in any manner related to, employed by, or affiliated with the insured or with a person who previously provided medical care to the insured.

e. Ensure that an independent review ~~entity~~ organization or any of its employees, agents, or licensed health care professionals utilized is not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insurer is a member.

f. Have a quality assurance program on file with the commissioner that ensures the timeliness and quality of reviews performed, the qualifications and independence of the licensed

health care professionals who perform the reviews, and the confidentiality of the review process.

g. Have on staff or contract with a licensed health care practitioner, as defined in section 514G.103, subsection 3, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

5. *Independent review process.* The independent review process shall be conducted as follows:

a. Within three business days of receiving a notice from the commissioner of the certification of a request for independent review or receipt of a denial of an insurer's appeal from such a certification, the insurer shall do all of the following:

(1) Select an independent review ~~entity~~ organization from the list certified by the commissioner and notify the insured in writing of the name, address, and telephone number of the selected independent review ~~entity selected~~ organization. The selected independent review ~~entity selected~~ organization shall utilize a licensed health care professional with qualifications appropriate to the benefit trigger determination that is under review.

(2) Notify the independent review ~~entity~~ organization that it has been selected to conduct an independent review of a benefit trigger determination and provide sufficient descriptive information to enable the independent review ~~entity~~ organization to provide licensed health care professionals who will be qualified to conduct the review.

(3) Provide the commissioner with a copy of the notices sent to the insured and to the selected independent review ~~entity selected~~ organization.

b. Within three business days of receiving a notice from an insurer that it has been selected to conduct an independent review, the independent review ~~entity~~ organization shall do one of the following:

(1) Accept its selection as the independent review ~~entity~~ organization, designate a qualified licensed health care professional to perform the independent review, and provide notice of that designation to the insured and the insurer, including a brief description of the health care professional's qualifications and the reasons that person is qualified to

determine whether the insured's benefit trigger has been met. A copy of this notice shall be sent to the commissioner via facsimile. The independent review ~~entity~~ organization is not required to disclose the name of the health care professional selected.

(2) Decline its selection as the independent review ~~entity~~ organization or, if the independent review ~~entity~~ organization does not have a licensed health care professional who is qualified to conduct the independent review available, request additional time from the commissioner to have a qualified licensed health care professional certified, and provide notice to the insured, the insurer, and the commissioner. The commissioner shall notify the independent review ~~entity~~ organization, the insured, and the insurer of how to proceed within three business days of receipt of such notice from the independent review ~~entity~~ organization.

c. An insured may object to the independent review ~~entity~~ organization selected by the insurer or to the licensed health care professional designated by the independent review ~~entity~~ organization to conduct the review by filing a notice of objection along with reasons for the objection, with the commissioner within ten days of receipt of a notice sent by the independent review ~~entity~~ organization pursuant to paragraph "*b*". The commissioner shall consider the insured's objection and shall notify the insured, the insurer, and the independent review ~~entity~~ organization of the commissioner's decision to sustain or deny the objection within two business days of receipt of the objection.

d. Within five business days of receiving a notice from the independent review ~~entity~~ organization accepting its selection or within five business days of receiving a denial of an objection to the independent review ~~entity~~ organization selected, whichever is later, the insured may submit any information or documentation in support of the insured's claim to both the independent review ~~entity~~ organization and the insurer.

e. Within fifteen days of receiving a notice from the independent review ~~entity~~ organization accepting its selection or within three business days of receipt of a denial of

an objection to the independent review ~~entity~~ organization selected, whichever is later, an insurer shall do all of the following:

(1) Provide the independent review ~~entity~~ organization with any information submitted to the insurer by the insured in support of the insured's internal appeal of the insurer's benefit trigger determination.

(2) Provide the independent review ~~entity~~ organization with any other relevant documents used by the insurer in making its benefit trigger determination.

(3) Provide the insured and the commissioner with confirmation that the information required under subparagraphs (1) and (2) has been provided to the independent review ~~entity~~ organization, including the date the information was provided.

f. The independent review ~~entity~~ organization shall not commence its review until fifteen days after the selection of the independent review ~~entity~~ organization is final including the resolution of any objection made pursuant to paragraph *"c"*. During this time period, the insurer may consider any information provided by the insured pursuant to paragraph *"d"* and overturn or affirm the insurer's benefit trigger determination based on such information. If the insurer overturns its benefit trigger determination, the independent review process shall immediately cease.

g. In conducting a review, the independent review ~~entity~~ organization shall consider only the information and documentation provided to the independent review ~~entity~~ organization pursuant to paragraphs *"d"* and *"e"*.

h. The independent review ~~entity~~ organization shall submit its decision as soon as possible, but not later than thirty days from the date the independent review ~~entity~~ organization receives the information required under paragraphs *"d"* and *"e"*, whichever is received later. The decision shall include a description of the basis for the decision and the date of the benefit trigger determination to which the decision relates. The independent review ~~entity~~ organization, for good cause, may request an extension of time from the commissioner to file its decision. A copy of the decision shall be mailed to the insured, the insurer, and the commissioner.

i. All medical records submitted for use by the independent review ~~entity~~ organization shall be maintained as confidential records as required by applicable state and federal laws. The commissioner shall keep all information obtained during the independent review process confidential pursuant to section 505.8, subsection 8, except that the commissioner may share some information obtained as provided under section 505.8, subsection 8, and as required by this chapter and rules adopted pursuant to this chapter.

j. If an insured dies before completion of the independent review, the review shall continue to completion if there is potential liability of an insurer to the estate of the insured or to a provider for rendering qualified long-term care services to the insured.

6. *Costs.* All reasonable fees and costs of the independent review ~~entity incurred~~ organization in conducting an independent review under this section shall be paid by the insurer.

7. *Immunity.* An independent review ~~entity~~ organization that conducts a review under this section is not liable for damages arising from determinations made during the review. Immunity does not apply to any act or omission made by an independent review ~~entity~~ organization in bad faith or that involves gross negligence.

8. *Effect of independent review decision.*

a. The review decision by the independent review ~~entity~~ organization conducting the review is binding on the insurer.

b. The independent review process set forth in this section shall not be considered a contested case under chapter 17A.

c. An insured may appeal the review decision by the independent review ~~entity~~ organization conducting the review by filing a petition for judicial review in the district court in the county in which the insured resides. The petition for judicial review shall be filed within fifteen business days after the issuance of the review decision by the independent review organization. The petition shall name the insured as the petitioner and the insurer as the respondent. The petitioner shall not name the independent review ~~entity~~ organization as a party. The commissioner shall not be named

as a respondent unless the insured alleges action or inaction by the commissioner under the standards articulated under section 17A.19, subsection 10. Allegations made against the commissioner under section 17A.19, subsection 10, must be stated with particularity. The commissioner may, upon motion, intervene in a judicial review proceeding brought pursuant to this paragraph. The findings of fact by the independent review ~~entity~~ organization conducting the review are conclusive and binding on appeal.

d. An insurer shall not be subject to any penalties, sanctions, or damages for complying in good faith with a review decision rendered by an independent review ~~entity~~ organization pursuant to this section.

e. Nothing contained in this section or in section 514G.109 shall be construed to limit the right of an insurer to assert any rights an insurer may have under a long-term care insurance policy related to:

(1) An insured's misrepresentation.

(2) Changes in the insured's benefit eligibility.

(3) Terms, conditions, and exclusions contained in the policy, other than failure to meet the benefit trigger.

f. The requirements of this section and section 514G.109 are not applicable to a group long-term care insurance policy that is governed by the federal Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. ~~§100~~ §1001 et seq.

g. The provisions of this section and section 514G.109 are in lieu of and supersede any other third-party review requirement contained in chapter 514J or in any other provision of law.

h. The insured may bring an action in the district court in the county in which the insured resides to enforce the review decision of the independent review ~~entity~~ organization conducting the review or the decision of the court on appeal.

9. *Receipt of notice.* Notice required by this section shall be deemed received within five days after the date of mailing.

Sec. 15. Section 515A.2, subsection 1, Code 2021, is amended by adding the following new paragraph:

NEW PARAGRAPH. *0a.* "*Commissioner*" means the commissioner of insurance.

Sec. 16. Section 515A.6, subsection 7, Code 2021, is amended to read as follows:

7. Notwithstanding any ~~other provision of the Code~~ law to the contrary, the commissioner ~~of insurance~~ shall provide for a hearing in a proceeding involving a workers' compensation insurance rate filing by a licensed rating organization in accordance with the provisions of this subsection and rules promulgated by the commissioner ~~of insurance~~ pursuant to chapter 17A. Except as otherwise provided herein, the provisions of this subsection shall not be subject to the requirements of chapter 17A. The procedures for such hearing shall be as follows:

a. The commissioner shall provide notice of the filing of the proposed rates at least thirty days before the effective date of the proposed rates by publishing a notice on the internet site of the insurance division of the department of commerce.

b. A public hearing shall be held on the proposed rates by the commissioner ~~of insurance~~ if within fifteen days of the date of publication a workers' compensation policyholder or an established organization with one or more workers' compensation policyholders among its members files a written demand with the commissioner ~~of insurance~~ for a hearing on the proposed rates.

c. The commissioner ~~of insurance~~ shall hold the hearing within twenty days after receipt of the written demand for a hearing and shall give not less than ten days written notice of the time and place of the hearing to the person or association filing the demand, to the rating organization, and to any other person requesting such notice.

d. At any such hearing, the rating organization shall bear the burden of proof to support the proposed rates by a preponderance of the evidence. The person or association requesting the hearing, and any other person admitted as a party to the proceeding, shall be given the opportunity to respond and introduce evidence and arguments on all the issues involved.

e. Within fifteen days after the start of the hearing, the commissioner ~~of insurance will~~ shall approve or disapprove the proposed rates and specify the reasons therefor. The

commissioner ~~of insurance~~ may suspend or postpone the effective date of the proposed rates pending the hearing and written decision thereon.

f. Judicial review of the decision of the commissioner ~~of insurance~~ on such rates may be sought in accordance with the provisions of chapter 17A.

g. Absent a request for a hearing as provided in paragraph "*b*", the commissioner shall issue an order approving or disapproving the proposed rates.

h. The waiting period for a workers' compensation insurance rate filing shall commence no earlier than the date that notice of the insurance rate filing is published.

Sec. 17. Section 515A.10, Code 2021, is amended to read as follows:

515A.10 Advisory organizations.

1. Every group, association or other organization of insurers, whether located within or outside of this state, which assists insurers which make their own filings or rating organizations in rate making, by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but which does not make filings under this chapter, shall be known as an advisory organization.

2. An advisory organization shall not provide a service relating to this chapter, and an insurer shall not utilize the services of an advisory organization for such purposes unless the advisory organization has obtained a license under subsection 3.

~~2.~~ 3. ~~Every~~ An advisory organization applying for a license shall ~~file~~ include with its application to the commissioner all of the following:

a. A copy of its constitution, its articles of agreement or association or its certificate of incorporation and of its bylaws, rules and regulations governing its activities.

b. A list of its members.

c. The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued at the commissioner's direction may be served.

d. An agreement that the commissioner may examine such advisory organization in accordance with the provisions of

section 515A.12.

e. A fee of one hundred dollars.

~~3.~~ 4. If, after ~~a~~ hearing, the commissioner finds that ~~the furnishing of such information or assistance involves~~ an advisory organization has engaged in any act or practice which is unfair, ~~or~~ unreasonable, or ~~otherwise inconsistent with the provisions~~ in violation of this chapter, the commissioner may issue ~~a written~~ an order ~~specifying in what respects such act or practice is unfair or unreasonable or otherwise inconsistent with the provisions of this chapter, and~~ requiring the ~~discontinuance of such act or practice~~ advisory organization to cease and desist such act or practice. The commissioner may, at any time after hearing, revoke or suspend the license of an advisory organization which does not comply with this chapter.

~~4.~~ 5. No insurer which makes its own filings nor any rating organization shall support its filings by statistics or adopt rate making recommendations, furnished to it by an advisory organization which has not complied with this section or with an order of the commissioner involving such statistics or recommendations issued under subsection ~~3~~ 4 of this section. If the commissioner finds such insurer or rating organization to be in violation of this subsection the commissioner may issue an order requiring the discontinuance of such violation.

6. A license issued under this section shall remain in effect for three years unless sooner suspended or revoked by the commissioner.

Sec. 18. Section 515D.4, subsection 2, paragraph a, Code 2021, is amended to read as follows:

a. The named insured or any operator who either resides in the same household or customarily operates an automobile insured under the policy has that person's driver's license suspended or revoked during ~~the policy term or, if the policy is a renewal, during its term or the one hundred eighty days immediately preceding its effective date.~~ any of the following:

(1) The term of the policy.

(2) The term of a renewal policy.

(3) Within one hundred eighty calendar days immediately preceding the effective date of a renewal of the policy.

Sec. 19. Section 515D.4, subsection 3, Code 2021, is amended

to read as follows:

3. This section shall not apply to any policy or coverage which has been in effect less than sixty calendar days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy. This section shall not apply to the nonrenewal of a policy.

Sec. 20. Section 515D.5, Code 2021, is amended to read as follows:

515D.5 Delivery of notice.

1. *a.* Notwithstanding the provisions of section 515.129A, a notice of cancellation of a policy shall not be effective unless mailed or delivered by the insurer to the named insured at least thirty calendar days prior to the effective date of cancellation, or, where the cancellation is for nonpayment of premium notwithstanding the provisions of section 515.129A, at least ten calendar days prior to the date of cancellation. A post office department certificate of mailing to the named insured at the address shown in the policy shall be proof of receipt of such mailing. Unless the reason accompanies the notice of cancellation, the notice shall state that upon written request of the named insured, mailed or delivered to the insurer not less than fifteen calendar days prior to the date of cancellation, the insurer will state the reason for cancellation together with notification of the right to a hearing before the commissioner within fifteen calendar days as provided in this chapter.

b. When the reason does not accompany the notice of cancellation, the insurer shall, upon receipt of a timely request by the named insured, state in writing the reason for cancellation. A statement of reason shall be mailed or delivered to the named insured within five calendar days after receipt of a request.

2. A notice of exclusion of a person under a policy pursuant to section 515D.4, is not effective unless written notice is mailed or delivered to the named insured at least twenty calendar days prior to the effective date of the exclusion. The written notice shall state the reason for the exclusion, together with notification of the right to a hearing before the commissioner pursuant to section 515D.10 within fifteen

calendar days of receipt or delivery of a statement of reason as provided in this section.

Sec. 21. Section 515D.6, Code 2021, is amended to read as follows:

515D.6 Prohibited reasons for nonrenewal.

1. No insurer shall refuse to renew a policy solely because of age, residence, sex, race, color, creed, or occupation ~~of an insured~~.

2. No insurer shall require a physical examination of a policyholder as a condition for renewal solely on the basis of age or other arbitrary reason. In the event that an insurer requires a physical examination of a policyholder, the burden of proof in establishing reasonable and sufficient grounds for such requirement shall rest with the insurer and the expenses incident to such examination shall be borne by the insurer.

Sec. 22. Section 515D.7, Code 2021, is amended to read as follows:

515D.7 Notice of intent.

1. Notwithstanding the provisions of sections 515.125, 515.128, 515.129B, and 515.129C, an insurer shall not fail to renew a policy except by notice to the insured as provided in this chapter. A notice of intention not to renew shall not be effective unless mailed or delivered by the insurer to the named insured at least thirty calendar days prior to the expiration date of the policy. A post office department certificate of mailing to the named insured at the address shown in the policy shall be proof of receipt of such mailing. Unless the reason accompanies the notice of intent not to renew, the notice shall state that, upon written request of the named insured, mailed or delivered to the insurer not less than thirty calendar days prior to the expiration date of the policy, the insurer will state the reason for nonrenewal.

2. When the reason does not accompany the notice of intent not to renew, the insurer shall, upon receipt of a timely request by the named insured, state in writing the reason for nonrenewal, together with notification of the right to a hearing before the commissioner within fifteen calendar days as provided herein. A statement of reason shall be mailed or delivered to the named insured within ten days after receipt

of a request.

3. This section shall not apply:

a. If the insurer has manifested its willingness to renew.

b. If the insured fails to pay any premium due or any advance premium required by the insurer for renewal.

c. If the insured is transferred from an insurer to an affiliate for future coverage as a result of a merger, acquisition, or company restructuring and if the transfer results in the same or broader coverage.

Sec. 23. Section 515D.10, Code 2021, is amended to read as follows:

515D.10 Hearing before commissioner.

Any named insured who has received a statement of reason for cancellation, or of reason for an insurer's intent not to renew a policy, may, within fifteen calendar days of the receipt or delivery of a statement of reason, request a hearing before the commissioner of insurance. The purpose of this hearing shall be limited to establishing the existence of the proof or evidence ~~used~~ stated by the insurer ~~in~~ as its reason for cancellation or intent not to renew. The burden of proof of the reason for cancellation or intent not to renew shall be upon the insurer. Other than the sharing of information required by this chapter and the rules adopted pursuant to the provisions of this chapter, the commissioner shall keep confidential the information obtained from the insured or in the hearing process, pursuant to section 505.8, subsection 8. The commissioner of insurance shall adopt rules ~~for carrying out~~ pursuant to chapter 17A to implement the provisions of this section.

Sec. 24. Section 515F.2, Code 2021, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. As used in this chapter, unless the context otherwise requires:

Sec. 25. Section 515F.2, Code 2021, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. *"Commissioner"* means the commissioner of insurance.

Sec. 26. Section 515F.8, subsection 3, paragraph a, Code 2021, is amended by adding the following new subparagraph:

NEW SUBPARAGRAPH. (7) A license fee of one hundred dollars.

Sec. 27. Section 515F.8, subsection 3, paragraph d, Code 2021, is amended to read as follows:

d. Duration. A license issued under this section shall remain in effect for ~~one year~~ three years unless the license is suspended or revoked. The commissioner may, at any time after hearing, revoke or suspend the license of an advisory organization which does not comply with ~~the requirements and standards of~~ this chapter.

Sec. 28. Section 515F.32, Code 2021, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. As used in this subchapter, unless the context otherwise requires:

Sec. 29. Section 515F.32, subsection 3, Code 2021, is amended to read as follows:

3. *"Insurer"* includes all companies or associations licensed to transact insurance business in this state under chapters 515, 518, and 518A, reciprocal insurers issued a certificate of authority pursuant to chapter 520, and companies or associations admitted or seeking to be admitted to do business in this state under any of those chapters, notwithstanding any provision of the Code to the contrary.

Sec. 30. Section 515F.36, subsection 2, paragraph a, subparagraphs (1) and (2), Code 2021, are amended to read as follows:

(1) American property casualty insurance association.

(2) ~~Property casualty insurers association of America~~ National association of mutual insurance companies.

Sec. 31. NEW SECTION. **515F.39 Cancellation or nonrenewal — FAIR notice.**

If basic property insurance coverage is canceled or not renewed other than for nonpayment of a premium pursuant to section 515.125, 515.126, 515.127, 515.128, 518.23, or 518A.29, the insurer shall notify the named insured that the named insured may be eligible for basic property insurance through the FAIR plan. The notice shall accompany the notice of cancellation or the intent not to renew.

Sec. 32. Section 515I.4, subsection 1, paragraph a, Code 2021, is amended to read as follows:

a. Capital and surplus or its equivalent under the laws of the insurer's domiciliary jurisdiction which equals the ~~greater of either~~ greatest of the following:

(1) The minimum capital and surplus requirements under the laws of this state.

(2) Fifteen million dollars.

(3) The risk-based capital level requirements pursuant to chapter 521E.

Sec. 33. Section 522.9, subsection 1, Code 2021, is amended to read as follows:

1. If an insurer fails, without just cause, to file an own risk and solvency assessment summary report by the filing date stipulated to the commissioner pursuant to section 522.5, subsection 1, paragraph "*c*", the commissioner shall, after notice and hearing, impose a penalty of five hundred dollars for each calendar day after the stipulated date that the summary report is not filed. The penalties shall be collected by the commissioner and deposited ~~in the general fund of the state~~ pursuant to section 505.7. The maximum penalty which may be imposed under this section is fifty thousand dollars.

DIVISION II

CEMETERY AND FUNERAL MERCHANDISE AND FUNERAL SALES

Sec. 34. Section 523A.204, subsections 1 and 2, Code 2021, are amended to read as follows:

1. A preneed seller shall file an annual report with the commissioner not later than April ~~1 of each year an annual report~~ 15 on a form prescribed by the commissioner.

2. A preneed seller filing an annual report shall pay a filing fee of ten dollars per purchase agreement sold during the year covered by the report. Duplicate filing fees are not required for the same purchase agreement. If a purchase agreement has multiple sellers, the filing fee shall be paid by the preneed seller actually providing the merchandise and services.

Sec. 35. Section 523A.204, Code 2021, is amended by adding the following new subsection:

NEW SUBSECTION. 4. The commissioner may impose a late fee of five dollars for each day after April 15 that a preneed seller fails to file the preneed seller's annual report. The

maximum late fee that may be imposed under this subsection is five hundred dollars. The fee shall be collected by the commissioner and deposited pursuant to section 505.7.

Sec. 36. Section 523A.501, subsection 7, Code 2021, is amended to read as follows:

7. A preneed seller's license ~~expires~~ shall expire annually on April ~~15~~ 30. If ~~the~~ a preneed seller has filed ~~a complete~~ an annual report pursuant to section 523A.204, subsection 1, and paid the required fees ~~as required in section 523A.204,~~ the commissioner shall renew the preneed seller's license until April ~~15~~ 30 of the following year.

Sec. 37. Section 523A.502, subsection 5, Code 2021, is amended to read as follows:

5. A sales license shall expire annually on April ~~15~~ 30. If ~~the~~ a sales agent has filed ~~a substantially complete~~ an annual report ~~as required in~~ pursuant to section 523A.502A, subsection 1, and has fulfilled the continuing education requirements pursuant to subsection 6, the commissioner shall renew the sales agent's sales license until April ~~15~~ 30 of the following year.

Sec. 38. Section 523A.502A, subsection 1, Code 2021, is amended to read as follows:

1. ~~A~~ No later than April 15, a sales agent shall file an annual report with the commissioner ~~not later than April 1 of each year an annual report~~ on a form prescribed by the commissioner describing each purchase agreement sold by the sales agent during the year. An annual report must be filed whether or not ~~sales were made~~ a sales agent sold any purchase agreements during the year and ~~even if the~~ whether or not a sales agent is ~~no longer~~ still an agent of a preneed seller or is still licensed by the commissioner.

Sec. 39. Section 523A.502A, Code 2021, is amended by adding the following new subsection:

NEW SUBSECTION. 3. The commissioner may impose a late fee of five dollars for each day after April 15 that a sales agent fails to file the sales agent's annual report. The maximum late fee that may be imposed pursuant to this section is five hundred dollars. The fee shall be collected by the commissioner and deposited pursuant to section 505.7.

Sec. 40. Section 523A.601, subsection 4, Code 2021, is amended by striking the subsection and inserting in lieu thereof the following:

4. All purchase agreements, including a purchase agreement delivered or executed by electronic means, must have a sales agent identified. A purchase agreement, including a purchase agreement delivered or executed by electronic means, shall be reviewed by the sales agent identified and named in the purchase agreement pursuant to subsection 1, paragraph *"a"*, and signed by the purchaser and seller. If the purchase agreement is for mortuary science services as *"mortuary science"* is defined in section 156.1, the purchase agreement must also be signed by a person licensed to deliver funeral services.

Sec. 41. Section 523A.807, subsection 3, unnumbered paragraph 1, Code 2021, is amended to read as follows:

If the commissioner finds that a person has violated section 523A.201, 523A.202, 523A.203, 523A.204, 523A.207, 523A.401, 523A.402, 523A.403, 523A.404, 523A.405, 523A.501, ~~or~~ 523A.502, or 523A.502A, or any rule adopted pursuant thereto, the commissioner may order any or all of the following:

Sec. 42. Section 523A.812, Code 2021, is amended to read as follows:

523A.812 Insurance division regulatory fund.

The insurance division may authorize the creation of a special revenue fund in the state treasury, to be known as the insurance division regulatory fund. The commissioner shall allocate annually from the filing fees paid pursuant to section 523A.204, two dollars for each purchase agreement reported on a preneed seller's annual report filed pursuant to section 523A.204 for deposit to the regulatory fund. The remainder of the fees collected pursuant to section 523A.204 shall be deposited as provided in section 505.7. The commissioner shall also allocate annually the examination fees paid pursuant to section 523A.814 and any examination expense reimbursement for deposit to the regulatory fund. The moneys in the regulatory fund shall be retained in the fund. The moneys are appropriated and, subject to authorization by the commissioner, may be used to pay examiners, examination expenses, investigative expenses, the expenses of mediation

ordered by the commissioner, consumer education expenses, the expenses of a toll-free telephone line to receive consumer complaints, and the expenses of receiverships established under section 523A.811. If the commissioner determines that funding is not otherwise available to reimburse the expenses of a person who receives title to a cemetery subject to chapter 523I, pursuant to such a receivership, the commissioner shall use moneys in the regulatory fund as necessary to preserve, protect, restore, and maintain the physical integrity of that cemetery and to satisfy claims or demands for cemetery merchandise, funeral merchandise, and funeral services based on purchase agreements which the commissioner determines are just and outstanding. ~~An annual allocation to the regulatory fund shall not be imposed if the current balance of the fund exceeds five hundred thousand dollars.~~

DIVISION III

RESIDENTIAL AND MOTOR VEHICLE SERVICE CONTRACTS

Sec. 43. Section 523C.3, subsection 2, paragraph b, Code 2021, is amended to read as follows:

b. If applicable, a fee in the amount of ~~fifty~~ thirty-five dollars for each motor vehicle service contract form submitted in an application as provided in subsection 1, paragraph *"f"*.

Sec. 44. Section 523C.4, subsection 3, paragraph c, Code 2021, is amended to read as follows:

c. If applicable, a fee in the amount of ~~fifty~~ thirty-five dollars for each motor vehicle service contract form submitted ~~in a~~ with the renewal application pursuant to subsection 2, and as provided in section 523C.3, subsection 1, paragraph *"f"*.

DIVISION IV

IOWA CEMETERY ACT

Sec. 45. Section 523I.102, subsection 6, Code 2021, is amended by adding the following new paragraph:

NEW PARAGRAPH. *d.* A cemetery under the jurisdiction and control of a cemetery commission pursuant to section 331.325, subsection 3, paragraph *"c"*.

Sec. 46. Section 523I.213, Code 2021, is amended to read as follows:

523I.213 Insurance division's enforcement fund.

A special revenue fund in the state treasury, to be known as

the insurance division's enforcement fund, is created under the authority of the commissioner. The commissioner shall ~~allocate annually from the examination fees paid pursuant to section 523I.808, an amount not exceeding fifty thousand dollars, for~~ deposit ~~to~~ all examination fees collected pursuant to section 523I.808 in the insurance division's enforcement fund. The moneys in the enforcement fund shall be retained in the fund. The moneys are appropriated and, subject to authorization by the commissioner, shall be used to pay examiners, examination expenses, investigative expenses, the expenses of consumer education, compliance, and education programs for filers and other regulated persons, and educational or compliance program materials, the expenses of a toll-free telephone line for consumer complaints, and the expenses of receiverships of perpetual care cemeteries established under section 523I.212.

Sec. 47. Section 523I.301, subsections 1 and 2, Code 2021, are amended to read as follows:

1. A cemetery shall disclose, prior to the sale of interment rights, whether opening and closing ~~of the interment space is~~ services are included in the purchase of the interment rights. If opening and closing services are not included in the sale of interment rights and the cemetery offers opening and closing services, the cemetery must disclose that the price for ~~this service~~ opening and closing services is subject to change and must disclose the current prices for opening and closing services provided by the cemetery.

2. The cemetery shall fully disclose all fees required for interment, entombment, ~~or~~ inurnment, or disinterment of human remains.

Sec. 48. Section 523I.309, subsection 6, Code 2021, is amended to read as follows:

6. A cemetery ~~may~~ shall disinter and relocate remains interred in the cemetery for the purpose of correcting an error made by the cemetery after obtaining a disinterment permit as required by section 144.34, unless the interested parties have a written agreement directing otherwise. The cemetery shall bear the costs of the disinterment and relocation. The cemetery shall provide written notice describing the error to the commissioner and to the person who has the right to

control the interment, relocation, or disinterment of the remains erroneously interred, by restricted certified mail at the person's last known address and sixty days prior to the disinterment. The notice shall include the location where the disinterment will occur and the location of the new interment space. A cemetery is not civilly or criminally liable for an erroneously made interment that is corrected in compliance with this subsection unless the error was the result of gross negligence or intentional misconduct.

Sec. 49. Section 523I.808, Code 2021, is amended to read as follows:

523I.808 ~~Examination~~ Annual report — examination fee.

An examination fee of ten dollars for each certificate of interment rights issued during the time period covered by the report shall be submitted with ~~the~~ a perpetual care cemetery's annual report ~~in an amount equal to five dollars for each certificate of interment rights issued during the time period covered by the report~~ filed pursuant to section 523I.813. The cemetery may charge the examination fee directly to the purchaser of the interment rights.

Sec. 50. Section 523I.813, subsection 3, Code 2021, is amended by striking the subsection and inserting in lieu thereof the following:

3. The commissioner may impose a late fee of five dollars for each day after April 30 that a perpetual care cemetery fails to file the perpetual care cemetery's annual report. The maximum late fee that shall be imposed by the commissioner is five hundred dollars. The late fee shall be collected by the commissioner and deposited pursuant to section 505.7.

DIVISION V

STATE INNOVATION WAIVER

Sec. 51. NEW SECTION. **505.18A State innovation waivers.**

1. The commissioner of insurance may develop by rule a state innovation waiver pursuant to section 1332 of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

2. The commissioner of insurance may submit an application on behalf of the state to the United States secretary of health and human services and the United States secretary of the

treasury for the state innovation waiver developed pursuant to subsection 1.

3. If a state innovation waiver submitted pursuant to subsection 2 is approved by the United States secretary of health and human services and the United States secretary of the treasury, the commissioner of insurance may implement the state innovation waiver in a manner consistent with applicable state and federal law.

4. The commissioner of insurance may adopt emergency rules under section 17A.4, subsection 3, and section 17A.5, subsection 2, paragraph "b", to implement the provisions of this section and the rules shall be effective immediately upon filing unless a later date is specified in the rules. Any rules adopted in accordance with this section shall also be published as a notice of intended action as provided in section 17A.4.

DIVISION VI

STUDY COMMITTEE — HEALTH INSURANCE MANDATES

Sec. 52. HEALTH INSURANCE MANDATES — STUDY.

1. The legislative council is requested to establish a study committee to meet during the 2021 legislative interim to accomplish the following:

a. Identify each health insurance mandate contained in chapter 514C, and in any other provision of the 2021 Iowa Code, and identify all of the following:

(1) The specific health insurance coverage required to be provided by each health insurance mandate.

(2) Each class of contract, policy, plan, and agreement that provides for third-party payment or prepayment of health or medical expenses that is subject to each health insurance mandate.

(3) Each class of contract, policy, plan, and agreement that provides for third-party payment or prepayment of health or medical expenses that is excluded from each health insurance mandate.

(4) Each type of health carrier that is subject to each health insurance mandate. For purposes of this section, "health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction

of the insurance commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. "Health carrier" includes the department of human services, or a managed care organization acting pursuant to a contract with the department of human services to administer the medical assistance program under chapter 249A or the healthy and well kids in Iowa (hawk-i) program under chapter 514I.

(5) Each type of health carrier that is excluded from each health insurance mandate.

b. For each health insurance mandate identified in paragraph "a", analyze all of the following:

(1) The fiscal impact to the state.

(2) The fiscal impact to each health carrier subject to each health insurance mandate.

(3) The impact to the premiums for individuals covered by a contract, policy, plan, or agreement of a health carrier under subparagraph (2).

c. For a possible future health insurance mandate related to continuity of care and nonmedical switching, analyze all of the following:

(1) The potential fiscal impact to the state.

(2) The potential fiscal impact to each health carrier that may be subject to the health insurance mandate.

(3) The potential impact to the premiums for individuals covered by a contract, policy, plan, or agreement of a health carrier under subparagraph (2).

d. For a possible future health insurance mandate related to the diagnosis and treatment of infertility, analyze all of the following:

(1) The potential fiscal impact to the state.

(2) The potential fiscal impact to each health carrier that may be subject to the health insurance mandate.

(3) The potential impact to the premiums for individuals covered by a contract, policy, plan, or agreement of a health carrier under subparagraph (2).

e. For a possible future health insurance mandate related to pediatric acute-onset neuropsychiatric syndrome (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), analyze all of the following:

(1) The potential fiscal impact to the state.

(2) The potential fiscal impact to each health carrier that may be subject to the health insurance mandate.

(3) The potential impact to the premiums for individuals covered by a contract, policy, plan, or agreement of a health carrier under subparagraph (2).

f. For a possible future health insurance mandate related to medically necessary food and low protein modified food product for individuals with certain inherited metabolic disorders, analyze all of the following:

(1) The potential fiscal impact to the state.

(2) The potential fiscal impact to each health carrier that may be subject to the health insurance mandate.

(3) The potential impact to the premiums for individuals covered by a contract, policy, plan, or agreement of a health carrier under subparagraph (2).

g. Identify the approximate number of Iowa residents that are covered by each of the following types of insurance:

(1) Individual health insurance.

(2) Small group health insurance.

(3) Large group health insurance.

(4) The medical assistance program under chapter 249A.

(5) The healthy and well kids in Iowa (hawk-i) program under chapter 514I.

2. The study committee shall have no more than fifteen members and shall be composed of the following members:

a. Two members of the senate, one to be appointed by the president of the senate and one to be appointed by the minority leader of the senate.

b. Two members of the house of representatives, one to be appointed by the speaker of the house of representatives and one to be appointed by the minority leader of the house of representatives.

c. The director of the insurance division of the department of commerce, or the director's designee.

d. The director of the department of human services, or the director's designee.

e. The consumer advocate of the consumer advocate bureau of the insurance division of the department of commerce, or the consumer advocate's designee.

f. At least one representative from each of the following:

(1) One or more trade organizations based in Iowa whose membership is comprised of independent insurance agents that sell health insurance.

(2) One or more health insurance trade organizations based in Iowa whose membership is comprised of companies or individuals engaged in the business of health insurance.

3. The study committee shall submit a report with its findings to the general assembly no later than December 31, 2021. The report shall not directly or indirectly disclose any of the following:

a. The identity of a specific health carrier.

b. The identity of a specific contract, policy, plan, or agreement that provides for third-party payment or prepayment of health or medical expenses.

PAT GRASSLEY
Speaker of the House

JAKE CHAPMAN
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 838, Eighty-ninth General Assembly.

MEGHAN NELSON
Chief Clerk of the House

Approved June 16, 2021

KIM REYNOLDS
Governor