CHAPTER 1159

PROFESSIONAL CORPORATION SHARES

H. F. 708

AN ACT to permit the issuance of shares of a professional corporation to persons who are licensed in other states to practice the profession which the corporation is licensed to practice in Iowa.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. Section four hundred ninety-six C point ten (496C.10), unnumbered paragraph one (1), Code 1979, is amended to read as follows:

Shares of a professional corporation may be issued, and treasury shares may be disposed of, only to individuals who are licensed to practice in this state, or in any other state or territory of the United States or in the District of Columbia, a profession which the corporation is authorized to practice.

Sec. 2. This Act is effective January first following its enactment.

Approved March 17, 1980

CHAPTER 1160

ACCIDENT AND SICKNESS INSURANCE

H. F. 2537

AN ACT relating to the sale of individual policies of accident and sickness insurance and subscriber contracts, relating to deductible and coinsurance provisions of contracts with health maintenance organizations, and providing penalties.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. Title twenty (XX), Code 1979, is amended by adding sections two (2) through nine (9) of this Act as a new chapter five hundred fourteen D (514D) of the Code.

Sec. 2. NEW SECTION. PURPOSE. The purpose of this division is to provide reasonable standardization, simplification, and disclosure of the terms and coverages of individual accident and sickness insurance policies issued under chapter five hundred fourteen A (514A) of the Code and individual subscriber contracts issued under chapter five hundred fourteen (514) of the Code, in order to facilitate public understanding and comparison and to eliminate provisions which may be misleading or unreasonably confusing in connection with the purchase of coverage or the settlement of claims.

Sec. 3. NEW SECTION. DEFINITIONS. As used in this division, unless the context otherwise requires:

1. "Accident and sickness insurance" means individual accident and sickness insurance within the meaning of section five hundred fourteen A point one (514A.1) of the Code. "Accident and sickness insurance" also means individual subscriber contracts for hospital service, or medical and surgical service, or individual pharmaceutical or optometric service issued under chapter five hundred fourteen (514) of the Code, and for purposes of this division, corporations issuing contracts under chapter five hundred fourteen (514) of the Code are deemed to be engaged in the business of insurance.

2. "Form" means and includes policies, contracts, riders, endorsements and applications used in connection with the sale of accident and sickness insurance under chapter five hundred fourteen (514) of the Code or chapter five hundred fourteen A (514A) of the Code.

3. "Policy" means the entire contract between the insurer and the insured, including the policy riders, endorsements, and the application, if attached, and includes individual subscriber contracts issued under chapter five hundred fourteen (514) of the Code.

4. "Medicare" means the Health Insurance for the Aged Act, title XVIII of the United States Social Security Act added by the amendment of 1965 as amended on or before the effective date of this Act.

Sec. 4. NEW SECTION. STANDARDS FOR POLICIES ESTABLISHED.

1. The commissioner shall issue rules to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of policies of individual accident and sickness insurance and individual subscriber contracts which shall be in addition to and in accordance with applicable laws of this state, including but not limited to sections five hundred fourteen A point one (514A.1) through five hundred fourteen A point twelve (514A.12) of the Code. These rules may include, but shall not be limited to, any of the following subjects:

a. Terms of renewability.
b. Initial and subsequent conditions of eligibility.
c. Nonduplication of coverage provisions.
d. Coverage of dependents.
e. Coverage of persons eligible for medicare by reason of age.
f. Preexisting conditions.
g. Termination of insurance.
h. Probationary periods.
i. Limitations.
j. Exceptions.
k. Reductions.
l. Elimination periods.
m. Requirements for replacement.
n. Recurrent conditions.
o. The definition of terms, including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and noncancelable.

2. The commissioner may issue rules with respect to policies of individual accident and sickness insurance and individual subscriber contracts that specify prohibited policies or subscriber contracts, or prohibited policy or contract provisions which the commissioner finds to be unjust, unfair, or unfairly discriminatory to the policyholder or any person insured under the policy or any beneficiary. This subsection does not authorize the commissioner to prohibit a policy or policy provision or subscriber contract or contract provision which is specifically authorized by statute.

3. A rule issued by the commissioner under this section shall not apply to a conversion policy issued pursuant to a contractual conversion privilege under a group or individual policy of accident and sickness insurance when such group or individual contract contains provisions that are inconsistent with the requirements of this chapter or any rule issued under this chapter.

4. A rule issued by the commissioner under this section shall not apply to policies being issued to employees or members being added to a franchise plan, as defined in section five hundred nine point fourteen (509.14) of the Code, which is in existence on the effective date of the rule.

Sec. 5. NEW SECTION. STANDARDS FOR BENEFITS ESTABLISHED.

1. The commissioner shall issue rules to establish minimum standards for benefits under each of the following categories of coverage contained in policies of individual accident and sickness insurance or subscriber contracts:

a. Basic hospital expense coverage.

b. Basic medical-surgical expense coverage.

c. Hospital confinement indemnity coverage.

d. Major medical expense coverage.

e. Disability income protection coverage.

f. Accident only coverage.

g. Specified disease or specified accident coverage.

h. Medicare supplement coverage.

i. Limited benefit health coverage.

2. This section does not prohibit the issuance of a policy which combines two or more of the categories of coverage enumerated in paragraphs a through f of subsection one (1) of this section. A category of coverage referred to in paragraph g, h or i of subsection one (1) of this section shall not be combined in a policy or contract either with another category of coverage referred to in paragraph g, h or i of subsection one (1) of this section or with a category of coverage referred to in any of paragraphs a through f of subsection one (1) of this section unless a rule issued by the commissioner specifically authorizes that combination of coverages.

3. The commissioner shall prescribe the method of identification of policies and contracts based upon coverages provided.

4. A policy of accident and sickness insurance or subscriber contract shall not be delivered or issued for delivery in this state unless the policy or contract meets the minimum standards prescribed under this section.

5. The commissioner may upon notice and hearing at any time after the initial filing or approval of any individual accident and sickness policy or

subscriber contract form, withdraw approval or suspend further sale of the form if the benefits provided are unreasonable in relation to the premium charge. The commissioner shall establish reasonable and creditable anticipated minimum loss ratios for medicare supplement and other accident and sickness insurance policies.

6. A rule issued by the commissioner under this section shall not apply to a conversion policy issued pursuant to a contractual conversion privilege under a group or individual policy of accident and sickness insurance when such group or individual contract contains provisions which are inconsistent with the requirements of this chapter or any rule issued under this chapter.

7. A rule issued by the commissioner under this section shall not apply to policies being issued to employees or members being added to a franchise plan, as defined in section five hundred nine point fourteen (509.14) of the Code, which is in existence on the effective date of the rule.

Sec. 6. NEW SECTION. DISCLOSURE OF COVERAGE.

1. Except as otherwise provided in subsection three (3) of this section, in order to provide for full and fair disclosure in the sale of individual accident and sickness insurance policies or subscriber contracts a policy or contract shall not be delivered or issued for delivery in this state unless the outline of coverage described in subsection two (2) of this section either accompanies the policy or contract or is delivered to the applicant at the time application is made and unless an acknowledgement of receipt or certificate of delivery of the outline is provided the insurer. In the event the policy or contract is issued on a basis other than that applied for, the outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and must clearly state that it is not the policy or contract for which application was made.

2. The commissioner shall prescribe the format and content of the outline of coverage required by subsection one (1) of this section. "Format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. The outline of coverage shall include all of the following:

a. A statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in section five (5) of this Act.

b. A description of the principal benefits and coverage provided in the policy or contract.

c. A statement of the exceptions, reductions and limitations contained in the policy or contract.

d. A statement of the renewal provisions including any reservation by the insurer of a right to change premiums.

e. A statement that the outline is a summary of the policy or contract issued or applied for and that the policy or contract should be consulted to determine governing contractual provisions.

If payment will not be made for services performed by a chiropractor acting within the scope of his or her license when those services would be compensable if performed by a medical doctor, then a statement that services performed by a chiropractor are not compensable shall be included in the outline of coverage.

3. The commissioner may prescribe disclosure rules for medicare supplement coverage which are determined to be in the public interest and which are designed to adequately inform the prospective insured of the need for and extent of coverage offered as medicare supplement coverage. For medicare supplement coverage, the outline of coverage required by subsection two (2) of this section shall be furnished to the prospective insured with the application form.

4. The commissioner may further prescribe by rule a standard form for and the contents of an informational brochure for persons eligible for medicare by reason of age, which is intended to improve the buyer's ability to select the most appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that this informational brochure be provided to prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that this brochure must be provided to prospective insureds eligible for medicare by reason of age upon request, but not later than at the time of delivery of the policy or contract.

5. The commissioner shall adopt rules prohibiting the advertising of forms titled as "nursing home" forms or inferring coverage for custodial care in an intermediate care facility as defined in section one hundred thirty-five C point one (135C.1) of the Code unless such forms provide coverage for custodial care in an intermediate care facility as defined in section one hundred thirty-five C point one (135C.1) of the Code.

Sec. 7. NEW SECTION. LIMITATION ON DEFENSES. Notwithstanding section five hundred fourteen A point three (514A.3), subsection one (1), paragraph b, subparagraph two (2) of the Code, or any contrary provision of chapter five hundred fourteen (514) of the Code, if the issuer of the policy of accident and sickness insurance or subscriber contract elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy or contract must cover any loss occurring after twelve months from the date of issue of the policy or contract from any preexisting condition not specifically excluded from coverage by terms of the policy or contract, and, except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.

Sec. 8. NEW SECTION. EXCLUSIONS. This division does not apply to any of the following:

1. A policy of credit accident and health or credit accident and sickness insurance.

2. A policy of accident and sickness insurance which is exempt from the provisions of sections five hundred fourteen A point one (514A.1) through five hundred fourteen A point twelve (514A.12) of the Code by virtue of an exemption set forth in section five hundred fourteen A point one (514A.1) or five hundred fourteen A point eight (514A.8) of the Code.

3. Any evidence of coverage issued to an enrollee of a health maintenance organization under chapter five hundred fourteen B (514B) of the Code.

Sec. 9. NEW SECTION. TITLE AND EFFECTIVE DATE OF CHAPTER. This chapter may be cited as the "Uniform individual accident and health insurance minimum standards Act". This chapter takes effect July 1, 1980. Rules issued by the commissioner of insurance pursuant to this chapter shall be subject to the provisions of chapter seventeen A (17A) of the Code, and all rules issued by the commissioner of insurance shall give the issuers of policies and contracts a reasonable time to achieve compliance.

Sec. 10. Chapter five hundred seven B (507B), Code 1979, is amended by adding the following new section:

NEW SECTION. SALE OF DUPLICATE COVERAGE PROHIBITED.

1. A person shall not knowingly engage in the sale of duplicate medicare supplement insurance coverage, as defined by rule of the commissioner.

2. The commissioner of insurance shall adopt rules pursuant to chapter seventeen A (17A) of the Code which define the sale of duplicate medicare supplement insurance coverage.

Sec. 11. Section five hundred fourteen A point three (514A.3), subsection one (1), paragraph b, Code 1979, is amended to read as follows:

b. A provision as follows:

Time limit on certain defenses: (1) After ~~three~~ two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of ~~such--three-year~~ this two-year period.

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial ~~three-year~~ two-year period, nor to limit the application of subsection 2, paragraphs "a", "b", "c", "d" and "e", in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age fifty or, (b) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "incontestable":

After this policy has been in force for a period of ~~three~~ two years during the lifetime of the insured, (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

(2) No claim for loss incurred or disability (as defined in the policy) commencing after ~~three~~ two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Sec. 12. Section five hundred fourteen B point five (514B.5), subsection three (3), Code 1979, is amended to read as follows:

3. The health maintenance organization provides or arranges for the provision of basic health care services on a prepaid basis, except that the

health maintenance organization may impose deductible and coinsurance charges subject to approval by the commissioner ~~which might be required to be paid by persons on whose behalf the federal government contracts with the health maintenance organization for health care services~~. The commissioner has the authority to promulgate rules pursuant to chapter seventeen A (17A) establishing reasonable maximum deductible and coinsurance charges which may be imposed by health maintenance organizations.

Approved May 19, 1980

CHAPTER 1161

INSURANCE POLICIES

H. F. 454

AN ACT relating to countersignatures on insurance policies.

Be It Enacted by the General Assembly of the State of Iowa:

Section 1. Section five hundred fifteen point fifty-two (515.52), Code 1979, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. Notwithstanding this section and sections five hundred fifteen point fifty-three (515.53) through five hundred fifteen point sixty-one (515.61) of the Code, if the law of another state does not require the countersignature of a licensed agent who resides in that state for insurance contracts and endorsements written, issued or placed in that state by a licensed agent who resides in this state, the countersignature of a licensed agent who resides in this state is not required for insurance contracts and endorsements written, issued, or placed in this state by a licensed agent who resides in that other state.

Sec. 2. This Act is effective January first following its enactment.

Approved March 21, 1980