pursuant to section 654.16A~~, a nonjudicial voluntary foreclosure procedure under section 654.18 or chapter 655A, or a deed in lieu of foreclosure under section 654.19~~.

Approved April 8, 2010

CHAPTER 1121

INSURANCE AND INSURANCE DIVISION REGULATORY AUTHORITY

S.F. 2201

AN ACT relating to various matters under the purview of the insurance division of the department of commerce including the Iowa grain indemnity fund board, uniform securities Act, a health care and insurance cost work group, applications for health insurance rate increases, an internet consumer guide, examination of insurance companies, life insurance companies and associations, special health and accident insurance coverages, utilization and cost control, external review of health care coverage decisions, insurance other than life, mortgage guaranty insurance, cemetery and funeral merchandise and funeral services, and regulation of cemeteries and making penalties applicable and including effective date provisions.

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

Section 1. Section 22.7, Code Supplement 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 65. Information obtained by the commissioner of insurance in the course of an examination of a cemetery as provided in section 523I.213A, subsection 7.

Sec. 2. Section 203D.4, subsection 1, Code 2009, is amended to read as follows:

1. The Iowa grain indemnity fund board is established to advise the department on matters relating to the fund and to perform the duties provided it in this chapter. The board is composed of the secretary of agriculture or a designee who shall serve as president; ~~the commissioner of insurance or a designee who shall serve as secretary;~~ the state treasurer or a designee who shall serve as treasurer; a representative of the banking industry appointed by the governor, who shall be selected from a list of three nominations made by the secretary of agriculture; and four representatives of the grain industry appointed by the governor, subject to confirmation by the senate, two of whom shall be representatives of producers and who shall be actively participating producers, and two of whom shall be representatives of licensed grain dealers and licensed warehouse operators and who shall be actively participating licensed grain dealers and licensed warehouse operators, each of whom shall be selected from a list of three nominations made by the secretary of agriculture. The term of membership of the banking industry representative and the grain industry representatives is three years, and the representatives are eligible for reappointment. However, of the grain industry representatives, only actively participating producers, and grain dealers and warehouse operators are eligible for reappointment. The banking industry representative and the grain industry representatives are entitled to a per diem as specified in section 7E.6 for each day spent in the performance of the duties of the board, plus actual expenses incurred in the performance of those duties. Four members of the board constitute a quorum, and the affirmative vote of four members is necessary for any action taken by the board, except that a lesser number may adjourn a meeting. A vacancy in the membership of the board does not impair the rights of a quorum to exercise all the rights and perform all the duties of the board.

Sec. 3. Section 502.305, subsection 2, Code Supplement 2009, is amended to read as follows:

2. *Filing*. Except as provided in subsection 10 and section 502.304A, subsection 3, paragraph "*g*", a person who files a registration statement or a notice filing shall pay a filing fee of one-tenth of one percent of the proposed aggregate sales price of the securities to be offered to persons in this state pursuant to the registration statement or notice filing. However, except as provided in subsection 10, section 502.302, subsection 1, paragraph "*a*", and section 502.304A, subsection 3, paragraph "*g*", the annual filing fee shall not be less than fifty dollars or more than one thousand dollars. The administrator shall retain the filing fee even if the notice filing is withdrawn or the registration is withdrawn, denied, suspended, revoked, or abandoned. The fees collected under this subsection shall be deposited as provided in section 505.7. The administrator may adopt rules requiring a filing to be made electronically. The rules may provide for such electronic filing either directly with the administrator or with a designee of the administrator. The rules may require that the filer pay any reasonable costs charged by the designee of the administrator for processing the filings and that the filer submit any fees paid through the designee.

Sec. 4. Section 505.7, Code Supplement 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 10. *a.* The commissioner shall assess the costs of carrying out the insurance division's duties pursuant to section 505.8, subsection 18, section 505.17, subsection 2, and sections 505.18 and 505.19 that are directly attributable to the performance of the division's duties involving specific health insurance carriers licensed to do business in this state. Such expenses shall be charged to and paid by the specific health insurance carrier to whom the expenses are attributable and upon failure or refusal of any such carrier to pay such expenses, the same may be recovered in an action brought in the name of the state. In addition, the commissioner may revoke the certificate of authority of a health insurance carrier licensed to do business in this state that fails to pay such expenses attributable to that carrier.

b. The commissioner shall assess the costs of carrying out the insurance division's duties generally pursuant to section 505.8, subsection 18, section 505.17, subsection 2, and sections 505.18 and 505.19, and for implementation and maintenance of health insurance information for consumers on the insurance division internet site, that are not attributable to a specific health insurance carrier, to all health insurance carriers that are licensed to do business in this state on a proportionate basis as provided by rules adopted by the commissioner.

Sec. 5. Section 505.8, Code Supplement 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 18. The commissioner shall annually convene a work group composed of the consumer advocate, health insurance carriers, health care providers, small employers that purchase health insurance under chapter 513B, and individual consumers in the state for the purpose of considering ways to reduce the cost of providing health insurance coverage and health care services, including but not limited to utilization of uniform billing codes, improvements to provider credentialing procedures, reducing out-of-state care expenses, annually assessing the impact of federal health care reform legislation on health care costs in the state and determining whether such legislation has reduced the cost of health insurance in the state, and the electronic delivery of explanation of benefits statements. The recommendations made by the work group shall be included in the annual report filed with the general assembly pursuant to section 505.18.

Sec. 6. Section 505.17, Code 2009, is amended to read as follows:

505.17 Confidential information.

1. *a.* Information, records, and documents utilized for the purpose of, or in the course of, investigation, regulation, or examination of an insurance company or insurance holding company, received by the division from some other governmental entity which treats such information, records, and documents as confidential, are confidential and shall not be

disclosed by the division and are not subject to subpoena. Such information, records, and documents do not constitute a public record under chapter 22.

b. The disclosure of confidential information, administrative or judicial orders which contain confidential information, or information regarding other action of the division which is not a public record subject to disclosure, to other insurance and financial regulatory officials may be permitted by the commissioner provided that those officials are subject to, or agree to comply with, standards of confidentiality comparable to those imposed on the commissioner.

2. Notwithstanding subsection 1, an application for a rate increase filed by a health insurance carrier and all information, records, and documents accompanying such an application or utilized for the purpose of, or in the course of consideration of the application by the commissioner, shall constitute a public record under chapter 22 except as provided in this subsection.

a. The commissioner shall consider the written request of a health insurance carrier to keep confidential certain details of an application or accompanying information, records, and documents. If the request includes a sufficient explanation as to why public disclosure of such details would give an unfair advantage to competitors, the commissioner shall keep such details confidential. If the commissioner elects to keep certain details confidential, the commissioner shall release only the nonconfidential details in response to a request for records made pursuant to chapter 22. If confidential details are withheld from a request for records made pursuant to chapter 22, the commissioner shall release an explanation of why the information was deemed confidential and a summary of the nature of the information withheld and the reasons for withholding the information.

b. In considering requests for confidential treatment, the commissioner shall narrowly construe the provisions of this subsection in order to appropriately balance an applicant's need for confidentiality against the public's right to information about the application.

Sec. 7. NEW SECTION. **505.18 Annual report.**

1. Consumers deserve to know the quality and cost of their health care insurance. Health care insurance transparency provides consumers with the information necessary, and the incentive, to choose health plans based on cost and quality. Reliable cost and quality information about health care insurance empowers consumer choice and consumer choice creates incentives at all levels, and motivates the entire health care delivery system to provide better health care and health care benefits at a lower cost. It is the purpose of this section to make information regarding the costs of health care insurance readily available to consumers through the consumer advocate bureau of the insurance division.

2. The commissioner in collaboration with the consumer advocate shall prepare and deliver a report to the governor and to the general assembly no later than November 15 of each year that provides findings regarding health spending costs for health insurance plans in the state for the previous fiscal year. The commissioner may contract with outside vendors or entities to assist in providing the information contained in the annual report. The report shall provide, at a minimum, the following information:

a. Aggregate health insurance data concerning loss ratios of health insurance carriers licensed to do business in the state.

b. Rate increase data.

c. Health care expenditures in the state and the effect of such expenditures on health insurance premium rates.

d. A ranking and quantification of those factors that result in higher costs and those factors that result in lower costs for each health insurance plan offered in the state.

e. The current capital and surplus and reserve amounts held in reserve by each health insurance carrier licensed to do business in the state.

f. A listing of any apparent medical trends affecting health insurance costs in the state.

g. Any additional data or analysis deemed appropriate by the commissioner to provide the general assembly with pertinent health insurance cost information.

h. Recommendations made by the work group convened pursuant to section 505.8, subsection 18.

Sec. 8. NEW SECTION. **505.19 Health insurance rate increase applications — public hearing and comment.**

1. All health insurance carriers licensed to do business in the state shall immediately notify policyholders of any application for a rate increase exceeding the average annual health spending growth rate stated in the most recent national health expenditure projection published by the centers for Medicare and Medicaid services of the United States department of health and human services, that is filed with the insurance division. Such notice shall specify the rate increase proposed that is applicable to each policyholder and shall include the ranking and quantitification [1] of those factors that are responsible for the amount of the rate increase proposed. The notice shall include information about how the policy holder can contact the consumer advocate for assistance.

2. The commissioner shall hold a public hearing at the time a carrier files for proposed health insurance rate increases exceeding the average annual health spending growth rate as provided in subsection 1, prior to approval or disapproval of the proposed rate increases for that carrier by the commissioner.

3. The consumer advocate shall solicit public comments on each proposed health insurance rate increase application if the increase exceeds the average annual health spending growth rate as provided in subsection 1, and shall post without delay all comments received on the insurance division's internet site prior to approval or disapproval of the proposed rate increase by the commissioner.

4. The consumer advocate shall present the public testimony and comments received for consideration by the commissioner in determining whether to approve or disapprove such health insurance rate increase proposals.

4A. *a.* For the purposes of this section, *"health insurance"* does not include any of the following:

(1) Coverage for accident-only, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical-payment insurance.

(6) Credit-only insurance.

(7) Coverage for on-site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

b. For the purposes of this section, *"health insurance"* does not include benefits provided under a separate policy as follows:

(1) Limited scope dental or vision benefits.

(2) Benefits for long-term care, nursing home care, home health care, or community-based care.

(3) Any other similar limited benefits as provided by rule of the commissioner.

c. For the purposes of this section, *"health insurance"* does not include benefits offered as independent noncoordinated benefits as follows:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

d. For the purposes of this section, *"health insurance"* does not include Medicare supplemental health insurance as defined under § 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided to coverage under group health insurance coverage.

5. The commissioner shall adopt rules pursuant to chapter 17A to implement the provisions of this section.

Sec. 9. NEW SECTION. **508.33A Limited purpose subsidiary life insurance companies.**

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

[1] According to enrolled Act; the word "quantification" probably intended

a. "Affiliated company" means a domestic life insurance company that is a directly or indirectly wholly owned subsidiary of the same parent.

b. "Parent" means a person as defined in section 521A.1 who directly or indirectly through one or more intermediaries wholly owns the organizing life insurance company.

c. "Risks" means risks associated with the life insurance policies and contracts written by the ceding domestic life insurance company or assumed by the ceding domestic life insurance company from an affiliated company, which were written by the affiliated company and for which the ceding domestic life insurance company holds direct statutory reserves for those policies and contracts as required by section 508.36.

2. *a.* A domestic life insurance company organized pursuant to the provisions of this chapter may organize a domestic limited purpose subsidiary life insurance company pursuant to the provisions of this chapter that is wholly owned by the organizing life insurance company. The limited purpose subsidiary life insurance company may reinsure risks of the organizing life insurance company, reinsure risks of affiliated companies, and access alternative forms of financing.

b. A limited purpose subsidiary life insurance company shall submit a plan of operation to the commissioner, and the commissioner shall approve the plan of operation with such amendments as the commissioner requires, before the limited purpose subsidiary life insurance company assumes any risks under a reinsurance contract. The plan of operation and any records, books, documents, reports, or other information that the commissioner requires a limited purpose subsidiary life insurance company to produce or disclose pursuant to rules adopted under subsection 6 or pursuant to an order of the commissioner shall be treated the same as information obtained by or disclosed to the commissioner pursuant to section 521A.6 and the commissioner shall have the powers enumerated in section 521A.6 as to that insurer.

3. The organizing life insurance company may invest funds from its surplus in a limited purpose subsidiary life insurance company organized pursuant to this section.

4. The organizing life insurance company's officers and directors may serve as officers and directors of a limited purpose subsidiary life insurance company organized pursuant to this section.

5. A limited purpose subsidiary life insurance company organized pursuant to this section shall be deemed to be licensed to transact the business of reinsurance for the purposes of section 521B.2, subsection 1, but may only reinsure risks of its organizing life insurance company and of affiliated companies. A limited purpose subsidiary life insurance company organized pursuant to this section may, upon approval of the commissioner, purchase reinsurance to cede the reinsurance risks assumed by the limited purpose subsidiary life insurance company.

6. The commissioner shall adopt rules pursuant to chapter 17A concerning limited purpose subsidiary life insurance companies, including but not limited to the organization, plans of operation, capital requirements including risk-based capital requirements, reserves, authorized investments, reinsurance assumed, material transaction restrictions and requirements, dividends and distributions, operations, and the conditions, forms, and approval of financing of limited purpose subsidiary life insurance companies organized pursuant to this section.

7. Admitted assets of a limited purpose subsidiary life insurance company shall include assets approved by the commissioner which shall be deemed to be, and reported as, admitted assets of the limited purpose subsidiary life insurance company.

8. The provisions of sections 508.5, 508.6, and 511.8, section 521.2, subsection 4, sections 521A.4 and 521A.5, and chapter 521E shall not be applicable to a limited purpose subsidiary life insurance company organized pursuant to this section.

9. A limited purpose subsidiary life insurance company shall not be organized pursuant to this section prior to the effective date of rules adopted by the commissioner regulating the organization and operation of limited purpose subsidiary life insurance companies as provided in subsection 6.

Sec. 10. Section 511.8, subsection 5, Code Supplement 2009, is amended to read as follows:

5. *Corporate obligations.* Subject to the restrictions contained in subsection 8 ~~hereof~~, bonds or other evidences of indebtedness issued, assumed, or guaranteed by a corporation incorporated under the laws of the United States of America, or of any state, district, or insular or territorial possession thereof; or of the Dominion of Canada, or any province thereof; and which meet the following qualifications:

a. (1) If fixed interest-bearing obligations, the net earnings of the issuing, assuming, or guaranteeing corporation available for its fixed charges for a period of five fiscal years next preceding the date of acquisition of the obligations by such insurance company shall have averaged per year not less than one and one-half times such average annual fixed charges of the issuing, assuming, or guaranteeing corporation applicable to such period, and, during at least one of the last two years of such period, its net earnings shall have been not less than one and one-half times its fixed charges for such year; or if, at the date of acquisition, the obligations are adequately secured and have investment qualities and characteristics wherein the speculative elements are not predominant.

(2) However, with respect to fixed interest-bearing obligations which are issued, assumed, or guaranteed by a financial company, the net earnings by the financial company available for its fixed charges for the period of five fiscal years preceding the date of acquisition of the obligations by the insurance company shall have averaged per year not less than one and one-fourth times such average annual fixed charges of the issuing, assuming, or guaranteeing financial company applicable to such period, and, during at least one of the last two years of the period, its net earnings shall have been not less than one and one-fourth times its fixed charges for such year; or if, at the date of acquisition, the obligations are adequately secured and speculative elements are not predominant in their investment qualities and characteristics. As used in this ~~paragraph~~ subparagraph (2), *"financial company"* means a corporation which on the average over its last five fiscal years preceding the date of acquisition of its obligations by the insurer, has had at least fifty percent of its net income, including income derived from subsidiaries, derived from the business of wholesale, retail, installment, mortgage, commercial, industrial or consumer financing, or from banking or factoring, or from similar or related lines of business.

b. If adjustment, income, or other contingent interest obligations, the net earnings of the issuing, assuming, or guaranteeing corporation available for its fixed charges for a period of five fiscal years next preceding the date of acquisition of the obligations by such insurance company shall have averaged per year not less than one and one-half times such average annual fixed charges of the issuing, assuming, or guaranteeing corporation and its average annual maximum contingent interest applicable to such period and, during at least one of the last two years of such period, its net earnings shall have been not less than one and one-half times the sum of its fixed charges and maximum contingent interest for such year, or if, at the date of acquisition, the obligations are adequately secure and have investment qualities and characteristics and speculative elements are not predominant.

c. Are securities that at the date of acquisition are rated three by the securities valuation office of the national association of insurance commissioners or have the equivalent rating by a rating organization that is approved by the national association of insurance commissioners as an acceptable rating organization and are listed or admitted to trading on a securities exchange in the United States or are publicly held and actively traded in the over-the-counter market and market quotations are readily available. If a security acquired under this paragraph is subsequently downgraded from a three rating by the securities valuation office of the national association of insurance commissioners or the equivalent by a national association of insurance commissioners' acceptable rating organization, the security no longer qualifies as a legal reserve investment.

d. The term *"net earnings available for fixed charges"* as used ~~herein shall mean~~ in this section means the net income after deducting all operating and maintenance expenses, taxes other than any income taxes, depreciation, and depletion, but nonrecurring items of income or expense may be excluded.

e. The term "*fixed charges*" as used ~~herein shall include~~ in this section includes interest on unfunded debt and funded debt on a parity with or having a priority to the obligation under consideration.

f. The term "*corporation*" as used in this chapter includes a joint stock association, a limited liability company, a partnership, or a trust.

g. The securities, real estate, and mortgages described in this section include participations, which means instruments evidencing partial or undivided collective interests in such securities, real estate, and mortgages.

Sec. 11. Section 511.8, subsection 8, Code Supplement 2009, is amended by adding the following new paragraph:

NEW PARAGRAPH. *d.* In addition to the restrictions contained in paragraphs "*a*" and "*b*", the investments of any company or association in securities included under subsection 5, paragraph "*c*", are not eligible in excess of two percent of the legal reserve, but not more than one-eighth of one percent of the legal reserve shall be invested in the securities of any one corporation.

Sec. 12. Section 511.8, subsection 16, Code Supplement 2009, is amended to read as follows:

16. *Deposit of securities.*

a. Securities in an amount not less than the legal reserve as defined in this section shall be deposited and the deposit maintained with the commissioner of insurance or at such places as the commissioner may designate as will properly safeguard them. There may be included in the deposit an amount of cash on hand not in excess of five percent of the deposit required, that deposit to be evidenced by a certified check, certificate of deposit, or other evidence satisfactory to the commissioner of insurance. Deposits of securities may be made in excess of the amounts required by this section. A stock company organized under the laws of this state shall not be required to make a deposit until the legal reserve, as ascertained by the commissioner, exceeds the amount deposited by it as capital. Real estate may be made a part of the deposit by furnishing evidence of ownership satisfactory to the commissioner and by conveying the real estate to the commissioner or the commissioner's successors in office by warranty deed. The commissioner and the successors in office shall hold the real estate in trust for the benefit of the policyholders of the company or members of the association. Real estate mortgage loans and policy loans may be made a part of the deposit by filing a verified statement of the loans with the commissioner, which statement is subject to check at the discretion of the commissioner.

b. The securities comprising the deposit of a company or association against which proceedings are pending under section 508.18 shall vest in the state for the benefit of all policyholders of the company or association.

c. Securities or title to real estate on deposit may be withdrawn at any time and other eligible securities may be substituted, provided the amount maintained on deposit is equal to the sum of the legal reserve and twenty-five thousand dollars. In the case of real estate the commissioner shall execute and deliver to the company or association a quitclaim deed to the real estate. Any company or association shall, if requested by the commissioner, at the time of withdrawing any securities on deposit, designate for what purpose the ~~same~~ securities are being withdrawn.

d. Companies or associations having securities or title to real estate on deposit with the commissioner of insurance shall have the right to collect all dividends, interest, rent, or other income from the deposit unless proceedings against the company or association are pending under section 508.18, in which event the commissioner shall collect such interest, dividends, rent, or other income and add the same to the deposit.

e. Any company or association receiving payments or partial payments of principal on any securities deposited with the commissioner of insurance shall notify the commissioner of such fact at such times and in such manner as the commissioner may prescribe, giving the amount and date of payment.

f. The commissioner of insurance may receive on deposit securities or title to real estate of alien companies authorized to do business in the state of Iowa, for the purpose of securing

its policyholders in the state of Iowa and the United States. The provisions ~~hereof~~ of this subsection not inconsistent with the deposit agreement shall apply to the deposits of such alien companies.

g. Common stocks or shares issued by any federal home loan bank eligible for inclusion in the legal reserve under subsection 18, paragraph "*c*", may be made a part of a deposit by filing a verified statement of the common stocks or shares issued by a federal home loan bank that are held in the legal reserve. Attached to the statement shall be the annual capital stock statement of the respective federal home loan bank showing membership stock balance and activity-based stock balance.

Sec. 13. Section 511.8, subsection 23, paragraphs c and e, Code Supplement 2009, are amended to read as follows:

c. If the loan is collateralized by cash or cash equivalents, the cash or cash equivalent collateral may be reinvested by the life insurance company or association in ~~either~~ class one money market funds as defined in subsection 24, individual securities which are eligible for inclusion in the legal reserve of the life insurance company or association, or in repurchase agreements fully collateralized by such securities if the life insurance company or association takes delivery of the collateral either directly or through an authorized custodian or pooled fund comprised of individual securities which are eligible for inclusion in the legal reserve of the life insurance company or association. If such reinvestment is made in individual securities or in repurchase agreements, the individual securities or the securities which collateralize the repurchase agreements shall mature in less than two hundred seventy days. If such reinvestment is made in a pooled fund, the average maturity of the securities comprising such pooled fund must be ~~less than two hundred seventy~~ one hundred eighty days or less and the individual maturities of the securities comprising such pooled fund must be three hundred ninety-seven days or less. Individual securities and securities comprising the pooled fund shall be investment grade. As used in this paragraph, "*maturity*" means the earlier of the fixed date on which the holder of the security is unconditionally entitled to receive principal and interest in full or the date on which the holder of the security is unconditionally entitled upon demand to receive principal and interest in full.

e. Securities loaned pursuant to this subsection are not eligible for inclusion in the legal reserve of the life insurance company or association in excess of ~~twenty~~ ten percent of the legal reserve.

Sec. 14. Section 511.8, subsection 23, Code Supplement 2009, is amended by adding the following new paragraph:

NEW PARAGRAPH. *f.* A life insurance company or association may continue to hold in the legal reserve of the life insurance company or association securities which are the subject of a reverse repurchase agreement. If such securities are held in the legal reserve of a life insurance company or association, the securities shall be subject to the limitations of paragraph "*e*" as if they were securities loaned pursuant to this subsection.

Sec. 15. NEW SECTION. **514C.26 Mental illness and substance abuse treatment coverage for veterans.**

1. Notwithstanding the uniformity of treatment requirements of section 514C.6, a group policy or contract providing for third-party payment or prepayment of health or medical expenses issued by a carrier, as defined in section 513B.2, or by an organized delivery system authorized under 1993 Iowa Acts, chapter 158, shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse if either of the following is satisfied:

a. The policy or contract is issued to an employer who on at least fifty percent of the employer's working days during the preceding calendar year employed more than fifty full-time equivalent employees. In determining the number of full-time equivalent employees of an employer, employers who are affiliated or who are able to file a consolidated tax return for purposes of state taxation shall be considered one employer.

b. The policy or contract is issued to a small employer as defined in section 513B.2, and such policy or contract provides coverage benefits for the treatment of mental illness and substance abuse.

2. Notwithstanding the uniformity of treatment requirements of section 514C.6, a plan established pursuant to chapter 509A for public employees shall provide coverage benefits to an insured who is a veteran for treatment of mental illness and substance abuse as defined in subsection 3.

3. For purposes of this section:

a. "Mental illness" means mental disorders as defined by the commissioner by rule.

b. "Substance abuse" means a pattern of pathological use of alcohol or a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when the alcohol or drug is withdrawn.

c. "Veteran" means the same as defined in section 35.1.

4. The commissioner, by rule, shall define *"mental illness"* consistent with definitions provided in the most recent edition of the American psychiatric association's diagnostic and statistical manual of mental disorders, as the definitions may be amended from time to time. The commissioner may adopt the definitions provided in such manual by reference.

5. This section shall not apply to accident only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance, or individual accident and sickness policies issued to individuals or to individual members of a member association.

6. A carrier, organized delivery system, or plan established pursuant to chapter 509A may manage the benefits provided through common methods including but not limited to providing payment of benefits or providing care and treatment under a capitated payment system, prospective reimbursement rate system, utilization control system, incentive system for the use of least restrictive and least costly levels of care, a preferred provider contract limiting choice of specific providers, or any other system, method, or organization designed to assure services are medically necessary and clinically appropriate.

7. *a.* A group policy or contract or plan covered under this section shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits unless the policy or contract or plan imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits.

b. A group policy or contract or plan covered under this section that imposes an aggregate annual or lifetime limit on substantially all medical and surgical coverage benefits shall not impose an aggregate annual or lifetime limit on mental illness or substance abuse coverage benefits which is less than the aggregate annual or lifetime limit imposed on substantially all medical and surgical coverage benefits.

8. A group policy or contract or plan covered under this section shall at a minimum allow for thirty inpatient days and fifty-two outpatient visits annually. The policy or contract or plan may also include deductibles, coinsurance, or copayments, provided the amounts and extent of such deductibles, coinsurance, or copayments applicable to other medical or surgical services coverage under the policy or contract or plan are the same. It is not a violation of this section if the policy or contract or plan excludes entirely from coverage benefits for the cost of providing the following:

a. Care that is substantially custodial in nature.

b. Services and supplies that are not medically necessary or clinically appropriate.

c. Experimental treatments.

9. This section applies to third-party payment provider policies or contracts and plans established pursuant to chapter 509A delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2011.

Sec. 16. Section 514F.6, Code 2009, is amended to read as follows:

514F.6 Credentialing — retrospective payment.

1. The commissioner shall adopt rules to provide for the retrospective payment of clean claims for covered services provided by a physician, advanced registered nurse practitioner, or physician assistant during the credentialing period, once the physician, advanced registered nurse practitioner, or physician assistant is credentialed.

2. For purposes of this section, *"physician"* means a licensed doctor of medicine and surgery or a licensed doctor of osteopathic medicine and surgery~~,~~; *"advanced registered nurse practitioner"* means a licensed nurse who is also registered to practice in an advanced role, *"physician assistant"* means a person who is licensed to practice as a physician assistant under the supervision of one or more physicians; and *"credentialing period"* means the time period between the health insurer's receipt of a physician's, advanced registered nurse practitioner's, or physician assistant's application for credentialing and approval of that application by the health insurer. *"Credentialing"* means a process through which a health insurer makes a determination based on criteria established by the health insurer concerning whether a physician, advanced registered nurse practitioner, or physician assistant is eligible to provide health care services to an insured and to receive reimbursement for the health care services provided under an agreement entered into between the physician, advanced registered nurse practitioner, or physician assistant and the health insurer. *"Clean claim"* means the same as defined in section 507B.4A, subsection 2, paragraph *"b"*.

Sec. 17. Section 514J.7, subsection 2, Code 2009, is amended to read as follows:

2. The independent review entity, within three business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the enrollee and the carrier containing a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity ~~does not need to~~ shall, upon request from the carrier, the enrollee, or the enrollee's treating health care provider, disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner. If the independent review entity does not have a person who is an expert in the treatment of the medical condition under review and certified by the commissioner to conduct an independent review, the independent review entity may either decline the review request or may request from the commissioner additional time to have such an expert certified. The independent review entity shall notify the commissioner by facsimile of its choice between these options within three business days of receipt of the notice from the carrier or organized delivery system. The commissioner shall provide a notice to the enrollee and carrier or organized delivery system of the independent review entity's decision and of the commissioner's decision as to how to proceed with the external review process within three business days of receipt of the independent review entity's decision.

Sec. 18. Section 515.125, subsection 1, Code 2009, is amended to read as follows:

1. Unless otherwise provided in section 515.127, ~~or~~ 515.128, 515.129A, 515.129B, or 515.129C, a policy or contract of insurance provided for in this chapter shall not be forfeited, suspended, or canceled except by notice to the insured as provided in this chapter. A notice of cancellation is not effective unless mailed or delivered by the insurer to the named insured at least thirty days before the effective date of cancellation, or, where cancellation is for nonpayment of a premium, assessment, or installment provided for in the policy, or in a note or contract for the payment thereof, at least ten days prior to the date of cancellation. The notice may be made in person, or by sending by mail a letter addressed to the insured at the insured's address as given in or upon the policy, anything in the policy, application, or a separate agreement to the contrary notwithstanding.

Sec. 19. NEW SECTION. **515.129A Cancellation of personal lines policies or contracts.**

1. A personal lines policy or contract of insurance which has been in effect for more than sixty days shall not be canceled except by notice to the insured as provided in this chapter.

2. Notice of cancellation of a personal lines policy or contract of insurance is not effective unless the cancellation is based on one or more of the following reasons:

a. Nonpayment of premium.

b. Failure to pay dues or fees where payment of dues or fees is a prerequisite to obtaining or continuing insurance coverage in force.

c. Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining, continuing, or presenting a claim under the policy.

d. Actions by the insured which substantially change or increase the risk insured.

e. The insured has acted in a manner which the insured knew or should have known was in violation or breach of a term or condition of the insurance policy or contract.

f. The occurrence of a change in the risk that substantially increases a hazard insured against after insurance coverage has been issued or renewed.

Sec. 20. NEW SECTION. **515.129B Nonrenewal of personal lines policies or contracts.**

1. An insurer shall not refuse to renew a personal lines policy or contract of insurance unless at least thirty days before the end of the policy or contract period the insurer delivers, mails, or electronically transmits to the first named insured, at the last known address of the first named insured, written notice of the insurer's intention not to renew the policy or contract upon expiration of the current policy or contract period as provided in section 515.129C. Proof of such mailing, electronic transmission, or delivery to the first named insured's last known address shall be maintained by the insurer.

2. The notice of intention not to renew shall include or be accompanied by a written explanation of the insurer's specific reason or reasons for the nonrenewal.

3. The transfer of a policy between affiliates of an insurance company shall not be considered a nonrenewal.

Sec. 21. NEW SECTION. **515.129C Notice of renewal or nonrenewal of personal lines policies of contracts.**

1. At least thirty days before the end of the policy or contract term, an insurer shall mail or deliver to the last known address of the first named insured a renewal policy or contract, an offer to renew the current policy or contract, or a notice of nonrenewal of the policy or contract. Information concerning the renewal policy or contract, the offer to renew the policy or contract, or the notice of nonrenewal of the policy or contract shall also be mailed, delivered, or transmitted electronically to the last known address of the producer of record of the policy or contract.

a. An offer to renew the policy or contract shall state the renewal premium and the date that the premium is due. The renewal premium shall be based on the known exposure as of the date of the offer to renew.

b. If the renewal premium is not received by the due date or the policy or contract expiration date, whichever is later, the policy or contract lapses.

2. If an insurer fails to comply with the notice requirements of this section, the policy or contract shall be extended on the same terms and conditions for another policy or contract term or until the effective date of similar insurance procured by the insured, whichever is earlier. The insurer may make continued coverage contingent upon the payment of premium.

3. Renewal of a policy or contract does not constitute a waiver or estoppel with respect to grounds for cancellation that existed before the effective date of the renewal.

Sec. 22. Section 515C.5, Code 2009, is amended to read as follows:

515C.5 Limit of outstanding liability.

1. ~~A~~ Unless a request to suspend the requirements of this section is granted by the commissioner as set forth in subsection 2, a mortgage guaranty insurer shall not at any time have outstanding a total liability, net of reinsurance, in excess of twenty-five times its capital, unassigned funds and contingency reserve. ~~It~~ A mortgage guaranty insurer shall not insure loans secured by properties in a single housing tract or in a contiguous tract ~~(not~~ which is not separated by more than one-half ~~mile)~~ mile in excess of ten percent of its capital, unassigned funds, and contingency reserve. Coverage may be provided only if the properties in such tract are residential buildings, buildings designed for occupancy by not more than four families, or owner-occupied mobile homes.

2. Upon request of a mortgage guaranty insurer, the commissioner may suspend the requirements contained in subsection 1 for such time and under such conditions as the commissioner may order. The commissioner may adopt rules as necessary relating to the consideration of such requests for suspension of those requirements.

Sec. 23. Section 523A.204, subsection 4, Code Supplement 2009, is amended to read as follows:

4. The commissioner shall levy an administrative penalty in the amount of up to five hundred dollars against a preneed seller that fails to file the annual report when due, payable to the state for deposit as provided in section 505.7. However, the commissioner may waive the administrative penalty upon a showing of good cause or financial hardship.

Sec. 24. Section 523A.401, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 9. The commissioner, by rule, may require written trust agreements and establish conditions for trusts holding insurance policies or maintaining ownership rights under insurance policies. The seller or any officer, director, agent, employee, or affiliate of the seller shall not serve as a trustee. The commissioner may require amendments to a trust agreement that is not in accord with the provisions of this chapter or rules adopted under this chapter.

Sec. 25. Section 523A.402, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 9. The commissioner, by rule, may require written trust agreements and establish conditions for trusts holding annuities or maintaining ownership rights under annuities. The seller or any officer, director, agent, employee, or affiliate of the seller shall not serve as a trustee. The commissioner may require amendments to a trust agreement that is not in accord with the provisions of this chapter or rules adopted under this chapter.

Sec. 26. Section 523A.502A, subsection 3, Code Supplement 2009, is amended to read as follows:

3. The commissioner shall levy an administrative penalty in the amount of up to five hundred dollars against a sales agent who fails to file an annual report when due, payable to the state for deposit as provided in section 505.7. However, the commissioner may waive the administrative penalty upon a showing of good cause or financial hardship.

Sec. 27. Section 523A.601, subsection 1, paragraph i, Code 2009, is amended to read as follows:

i. Include an explanation of regulatory oversight by the insurance division in twelve point boldface type, in substantially the following language:

THIS AGREEMENT IS SUBJECT TO RULES ADMINISTERED BY THE IOWA INSURANCE DIVISION. YOU MAY CALL THE INSURANCE DIVISION AT ~~(515)281-4441~~ (515)281–5705. WRITTEN INQUIRIES OR COMPLAINTS SHOULD BE MAILED TO THE IOWA SECURITIES AND REGULATED INDUSTRIES BUREAU, 330 MAPLE STREET, DES MOINES, IOWA 50319.

Sec. 28. Section 523A.807, subsection 3, unnumbered paragraph 1, Code Supplement 2009, is amended to read as follows:

If the commissioner finds that a person has violated section 523A.201, 523A.202, 523A.203, 523A.207, 523A.401, 523A.402, 523A.403, 523A.404, 523A.405, 523A.501, ~~or~~ 523A.502, or 523A.504 or any rule adopted pursuant thereto, the commissioner may order any or all of the following:

Sec. 29. Section 523I.213A, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 7. Notwithstanding chapter 22, the commissioner shall not make information obtained in the course of an examination public, except when a duty under this chapter requires the commissioner to take action against a cemetery or to cooperate with another law enforcement agency, or when the commissioner is called as a witness in a civil or criminal proceeding.

Sec. 30. Section 523I.312, subsection 2, paragraph n, Code 2009, is amended to read as follows:

n. Include an explanation of regulatory oversight by the insurance division in twelve point boldface type, in substantially the following language:

THIS AGREEMENT IS SUBJECT TO RULES ADMINISTERED BY THE IOWA INSURANCE DIVISION. YOU MAY CALL THE INSURANCE DIVISION WITH INQUIRIES OR COMPLAINTS AT ~~(515)281-4441~~ (515)281–5705. WRITTEN INQUIRIES OR COMPLAINTS SHOULD BE MAILED TO: IOWA SECURITIES AND REGULATED INDUSTRIES BUREAU, 330 MAPLE STREET, DES MOINES, IOWA 50319.

Sec. 31. Section 523I.813, subsection 3, Code Supplement 2009, is amended to read as follows:

3. The commissioner shall levy an administrative penalty in the amount of up to five hundred dollars against a cemetery that fails to file the annual report when due, payable to the state for deposit as provided in section 505.7. However, the commissioner may waive the administrative penalty upon a showing of good cause or financial hardship.

Sec. 32. 2009 Iowa Acts, chapter 118, section 1, is amended by adding the following new subsection:

NEW SUBSECTION. 6A. The commission shall also complete an annual review of the cost of health insurance mandates currently imposed on health insurance regulated by the state and provide projections of the cost of any mandates that the commission determines may be considered by the general assembly during the upcoming legislative session. The review and projections shall be included in the annual reports provided by the commission to the general assembly pursuant to this section.

Sec. 33. EFFECTIVE UPON ENACTMENT. The following provisions of this Act, being deemed of immediate importance, take effect upon enactment:

1. The section of this Act enacting section 505.7, subsection 10.
2. The section of this Act enacting section 505.8, subsection 18.
3. The section of this Act amending section 505.17.
4. The sections of this Act enacting sections 505.18 and 505.19.
5. The section of this Act amending 2009 Iowa Acts, chapter 118, section 1.

Approved April 9, 2010

CHAPTER 1122

REGULATION OF MIXED MARTIAL ARTS MATCHES AND EVENTS

S.F. 2286

AN ACT relating to the regulation of professional and amateur mixed martial arts matches and events by the labor commissioner and providing penalties.

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

Section 1. Section 90A.1, Code 2009, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. *"Mixed martial arts match"* means a professional or amateur mixed martial arts match or event that is open to the public and an admission fee is charged, a donation is requested from those in attendance, or merchandise or refreshments are available for purchase.