# CHAPTER 15
# UNFAIR TRADE PRACTICES

[Prior to 10/22/86, Insurance Department[510]]

**191—15.1(507B) Purpose.** This chapter is intended to establish certain minimum standards and guidelines of conduct by identifying unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, as prohibited by Iowa Code chapter 507B.

**191—15.2(507B) Definitions.**

*"Advertisement"* for the purpose of these rules shall be material designed to create public interest in insurance or an insurer, or to induce the public to purchase, increase, modify, reinstate or retain a policy including:

1. Printed and published material, audio and visual material, and descriptive literature of an insurer or producer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, computer on-line networks and similar displays; descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; sales talks, presentations, and material for use by producers; and material and oral instruction used by an insurer or producer for the recruitment, training, and education of producers in the sale of insurance.

2. However, for the purpose of these rules "advertisement" shall not include: communications or materials used within an insurer's own organization and not intended for dissemination to the public; communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy; and a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

*"Duplicate Medicare supplement insurance"* shall mean the sale or the attempt to knowingly sell to a person a policy of insurance designed to supplement Medicare benefits as provided in The Health Insurance for the Aged Act, Title XVII of the Social Security Amendments of 1965 as then constituted or later amended when the person is already insured under such a policy.

*"Duplication"* means policies of the same coverage type according to minimum standards classifications outlined in 191 IAC 36.6(514D) which overlap to the extent that a reasonable person would not consider the ownership of the policies to be beneficial.

*"Exception"* for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

*"Illustrated scale"* shall mean a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policyholder than the lesser of the disciplined current scale or the currently payable scale as defined in 191 IAC 14.4(507B).

*"Insurer"* shall mean any person, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the business of insurance.

*"Limitation"* for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

*"Person"* shall mean any individual, corporation, association, partnership, trust or benevolent association.

*"Policy"* shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for insurance benefits.

*"Preneed funeral contract or prearrangement"* shall mean an agreement by or for a person before the person's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

*"Producer"* shall mean a person who solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance for risks residing, located or to be performed in this state.

*"Reduction"* for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

*"Twisting"* shall mean any action by a producer or insurer to induce or attempt to induce any person to lapse, forfeit, surrender, terminate, retain, assign, borrow or convert a policy in order that such person procure another policy, when such action would operate to the overall detriment of the interests of the person.

**191—15.3(507B) Advertising.**

**15.3(1)** *Form and content of advertisements.* The format and content of an advertisement shall be truthful and sufficiently complete and clear to avoid deception or the capacity or tendency to misrepresent or deceive. Whether an advertisement has a capacity or tendency to misrepresent or deceive shall be determined by the overall impression that the advertisement may be reasonably expected to create upon a person in the segment of the public to which it is primarily directed and who has average education, intelligence and familiarity with insurance terminology for products in that market.

**15.3(2)** *Prohibited terms and disclosure requirements for health insurance.*

*a.* No advertisement shall contain or use words or phrases such as "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

*b.* No advertisement shall contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

*c.* No advertisement of a benefit for which payment is conditional upon confinement in hospital or similar facility shall use words or phrases such as "tax free," "extra cash" and substantially similar phrases which have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable a person to make a profit from being hospitalized.

*d.* No advertisement shall use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

*e.* An advertisement which refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

*f.* An advertisement may contain a brief description of coverage in an invitation to inquire so long as it is limited to a brief description of the loss for which benefits are payable. The brief description may also contain the dollar amount of benefits payable or the period of time during which benefits are payable, or both, but may not refer to the cost of the policy.

*g.* An advertisement for a policy which contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss shall prominently disclose the existence of such periods.

**15.3(3)** *Prohibited terms in life insurance and annuity policies.* No advertisement for a life insurance or annuity policy shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," "retirement plan," or other similar term which has the capacity or tendency to mislead an insured or prospective insured to believe that the insurer is offering something other than an insurance policy or some benefit not available to other persons of the same class and equal expectation of life. An advertisement shall not state that there are "no more premiums" or that premiums will "vanish" or "disappear" or use similar terms when such statement is not based on the guaranteed rates.

**15.3(4)** *Exclusions, limitations, exceptions and reductions.* Words and phrases used in an advertisement to describe policy exclusions, limitations, exceptions and reductions shall clearly, prominently and accurately indicate the negative or limited nature of the exclusions, limitations, exceptions and reductions.

**15.3(5)** *Use of statistics.* An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

**15.3(6)** *Introductory, initial or special offers.*

*a.* An advertisement shall not directly or by implication represent that a policy is an introductory, initial or special offer, or that a person will receive advantages not available at a later date, or that the offer is available only to a specified group of persons, unless such is the fact.

*b.* An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in each portion of the advertisement where the initial reduced premium appears. This paragraph shall not apply to annual renewable term policies.

**15.3(7)** *Testimonials or endorsements by third parties.*

*a.* Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules.

*b.* If the person making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements constitutes compensation and requires disclosure. This rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

*c.* An advertisement which states or implies that an insurer or an insurance product has been approved or endorsed by any person or other organizations must also disclose any proprietary or other relationship between the parties.

**15.3(8)** *Disparaging and incomplete comparisons and statements.* An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of noncomparable policies of other insurers, and shall not disparage other insurers, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of an insurer in the insurance business.

**15.3(9)** *Identity of insurer.*

*a.* The name of the actual insurer shall be clearly identified in all advertisements for a particular policy. An advertisement shall not use a trade name, insurance group designation, name of a parent company, name of a particular company division, service mark, slogan, symbol or other device which would have the capacity and tendency to misrepresent the true identity of an insurer.

*b.* No advertisement shall use any combination of words, symbols, or physical materials which by its content, phraseology, shape, color or other characteristics is so similar to combinations of words, symbols, or physical materials used by a municipal, state or federal agency that it would lead a reasonable person to believe that the advertisement is approved, endorsed or accredited by an agency of the municipal, state, or federal government.

**15.3(10)** *Disclosure requirements for life insurance and annuities.*

*a.* An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

*b.* An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

*c.* Dividends.

(1) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends for an annuity are illustrated, the illustration must be based on the insurer's illustrated scale and must contain a statement that the illustration is not to be construed as a guarantee or estimate of dividends to be paid in the future.

(2) An advertisement shall not state or imply that the illustrated scale under a participating policy or pure endowments will be or can be sufficient at any future time to ensure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains (1) what benefits or coverage would be provided at such time and (2) under what conditions this would occur.

*d.* An advertisement of a deferred annuity shall not state the net premium accumulation interest rate unless it discloses in close proximity thereto and with equal prominence the actual relationship between the gross and net premiums.

*e.* An advertisement that states the projected values of a policy must use the guaranteed interest rates in determining such projected values and, in addition, may show other projected values based on interest rates which comply with the illustrated scale. Any statements containing or based upon an interest rate higher than the guaranteed accumulation interest rates shall likewise set forth with equal prominence comparable statements containing or based upon the guaranteed accumulation interest rates. If the policy does not contain a provision for a guaranteed interest rate, any advertisement showing projected values must clearly state that the rates are not guaranteed. This subrule does not apply to an illustration or supplemental illustration subject to the provisions of the Life Illustrations Model Regulation, 191 IAC 14.

*f.* An advertisement or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such advertisement may be used for the purpose of demonstrating the cash flow pattern of a policy if such advertisement is accompanied by a statement disclosing that the advertisement does not recognize that, because of interest, a dollar in the future may not have the same value as a dollar at the time of the presentation.

*g.* An advertisement of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are also shown separately in close proximity thereto.

*h.* A statement regarding the use of life insurance cost indexes shall include an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

*i.* A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the insurer's illustrated scale and is not guaranteed.

**191—15.4(507B) Life insurance cost and benefit disclosure requirements.**

**15.4(1)** The definition of terms applicable to this rule and its appendices will be found in Appendix I.

**15.4(2)** Except as hereafter exempted, this rule shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This rule shall apply to any insurer issuing life insurance contracts including fraternal benefit societies.

Unless otherwise specifically included, this rule shall not apply to:

*a.* Annuities.

*b.* Credit life insurance.

*c.* Group life insurance, except for disclosures relating to preneed funeral contracts or prearrangements as provided herein. These disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy.

*d.* Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

*e.* Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

**15.4(3)** Prior to or at delivery of a life insurance policy, an insurer or producer shall provide the prospective purchaser the following:

*a.* A life insurance buyer's guide in the current form prescribed by the National Association of Insurance Commissioners or language approved by the commissioner of insurance, and

*b.* A policy summary as defined in Appendix I.

**15.4(4)** A policy summary is not required to include information available in the policy form or illustration. If an illustration subject to the provisions of 191 IAC 14, Life Insurance Illustrations Model Regulation, is used in the sale of a policy, delivery of a policy summary is not required. A policy summary may not include any element that is not guaranteed.

**191—15.5(507B) Health insurance sales to persons 65 years of age or older.**

**15.5(1)** The sale of duplicate Medicare supplement insurance is prohibited.

**15.5(2)** Prohibition of sale without acknowledgment of nonduplication.

*a.* Insurers or producers shall obtain an acknowledgment of nonduplication as set forth in Appendix II with all applications for any type of health insurance sold to an individual who is 65 years of age or older. This acknowledgment shall be obtained at the same time as the application and shall be submitted to the insurer with the application.

*b.* In order to obtain this acknowledgment, insurers or producers shall offer to examine all health insurance policies owned by a prospective purchaser and advise that person as to whether the purchase of the proposed policy will result in any duplication of benefits.

*c.* Insurers who do not use producers shall implement a similar system of review at no cost to the proposed insured.

**191—15.6(507B) Preneed funeral contracts or prearrangements.**

**15.6(1)** *Advertising.* An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement which is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

*a.* The fact that a life insurance policy or annuity contract is involved or being used to fund a prearrangement, and

*b.* The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

**15.6(2)** *Application.* Prior to accepting an application, initial premium or deposit, an insurer or producer must adequately disclose:

*a.* The relationship of the life insurance policy or annuity contract to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

*b.* The impact on the prearrangement of any:

(1) Changes in the life insurance policy or annuity contract including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds,

(2) Penalties to be incurred by the policyholder as a result of failure to make premium payments,

(3) Penalties to be incurred or moneys to be received as a result of cancellation or surrender of the life insurance policy or annuity contract;

*c.* A list of the merchandise and services which are supplied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

*d.* All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy or annuity contract and the amount actually needed to fund the prearrangement;

*e.* Any penalties or restrictions including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

*f.* The fact that a sales commission or other form of compensation is being paid and, if so, the identity of the person to whom it is paid.

**191—15.7(507B) Twisting prohibited.** No insurer or producer shall engage in the act of twisting.

**191—15.8(507B) Sales presentation guidelines.**

**15.8(1)** *Required disclosures.* A producer shall inform the prospective purchaser, prior to commencing an insurance sales presentation, that the producer is acting as an insurance producer and inform the prospective purchaser of the producer's full name and the full name of the insurance company which the producer will represent in the insurance sales presentation. In sales situations in which a producer is not involved, the insurer shall identify its full name to a prospective purchaser.

**15.8(2)** *Improper sales tactics.*

*a.* Producers and insurers shall not employ any method of marketing or tactic which uses undue pressure, force, fright, threat, whether explicit or implied, to solicit the purchase of insurance.

*b.* A producer shall not, without good cause:

(1) Allow a producer or a relative of a producer to be named as owner or beneficiary of a life insurance policy or annuity insuring the life of an unrelated insurance customer. Transactions which involve nominal interim ownership immediately precedent to transfer of ownership into trust are exempt from this subrule;

(2) Be named as a beneficiary in a will of an unrelated insurance customer;

(3) Obtain a personal loan or a monetary gift from an unrelated insurance customer;

(4) Execute a transaction for an insurance customer without authorization by the customer to do so; or

(5) Commit any act which shows that the producer has exerted undue influence over a person to take advantage of the producer/customer relationship.

*c.* Producers and insurers shall not, without good cause:

(1) Fail or refuse to furnish any person, upon reasonable request, information to which that person is entitled, or to respond to a formal written request or complaint from any person.

(2) Sell an insurance policy or rider to a person which is a duplication of a policy or rider which the person owns or for which the person has applied at the time of sale.

**15.8(3)** *Prohibited designations and fees.*

*a.* A producer shall not represent, directly or indirectly, that the producer is a "financial planner," "investment adviser," "financial counselor," or any other specialist engaged in the business of giving financial planning or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when the sole intent of the producer is to engage in the sale of insurance. This subrule does not prohibit the use of designations acquired through a recognized national program.

*b.* Producers shall not charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies. This prohibition shall not apply to assigned risk policies and commercial property/casualty policies. Any additional fee that a producer intends to charge for assigned risk policies and commercial property/casualty policies must be fully disclosed to the insured.

**15.8(4)** *Suitability.* A producer shall not recommend to any person the purchase, sale or exchange of any life insurance policy, annuity or any rider, endorsement or amendment thereto, without reasonable grounds to believe that the transaction or recommendation is not unsuitable for the person based upon reasonable inquiry concerning the person's insurance objectives, financial situation and needs, age and other relevant information known by the producer. For purposes of this subrule, when a producer recommends a group life insurance policy or annuity, "person" shall refer to the intended group policyowner.

**191—15.9(507B) Right to return a life insurance policy or annuity (free-look).** The owner of an individual policy has the right, within ten days after receipt of a life insurance policy or annuity, to a free-look period. During this period, the policyowner may return the life insurance policy or annuity to the insurer at its home office, branch office, or to the producer through whom it was purchased. If so returned, the premium paid will be promptly refunded, the policy or annuity voided and the parties returned to the same position as if a policy or annuity had not been issued.

**191—15.10(507B) Uninsured/underinsured automobile coverage—notice required.**

**15.10(1)** *Contents of notice.* Automobile insurance policies delivered in this state shall include a notice which contains and is limited to the following language:

NOTICE REGARDING UNINSURED/UNDERINSURED COVERAGE

Uninsured/underinsured coverage does not cover damage done to your vehicle. It provides benefits only for bodily injury caused by an uninsured or underinsured motorist. If you wish to be insured for damage done to your vehicle, you must have collision coverage. Please check your policy to make sure you have the coverage desired.

**15.10(2)** *Form of notice.* Notice may be provided on a separate form or may be stamped on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the notice in this rule is required by the insurance division.

**191—15.11(507B) Unfair discrimination.**

**15.11(1)** *Sex discrimination.*

*a.* A contract shall not be denied to a person based solely on that individual's sex or marital status. No benefits, terms, conditions or type of coverage shall be restricted, modified, excluded, or reduced on the basis of the sex or marital status of the insured or prospective insured except to the extent permitted under the Iowa Code or Iowa Administrative Code. An insurer may consider marital status for the purpose of defining persons eligible for dependents' benefits. This subrule does not apply to group life insurance policies or group annuity contracts issued in connection with pension and welfare plans which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

*b.* Specific examples of practices prohibited by this subrule include, but are not limited to, the following:

(1) Denying coverage to persons of one sex employed at home, employed part-time or employed by relatives when coverage is offered to persons of the opposite sex similarly employed.

(2) Denying policy riders to persons of one sex when the riders are available to persons of the opposite sex.

(3) Denying a policy under which maternity coverage is available to an unmarried female when that same policy is available to a married female.

(4) Denying, under group contracts, dependent coverage to spouses of employees of one sex, when dependent coverage is available to spouses of employees of the opposite sex.

(5) Denying disability income coverage to employed members of one sex when coverage is offered to members of the opposite sex similarly employed.

(6) Treating complications of pregnancy differently from any other illness or sickness under the contract.

(7) Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one sex.

(8) Offering lower maximum monthly benefits to members of one sex than to members of the opposite sex who are in the same underwriting and occupational classification under a disability income contract.

(9) Offering more restrictive benefit periods and more restrictive definitions of disability to members of one sex than to members of the opposite sex in the same underwriting and occupational classifications under a disability income contract.

(10) Establishing different contract conditions based on gender which limit the benefit options a policyholder may exercise.

(11) Limiting the amount of coverage due to an insured's or prospective insured's marital status unless such limitation applies only to coverage for dependents and is uniformly applied to males and females.

*c.* When rates are differentiated on the basis of sex, an insurer must, upon the request of the commissioner of insurance, justify the rate differential in writing to the satisfaction of the commissioner. All rates shall be based on sound actuarial principles or a valid classification system and actual experience statistics, if available.

*d.* This subrule shall not affect the right of fraternal benefit societies to determine eligibility requirements for membership. If a fraternal benefit society does, however, admit members of both sexes, this subrule is applicable to the insurance benefits available to its members.

**15.11(2)** *Physical or mental impairment.* No contract, benefits, terms, conditions or type of coverage shall be denied, restricted, modified, excluded or reduced solely on the basis of physical or mental impairment of the insured or prospective insured except where based on sound actuarial principles or related to actual or reasonably anticipated experience. For purposes of this subrule, both blindness and partial blindness shall be considered a physical impairment.

**15.11(3)** *Income discrimination.* An insurer shall not refuse to issue, limit the amount or apply different rates to persons of the same class in the sale of individual life insurance based solely upon the prospective insured's legal source or level of income, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The portion of this subrule pertaining to level of income does not:

*a.* Apply to the sale of disability income insurance of any kind or of any insurance designed to protect against economic loss due to a disruption in the regular flow of a person's earned income;

*b.* Prohibit the sale of any insurance or annuity which is made available only to employees;

*c.* Prohibit basing the amount of insurance sold to an employee on a multiple or a percentage of the employee's salary or prohibit limiting availability to employees who have achieved a certain employment status as defined by the employer;

*d.* Prohibit insurers from providing life or health insurance as an incidental benefit through a qualified pension plan;

*e.* Prohibit insurers from applying suitability standards which include income as a factor in the sale of any life insurance or annuity products;

*f.* Prohibit insurers from establishing maximum or minimum amounts of insurance that will be issued to individuals so long as this is pursuant to a preexisting specialized marketing strategy which the insurer can demonstrate is related to the financial capacity of the insurer to write business or to bona fide transaction costs.

**15.11(4)** *Domestic abuse.* A contract shall not be denied to a person based solely on the fact such person has been or is believed to have been a victim of domestic abuse as defined in Iowa Code section 236.2.

**191—15.12(507B) Testing restrictions of insurance applications for the human immunodeficiency virus.**

**15.12(1)** *Written release.* No insurer shall obtain a test of any person in connection with an application for insurance for the presence of an antibody to the human immunodeficiency virus unless the person to be tested provides a written release on a form which contains the following information:

*a.* A statement of the purpose, content, use, and meaning of the test.

*b.* A statement regarding disclosure of the test results including information explaining the effect of releasing the information to an insurer.

*c.* A statement of the purpose for which test results may be used.

**15.12(2)** *Form.* A preapproved form is provided in Appendix III. An insurer wishing to utilize a form which deviates from the language in the appendix to these rules shall submit the form to the insurance division for approval. Any form containing, but not limited to, the language in the appendix shall be deemed approved.

**191—15.13(507B) Records maintenance.**

**15.13(1)** *Complaint and business records.*

*a.* An insurer shall maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner.

*b.* An insurer shall maintain a complete record of all the complaints received since the date of its last examination by the insurer's state of domicile or port-of-entry state. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. Appendix IV sets forth the minimum information required to be contained in the complaint record.

**15.13(2)** *Insurer's control over advertisements.* Every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements which explain a particular policy. All such advertisements, whether written, created, designed or presented by the insurer or its appointed producer, shall be the responsibility of the insurer whose particular policies are so advertised. As part of this requirement, each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its policies, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the insurance division. All such advertisements shall be maintained for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

**191—15.14(507B) Enforcement section—cease and desist and penalty orders.** If, after hearing, the commissioner finds that an insurer or producer has engaged in an unfair trade practice in violation of these rules or unfair competition or unfair and deceptive acts or practices in violation of Iowa Code chapter 507B, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer or producer charged with the violation a copy of the findings in an order requiring the insurer or producer to cease and desist from engaging in the act or practice. The commissioner also may order one or more of the following:

1. Payment of a monetary penalty of not more than $1,000 for each violation, but not to exceed an aggregate penalty of $10,000. If the insurer or producer knew or reasonably should have known that its actions were in violation of these rules, the penalty shall be not more than $5,000 for each violation but not to exceed an aggregate penalty of $50,000;
2. Suspension or revocation of the insurer's certificate of authority or the producer's license if the insurer or producer knew or reasonably should have known that it was in violation of this rule;
3. Full disclosure by the insurer of all terms and conditions of the policy to the policyowner;
4. Payment of the costs of the investigation and administrative expenses related to any violation.

**191—15.15(507B) Use of aftermarket crash parts in automobile insurance policies—notice required.**

**15.15(1)** *Contents of notice.* Any automobile insurance policy delivered in this state that pays benefits based on the cost of aftermarket crash parts as defined in Iowa Code chapter 537B or that requires the insured to pay the difference between the cost of original equipment manufacturer parts and the cost of aftermarket crash parts shall include a notice which contains and is limited to the following language:

NOTICE—PAYMENT FOR AFTERMARKET CRASH PARTS

Physical damage coverage under this policy includes payment for aftermarket crash parts. If you repair the vehicle using more expensive original equipment manufacturer (OEM) parts, you may pay the difference. Any warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle.

**15.15(2)** *Form of notice.* Notice may be provided on a separate form or may be printed prominently on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application, but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the insurance division requires the notice in this rule.

**191—15.16(507B) Audit procedures for medical claims.**

**15.16(1)** *Prohibitions.* This rule applies to all claims paid on or after January 1, 2002:

*a.* Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.

*b.* Absent a reasonable basis to suspect fraud, an insurer may not audit a claim with a billed charge of less than $25.

**15.16(2)** *Standards.*

*a.* In auditing a claim, the insurer must make a reasonable effort to ensure that the audit is performed by a person or persons with appropriate qualifications for the type of audit being performed.

*b.* In auditing a claim, the auditor must use the coding guidelines and instructions that were in effect on the date the medical service was provided.

**15.16(3)** *Contents of audit request.* All correspondence regarding the audit of a claim must include the following information:

*a.* The name, address, telephone number and contact person of the insurer conducting the audit,

*b.* The name of the entity performing the audit if not the insurer,

*c.* The purpose of the audit, and

*d.* If included in the audit, the specific coding or billing procedure that is under review.

This rule is intended to implement Iowa Code section 507B.4, subsection 9, as amended by 2001 Iowa Acts, chapter 69.

**191—15.17(507B) Prompt payment of claims.** Effective July 1, 2002, the following provisions apply:

**15.17(1)** *Definitions and scope.*

*a.* For purposes of this rule, the following definitions apply:

*"Circumstance requiring special treatment"* means:

1. A claim that an insurer has a reasonable basis to suspect may be fraudulent or that fraud or a material misrepresentation may have occurred under the benefit certificate or policy or in obtaining such certificate or policy; or

2. A matter beyond the insurer's control, such as an act of God, insurrection, strike or other similar labor dispute, fire or power outage or, for a group-sponsored health plan, the failure of the sponsoring group to pay premiums to the insurer in a timely manner; or

3. Similar unique or special circumstances which would reasonably prevent an insurer from paying an otherwise clean claim within 30 days.

*"Clean claim"* means clean claim as defined in 2001 Iowa Acts, chapter 69, section 8(2b).

*"Coordination of benefits for third-party liability"* means a claim for benefits by a covered person who has coverage under more than one health benefit plan.

*"Insurer"* means insurer as defined in 2001 Iowa Acts, chapter 69, section 7.

*"Properly completed billing instrument"* means:

1. In the case of a health care provider that is not a health care professional:

- The Health Care Finance Administration (HCFA) Form 1450, also known as Form UB-92, or similar form adopted by its successor Centers for Medicare/Medicaid Services (CMS) as adopted by the National Uniform Billing Committee (NUBC) with data element usage prescribed in the UB-92 National Uniform Billing Data Elements Specification Manual, or
- The electronic format for institutional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; or

2. In the case of a health care provider that is a health care professional:

- The HCFA Form 1500 paper form or its successor as adopted by the National Uniform Claim Committee (NUCC) and further defined by the NUCC in its implementation guide; or
- The electronic format for professional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; and

3. Any other information reasonably necessary for an insurer to process a claim for benefits under the benefit certificate or policy with the insured contract.

*b.* Scope. This subrule applies to claims submitted to an insurer as defined above on or after July 1, 2002, and is limited to policies issued, issued for delivery, or renewed in this state.

**15.17(2)** *Insurer duty to promptly pay claims and pay interest.*

*a.* Insurers subject to this subrule shall either accept and pay or deny a clean claim for health care benefits under a benefit certificate or policy issued by the insurer within 30 days after the insurer's receipt of such claim. A clean claim is considered to be paid on the date upon which a check, draft, or other valid negotiable instrument is written. Insurers shall implement procedures to ensure that these payments are promptly delivered.

*b.* Insurers or entities that administer or process claims on behalf of an insurer who fail to pay a clean claim within 30 days after the insurer's receipt of a properly completed billing instrument shall pay interest. Interest shall accrue at the rate of 10 percent per annum commencing on the thirty-first day after the insurer's receipt of all information necessary to establish a clean claim. Interest will be paid to the claimant or provider based upon who is entitled to the benefit payment.

*c.* Insurers shall have 30 days from the receipt of a claim to request additional information to establish a clean claim. An insurer shall provide a written or electronic notice to the claimant or health care provider if additional information is needed to establish a clean claim. The notice shall include a full explanation of the information necessary to establish a clean claim.

*d.* Effective January 1, 2003, when a claim involves coordination of benefits, an insurer is required to comply with the requirements of this subrule when that insurer's liability has been determined.

**15.17(3)** *Certain insurance products exempt.* Claims paid under the following insurance products are exempt from the provisions of this subrule: liability insurance, workers' compensation or similar insurance, automobile or homeowners insurance, medical payment insurance, disability income insurance, or long-term care insurance.

This rule is intended to implement 2001 Iowa Acts, chapter 69, section 8, and Iowa Code section 507B.4 as amended by 2001 Iowa Acts, chapter 69.

These rules are intended to implement Iowa Code chapter 507B.

## Appendix I
## LIFE INSURANCE COST AND BENEFIT DISCLOSURE

Definitions.

"Annual premium" for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

"Cash dividend" means dividends which can be applied toward payment of gross premiums which comply with the illustrated scale.

"Equivalent level annual dividend" is calculated by applying the following steps:

1. Accumulate the annual cash dividends at 5 percent interest compounded annually to the end of the tenth and twentieth policy years.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
3. Divide the results of paragraph "2" by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

"Equivalent level death benefit" of a policy or term life insurance rider is an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death other than suicide, or other specifically enumerated exclusions, at the beginning of each policy year for 10 and 20 years at 5 percent interest compounded annually to the end of the tenth and twentieth policy years respectively.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

"Generic name" means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

"Life insurance net payment cost index." The life insurance net payment cost index is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

"Life insurance surrender cost index." The life insurance surrender cost index is calculated by applying the following steps:

1. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.