

## F I N A L R E P O R T

### INSURANCE GUARANTY FUND AND RISK-SHARING STUDY COMMITTEE

January, 1986

The Insurance Guaranty Fund and Risk Sharing Study Committee was mandated by House File 570 which was enacted by the First Session of the Seventy-first General Assembly. The Committee was established to study the manner in which states presently administer guaranty fund laws which provide for the indemnification of losses of policyholders of insolvent life and health insurance companies as well as the manner in which states administer risk-sharing pools which provide accident and health insurance to persons who are uninsurable. The Committee was specifically mandated to consider issues relating to the administration of the cash flow and funding of the insurance programs, including the collection and deposit of funds, assessments, creation of a permanent state funding mechanism, granting of credits which recognize losses attributable to providing comprehensive health coverage to the unemployed or uninsurable public or individuals whose group health coverage is terminated because membership in the group is terminated.

Members of the Study Committee included:

Senator William Palmer, Co-chairperson  
Representative Phil Brammer, Co-chairperson  
Senator Patrick J. Deluhery  
Senator Michael Gronstal  
Senator Edgar H. Holden  
Senator John Jensen  
Representative Jack Hatch  
Representative Kyle Hummel  
Representative Joseph Kremer  
Representative Tom Swartz  
Mr. Herman Bailey  
Mr. Bruce Foudree  
Mr. Donald Rowen  
Mr. Bob Rush

#### DISCUSSION OF COMMITTEE MEETINGS

The Study Committee was initially granted two meetings and was subsequently granted two additional meetings upon petition to the Legislative Council.

At the first meeting the Committee received testimony from individuals representing several different groups regarding the extent of the need and suggestions for providing comprehensive

medical coverage for persons who currently do not have health and accident insurance due to chronic health problems or inability to pay the insurance premiums. Presentations were made on behalf of the Iowa Life Insurance Association, Blue Cross/Blue Shield of Iowa, the United Automobile Workers, Communicating for Agriculture, the Iowa Department of Human Services, and the Iowa Hospital Association.

At the second and third meetings of the Committee, Committee members reviewed and amended drafts of various risk-sharing proposals. In addition, at the third meeting the Committee heard from Denise Horner of the Iowa Insurance Department and representatives of the Iowa Life Insurance Association regarding establishing an insurance guaranty fund to cover the losses of policyholders of insolvent life and health and accident insurers. The Committee also heard a presentation from Mr. Richard Cleland of the Consumer Protection Division of the Attorney General's Office regarding consumer problems relating to financial planning and self-insurance plans.

At the final meeting, the Committee finalized the language and adopted as recommendations on the risk-sharing pool concept, establishing an insurance guaranty fund, and a bill providing for continuation of health insurance coverage for a person terminated from a group covered by a group health plan. The Committee also adopted a resolution relating to funding for the state Insurance Department. Finally, the Committee heard a presentation from Ms. Nancy Haigh and Mr. Kent Westmaas from the State Department of Human Services relating to the state's medically needy program and the potential costs and expanded coverages resulting from changing the eligibility requirements for the program.

#### RECOMMENDATIONS

The Committee approved the following bills and resolution as Committee recommendations:

1. An Act establishing the Iowa comprehensive health association, providing for a plan of operation, establishing financial procedures, providing eligible expenses, excluding certain requirements, and relating to other provisions of health insurance coverage.
2. An Act relating to insurance guaranty associations by creating an Iowa life and health insurance guaranty association.
3. An Act permitting an individual who is covered by a group health plan to continue coverage under the plan for up to twelve months.
4. A Committee resolution recommending increased funding for the state insurance department.

Copies of the bills and resolution are attached.

SENATE/HOUSE FILE \_\_\_\_\_  
BY (PROPOSED COMMITTEE ON SMALL  
BUSINESS AND COMMERCE BILL  
BY THE INSURANCE GUARANTY  
FUND AND RISK SHARING POOL  
STUDY COMMITTEE)

Passed Senate, Date \_\_\_\_\_ Passed House, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

**A BILL FOR**

1 An Act establishing the Iowa comprehensive health association,  
2 providing for a plan of operation, establishing financial  
3 procedures, providing eligible expenses, excluding certain  
4 requirements, and relating to other provisions of health  
5 insurance coverage.

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

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1 Section 1. NEW SECTION. 514E.1 DEFINITIONS.

2 As used in this chapter, unless the context otherwise re-  
3 quires:

4 1. "Association" means the Iowa comprehensive health as-  
5 sociation established by section 514E.2.

6 2. "Association policy" means an individual policy issued  
7 by the association that provides the coverage specified in  
8 section 514E.4.

9 3. "Carrier" means an insurer providing accident and sick-  
10 ness insurance under chapter 509, 514 or 514A and includes a  
11 health maintenance organization established under chapter 514B  
12 if payments received by the health maintenance organization  
13 are considered premiums pursuant to section 514B.31 and are  
14 taxed under chapter 432. "Carrier" also includes a  
15 corporation which becomes a mutual insurer pursuant to section  
16 514.23 and any other person as defined in section 4.1,  
17 subsection 13, who is or may become liable for the tax imposed  
18 by chapter 432.

19 4. "Commissioner" means the commissioner of insurance.

20 5. "Eligible expenses" means the usual, customary and rea-  
21 sonable charges for the health care services specified in  
22 section 514E.4.

23 6. "Health care facility" means a health care facility as  
24 defined in section 135C.1, subsection 4, a hospital as defined  
25 in section 135B.1, subsection 1, or a community mental health  
26 center established under chapter 230A.

27 7. "Health care services" means hospital services, medical  
28 or surgical services, dental services, or pharmaceutical or  
29 optometric services, the coverage of which is authorized under  
30 chapter 509, 514, 514A, or 514B as limited by sections 514E.4  
31 and 514E.5, and includes services for the purposes of prevent-  
32 ing, alleviating, curing, or healing human illness, injury, or  
33 physical disability.

34 8. "Health insurance" means accident and sickness  
35 insurance authorized by chapter 509, 514 or 514A.

1 9. "Health insurance trust fund" means the fund created in .  
2 section 514E.3.

3 10. "Insured" means an individual who is provided  
4 qualified comprehensive health insurance under an association  
5 policy, which policy may include dependents and other covered  
6 persons.

7 11. "Medicaid" means the federal-state assistance program  
8 established under Title XIX of the federal Social Security  
9 Act.

10 12. "Medicare" means the federal government health  
11 insurance program established under Title XVIII of the Social  
12 Security Act.

13 13. "Policy" means a contract, policy, or plan of health  
14 insurance.

15 14. "Policy year" means a consecutive twelve-month period  
16 during which a policy provides or obligates the carrier to  
17 provide health insurance.

18 Sec. 2. NEW SECTION. 514E.2 IOWA COMPREHENSIVE HEALTH  
19 ASSOCIATION.

20 1. There is established a nonprofit corporation known as  
21 the Iowa comprehensive health insurance association which  
22 shall assure that health insurance, as limited by sections  
23 514E.4 and 514E.5, is made available to each eligible Iowa  
24 resident applying to the association for coverage. All  
25 carriers as defined in section 514E.1, subsection 3, providing  
26 health insurance or health care services in Iowa shall be mem-  
27 bers of the association. The association shall operate under  
28 a plan of operation established and approved under subsection  
29 3 and shall exercise its powers through a board of directors  
30 established under this section.

31 2. The board of directors of the association shall consist  
32 of not less than five nor more than nine members selected by  
33 the members of the association, subject to approval by the  
34 commissioner.

35 In order to select the initial board of directors and

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1 organize the association, the commissioner shall give notice  
2 to all carriers of the time and place of the organizational  
3 meeting. In determining voting rights at the organizational  
4 meeting, each carrier member is entitled to one vote in person  
5 or by proxy. If the board of directors is not selected within  
6 sixty days after the organizational meeting, the commissioner  
7 shall appoint the initial board. In approving or selecting  
8 members of the board, the commissioner shall consider whether  
9 all carriers are fairly represented. Members of the board may  
10 be reimbursed from the moneys of the association for expenses  
11 incurred by them as members, but shall not be otherwise  
12 compensated by the association for their services.

13 3. The association shall submit to the commissioner a plan  
14 of operation for the association and any amendments necessary  
15 or suitable to assure the fair, reasonable, and equitable ad-  
16 ministration of the association. The plan of operation  
17 becomes effective upon approval in writing by the commissioner  
18 prior to the date on which the coverage under this chapter  
19 must be made available. After notice and hearing, the  
20 commissioner shall approve the plan of operation if the plan  
21 is determined to be suitable to assure the fair, reasonable,  
22 and equitable administration of the association, and provides  
23 for the sharing of association losses, if any, on an equitable  
24 and proportionate basis among the member carriers. If the  
25 association fails to submit a suitable plan of operation  
26 within one hundred eighty days after the appointment of the  
27 board of directors, or if at any later time the association  
28 fails to submit suitable amendments to the plan, the  
29 commissioner shall adopt, pursuant to chapter 17A, rules  
30 necessary to implement this section. The rules shall continue  
31 in force until modified by the commissioner or superseded by a  
32 plan submitted by the association and approved by the  
33 commissioner. In addition to other requirements, the plan of  
34 operation shall provide for all of the following:

35 a. The handling and accounting of assets and moneys of the

1 association.

2 b. The amount and method of reimbursing members of the  
3 board.

4 c. Regular times and places for meeting of the board of  
5 directors.

6 d. Records to be kept of all financial transactions, and  
7 the annual fiscal reporting to the commissioner.

8 e. Procedures for selecting the board of directors and  
9 submitting the selections to the commissioner for approval.

10 f. Establishing, in cooperation with the commissioner of  
11 insurance and the state comptroller, procedures for the  
12 determination and payment to the association from the health  
13 insurance trust fund of amounts which represent the net loss  
14 for the preceding calendar year to the association. The  
15 amount of the payment shall be based upon the amount of funds  
16 deposited in the health insurance trust fund and the amount of  
17 net loss of the association. If funds deposited in the health  
18 insurance trust fund are insufficient to pay all of the  
19 losses, the state comptroller shall notify the commissioner of  
20 insurance and the association of the amount of the deficiency.

21 g. The periodic advertising of the general availability of  
22 health insurance coverage from the association.

23 h. Additional provisions necessary or proper for the  
24 execution of the powers and duties of the association.

25 4. The plan of operation may provide that the powers and  
26 duties of the association may be delegated to a person who  
27 will perform functions similar to those of the association. A  
28 delegation under this section takes effect only upon the  
29 approval of both the board of directors and the commissioner.  
30 The commissioner shall not approve a delegation unless the  
31 protections afforded to the insured are substantially  
32 equivalent to or greater than those provided under this  
33 chapter.

34 5. The association has the general powers and authority  
35 enumerated by this subsection and executed in accordance with

1 the plan of operation approved by the commissioner under  
2 subsection 3. The association has the general powers and  
3 authority granted under the laws of this state to carriers  
4 licensed to issue health insurance. In addition, the  
5 association may do any of the following:

- 6 a. Enter into contracts as necessary or proper to carry  
7 out this chapter.
- 8 b. Sue or be sued, including taking any legal action  
9 necessary or proper for recovery of any assessments for, on  
10 behalf of, or against participating carriers.
- 11 c. Take legal action necessary to avoid the payment of im-  
12 proper claims against the association or the coverage provided  
13 by or through the association.
- 14 d. Establish or utilize a medical review committee to  
15 determine the reasonably appropriate level and extent of  
16 health care services in each instance.
- 17 e. Establish appropriate rates, scales of rates, rate  
18 classifications, and rating adjustments, which rates shall not  
19 be unreasonable in relation to the coverage provided and the  
20 reasonable operations expenses of the association.
- 21 f. Pool risks among members.
- 22 g. Issue association policies on an indemnity or provision  
23 of service basis providing the coverage required by this  
24 chapter.
- 25 h. Administer separate pools, separate accounts, or other  
26 plans or arrangements considered appropriate for separate  
27 members or groups of members.
- 28 i. Operate and administer any combination of plans, pools,  
29 or other mechanisms considered appropriate to best accomplish  
30 the fair and equitable operation of the association.
- 31 j. Appoint from among members appropriate legal,  
32 actuarial, and other committees as necessary to provide  
33 technical assistance in the operation of the association,  
34 policy and other contract design, and any other functions  
35 within the authority of the association.

1 k. Hire independent consultants as necessary.

2 1. Develop a method of advising applicants of the availa-  
3 bility of other coverages outside the association, and shall  
4 promulgate a list of health conditions the existence of which  
5 would make an applicant eligible without demonstrating a re-  
6 jection of coverage by one carrier.

7 m. Include in its policies a provision providing for  
8 subrogation rights by the association in a case in which the  
9 association pays expenses on behalf of an individual who is  
10 injured or suffers a disease under circumstances creating a  
11 liability upon another person to pay damages to the extent of  
12 the expenses paid by the association.

13 6. Rates for coverages issued by the association shall not  
14 be unreasonable in relation to the benefits provided, the risk  
15 experience, and the reasonable expenses of providing coverage.  
16 Separate scales of rates based on age may apply for individual  
17 risks. Rates must take into consideration the extra morbidity  
18 and administration expenses, if any, for risks insured in the  
19 association. The rates for a given classification shall not  
20 be more than one hundred fifty percent of the average premium  
21 or payment rate for that classification charged by the five  
22 carriers with the largest health insurance premium or payment  
23 volume in the state during the preceding calendar year. In  
24 determining the average rate of the five largest carriers, the  
25 rates or payments charged by the carriers shall be actuarially  
26 adjusted to determine the rate or payment that would have been  
27 charged for benefits similar to those issued by the  
28 association.

29 7. Following the close of each calendar year, the  
30 association shall determine the net premiums and payments, the  
31 expenses of administration, and the incurred losses of the  
32 association for the year. The association shall certify the  
33 amount of any net loss for the preceding calendar year to the  
34 commissioner of insurance and state comptroller who shall make  
35 payment to the association according to procedures established

1 under subsection 3, paragraph "f". Any remaining loss, after  
2 payment to the association from the health insurance trust  
3 fund, shall be assessed by the association to all members in  
4 proportion to their respective shares of total health  
5 insurance premiums or payments for subscriber contracts  
6 received in Iowa during the second preceding calendar year, or  
7 with paid losses in the year, coinciding with or ending during  
8 the calendar year or on any other equitable basis as provided  
9 in the plan of operation. In sharing losses, the association  
10 may abate or defer in any part the assessment of a member, if,  
11 in the opinion of the board, payment of the assessment would  
12 endanger the ability of the member to fulfill its contractual  
13 obligations. The association may also provide for an initial  
14 or interim assessment against members of the association if  
15 necessary to assure the financial capability of the  
16 association to meet the incurred or estimated claims expenses  
17 or operating expenses of the association until the next  
18 calendar year is completed. Net gains, if any, must be held  
19 at interest to offset future losses or allocated to reduce  
20 future premiums.

21 8. The association shall conduct periodic audits to assure  
22 the general accuracy of the financial data submitted to the  
23 association, and the association shall have an annual audit of  
24 its operations, made by an independent certified public  
25 accountant.

26 9. The association is subject to examination by the  
27 commissioner of insurance. Not later than April 30 of each  
28 year, the board of directors shall submit to the commissioner  
29 a financial report for the preceding calendar year in a form  
30 approved by the commissioner.

31 10. All policy forms issued by the association must be  
32 filed with and approved by the commissioner before their use.

33 11. The association shall not issue an association policy  
34 to an individual who, on the effective date of the coverage  
35 applied for, has not been rejected for, already has, or will

1 have coverage similar to an association policy, as an insured  
2 or covered dependent.

3 12. The association shall pay an agent's referral fee of  
4 twenty-five dollars to each insurance agent who refers an  
5 applicant to the association if that applicant is accepted.

6 13. The association is exempt from payment of all fees and  
7 all taxes levied by this state or any of its political  
8 subdivisions.

9 14. A member who, after July 1, 1986, has paid one or more  
10 assessments levied under this chapter may take a credit  
11 against the premium taxes, or similar taxes, upon revenues or  
12 income of the member that are imposed by the state on health  
13 insurance premiums pursuant to chapter 432 or payments subject  
14 to taxation under section 514B.31, up to the amount of twenty  
15 percent of those taxes due, for each of the five calendar  
16 years following the year for which an assessment was paid, or  
17 until the aggregate of those assessments has been offset by  
18 credits against those taxes if this occurs first. If a member  
19 ceases doing business, all uncredited assessments may be  
20 credited against its premium tax liability for the year it  
21 ceases doing business.

22 Sec. 3. NEW SECTION. 514E.3 HEALTH INSURANCE TRUST FUND  
23 -- DEPOSIT OF MONEYS.

24 A health insurance trust fund is created within the state  
25 treasury. Commencing in the calendar year beginning January  
26 1, 1987, and annually thereafter, there shall be deposited in  
27 the health insurance trust fund twenty-five percent of the  
28 moneys set aside pursuant to 1985 Iowa Acts, chapter 239,  
29 section 8. The moneys in the health insurance trust fund and  
30 any income to the fund shall be used to make the payments  
31 provided for in section 514E.2, subsection 3, paragraph "f".  
32 If after making a payment, there is a balance remaining in the  
33 health insurance trust fund, the balance shall be retained in  
34 the fund together with any interest or earnings that is earned  
35 on the balance and may be used to cover future expenses of the

1 association. However, if the balance of the health insurance  
2 trust fund after the payments provided for in section 514E.2,  
3 subsection 3, paragraph "f" exceeds ten million dollars, then  
4 the amount of the funds in excess of the ten million dollars  
5 shall be transferred to the separate account established in  
6 1985 Iowa Acts, chapter 239, section 8.

7 Moneys deposited in the health insurance trust fund may be  
8 invested by the treasurer of state in the same manner as  
9 moneys in the general fund.

10 Sec. 4. NEW SECTION. 514E.4 ASSOCIATION POLICY --  
11 COVERAGE AND BENEFIT REQUIREMENTS -- ELIGIBLE EXPENSES.

12 The association policy shall pay only the usual, customary  
13 and reasonable charges for medically necessary eligible health  
14 care services which exceed the deductible and coinsurance  
15 amounts applicable under section 514E.6. Eligible expenses  
16 are the charges for the following health care services  
17 furnished by a health care provider in an emergency situation  
18 or furnished or prescribed by a health care provider:

19 1. Hospital services, including charges for the most  
20 common semiprivate room, for the most common private room if  
21 semiprivate rooms do not exist in the health care facility, or  
22 for the private room if medically necessary, but limited to a  
23 total of one hundred eighty days in a calendar year.

24 2. Professional services for the diagnosis or treatment of  
25 injuries, illnesses, or conditions, other than mental or  
26 dental, which are rendered by a health care provider, or at  
27 the direction of a health care provider, by a staff of  
28 registered nurses, licensed practical nurses, or other health  
29 care providers.

30 3. The first twenty professional visits for the diagnosis  
31 or treatment of one or more mental conditions, rendered during  
32 a calendar year by one or more health care providers, or at  
33 their direction, by their staff of registered nurses, licensed  
34 practical nurses, or other health care providers.

35 4. Drugs and contraceptive devices requiring a prescrip-

1 tion.

2 5. Services of a skilled nursing facility as defined in  
3 section 135C.1, subsection 3, or services in an intermediate  
4 care facility as defined in section 135C.1, subsection 2, to  
5 the same extent as the services would be paid in a skilled  
6 nursing facility, for not more than one hundred eighty days in  
7 a calendar year.

8 6. Homemaker-home health services up to one hundred eighty  
9 days of service in a calendar year.

10 7. Use of radium or other radioactive material.

11 8. Oxygen.

12 9. Anesthetics.

13 10. Prostheses, other than dental.

14 11. Rental of durable medical equipment, other than eye  
15 glasses and hearing aids, which have no personal use in the  
16 absence of the condition for which prescribed.

17 12. Diagnostic X rays and laboratory tests.

18 13. Oral surgery for any of the following:

19 a. Excision of partially or completely erupted impacted  
20 teeth.

21 b. Excision of a tooth root without the extraction of the  
22 entire tooth.

23 c. The gums and tissues of the mouth when not performed in  
24 connection with the extraction or repair of teeth.

25 14. Services of a physical therapist and services of a  
26 speech therapist.

27 15. Professional ambulance services to the nearest health  
28 care facility qualified to treat the illness, injury, or  
29 condition.

30 16. Processing of blood, including but not limited to,  
31 collecting, testing, fractionating, and distributing blood.

32 Sec. 5. NEW SECTION. 514E.5 EXPENSES EXCLUDED.

33 Eligible expenses shall not include an expense for any of  
34 the following:

35 1. Services for which a charge is not made in the absence

1 of insurance or for which there is no legal obligation on the  
2 part of a patient to pay.

3 2. Services and charges made for benefits provided under  
4 the laws of the United States, including Medicare and  
5 Medicaid, military service-connected disabilities, medical  
6 services provided for members of the armed forces and their  
7 dependents or for employees of the armed forces of the United  
8 States, and medical services financed on behalf of all  
9 citizens by the United States.

10 3. Benefits which would duplicate the provision of  
11 services or payment of charges for any care for an injury,  
12 disease, or condition for which either of the following  
13 applies:

14 a. It arises out of and in the course of an employment  
15 subject to a workers' compensation or similar law.

16 b. Benefits for it are payable without regard to fault  
17 under a coverage required to be contained in any motor vehicle  
18 or other liability insurance policy or equivalent self-  
19 insurance. However, this does not authorize exclusion of  
20 charges that exceed the benefits payable under the applicable  
21 workers' compensation or no-fault coverage.

22 4. Care which is primarily for a custodial or domiciliary  
23 purpose.

24 5. Cosmetic surgery unless provided as the result of an  
25 injury or medically necessary surgical procedure.

26 6. Services the provision of which is not within the scope  
27 of the license or certificate of the institution or individual  
28 rendering the services.

29 7. That part of any charge for services or articles  
30 rendered or prescribed by a health care provider which exceeds  
31 the prevailing charge in the locality where the service is  
32 provided, or a charge for services or articles not medically  
33 necessary.

34 8. Services rendered prior to the effective date of  
35 coverage under this plan for the person on whose behalf the

1 expense is incurred.

2 9. Routine physical examinations including examinations to  
3 determine the need for eye glasses and hearing aids.

4 10. Illness or injury due to an act of war.

5 11. Service of a blood donor and any fee for failure to  
6 replace the first three pints of blood provided to an eligible  
7 person each calendar year.

8 12. Personal supplies or services provided by a health  
9 care facility or any other nonmedical or nonprescribed supply  
10 or service.

11 13. Experimental services or supplies. Experimental means  
12 a service or supply not recognized by the appropriate medical  
13 board as normal mode of treatment for the illness or injury  
14 involved.

15 14. Eye surgery if corrective lenses would alleviate the  
16 problem.

17 The coverage and benefit requirements of this section for  
18 association policies shall not be altered by any other state  
19 law without specific reference to this chapter indicating a  
20 legislative intent to add or delete from the coverage  
21 requirements of this chapter.

22 This chapter does not prohibit the association from issuing  
23 additional types of health insurance policies with different  
24 types of benefits which, in the opinion of the board of  
25 directors, may be of benefit to the citizens of the state.

26 Sec. 6. NEW SECTION. 514E.6 POLICIES, DEDUCTIBLE AND  
27 COINSURANCE REQUIREMENTS -- LIMITATIONS -- LIFETIME BENEFIT  
28 LIMIT.

29 1. Except as provided in subsection 3, an association  
30 policy offered in accordance with this chapter shall include a  
31 deductible. Deductibles of five hundred dollars and one  
32 thousand dollars on a per person per calendar year basis shall  
33 be offered. The board may authorize deductibles in other  
34 amounts. The deductibles must be applied to the first five  
35 hundred dollars, one thousand dollars, or other authorized

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1 amount of eligible expenses incurred by the covered person.

2 2. Except as provided in subsection 3, a mandatory  
3 coinsurance requirement shall be imposed at the rate of twenty  
4 percent of eligible expenses in excess of the mandatory  
5 deductible.

6 3. The maximum aggregate out-of-pocket payments for  
7 eligible expenses by the insured in the form of deductibles  
8 and coinsurance shall not exceed in a policy year:

9 a. One thousand five hundred dollars for an individual  
10 five-hundred-dollar deductible policy.

11 b. Two thousand dollars for an individual one-thousand-  
12 dollar deductible policy.

13 c. Three thousand dollars for a family five-hundred-dollar  
14 deductible policy.

15 d. Four thousand dollars for a family one-thousand-dollar  
16 deductible policy.

17 e. An amount authorized by the board for any other de-  
18 ductible policy.

19 4. For a family policy, the maximum annual deductible  
20 under the policy shall be the deductible chosen for a maximum  
21 of two individuals under the policy.

22 5. Eligible expenses incurred by a covered person in the  
23 last three months of a calendar year, and applied toward a  
24 deductible, shall also be applied toward the deductible amount  
25 in the next calendar year.

26 6. The lifetime benefit per covered person is two hundred  
27 fifty thousand dollars.

28 7. The association shall, in addition to other policies,  
29 offer Medicare supplement policies designed to supplement  
30 Medicare and provide coverage of at least fifty percent of the  
31 deductible and eighty percent of the covered expenses in  
32 section 514E.4. Medicare supplement plans are subject to the  
33 same limitations on premiums, deductibility, and annual out-  
34 of-pocket expenses as other association policies.

35 Sec. 7. NEW SECTION. 514E.7 POLICIES -- ELIGIBLE PERSONS

1 -- DEPENDENT COVERAGE -- PREEXISTING CONDITIONS.

2 1. A person is not eligible for an association policy if  
3 the person, at the effective date of coverage, has or will  
4 have coverage under any insurance plan that has coverage  
5 equivalent to an association policy. Only residents of this  
6 state are eligible for an association policy. Coverage under  
7 an association policy is in excess of, and shall not  
8 duplicate, coverage under any other form of health insurance.

9 2. A person is eligible to apply for an association policy  
10 only if that person has been rejected for similar health  
11 insurance coverage or is only offered health insurance  
12 coverage at a rate exceeding the association rate.

13 3. An association policy shall provide that coverage of a  
14 dependent unmarried person terminates when the person becomes  
15 nineteen years of age or, if the person is enrolled full time  
16 in an accredited educational institution, terminates at  
17 twenty-five years of age. The policy shall also provide in  
18 substance that attainment of the limiting age does not operate  
19 to terminate coverage when the person is and continues to be  
20 both of the following:

21 a. Incapable of self-sustaining employment by reason of  
22 mental retardation or physical handicap.

23 b. Primarily dependent for support and maintenance upon  
24 the person in whose name the contract is issued.

25 Proof of incapacity and dependency must be furnished to the  
26 carrier within one hundred twenty days of the person's attain-  
27 ment of the limiting age, and subsequently as may be required  
28 by the carrier, but not more frequently than annually after  
29 the two-year period following the person's attainment of the  
30 limiting age.

31 4. An association policy that provides coverage for a  
32 family member of the person in whose name the contract is  
33 issued shall also provide, as to the family member's coverage,  
34 that the health insurance benefits applicable for children  
35 include the coverage required under section 514C.1.

1 5. An association policy may contain provisions under  
2 which coverage is excluded during a period of six months  
3 following the effective date of coverage as to a given covered  
4 individual for preexisting conditions, as long as either of  
5 the following exist:

6 a. The condition has manifested itself within a period of  
7 six months before the effective date of coverage in such a  
8 manner as would cause an ordinarily prudent person to seek  
9 diagnosis or treatment.

10 b. Medical advice or treatment was recommended or received  
11 within a period of six months before the effective date of  
12 coverage.

13 These preexisting condition exclusions shall be waived to  
14 the extent to which similar exclusions have been satisfied  
15 under any prior health insurance coverage which was  
16 involuntarily terminated, if the application for pool coverage  
17 is made not later than thirty days following the involuntary  
18 termination. In that case, coverage in the pool shall be  
19 effective from the date on which the prior coverage was  
20 terminated.

21 This subsection does not prohibit preexisting conditions  
22 coverage in an association policy that is more favorable to  
23 the insured than that specified in this subsection.

24 6. An individual is not eligible for coverage by the  
25 association if any of the following apply:

26 a. The individual is at the time of application eligible  
27 for health care benefits under chapter 249A.

28 b. The individual has terminated coverage by the  
29 association within the past twelve months.

30 c. The individual is an inmate of a public institution or  
31 is eligible for public programs for which medical care is  
32 provided.

33 Sec. 8. NEW SECTION. 514E.8 POLICIES -- RENEWAL  
34 PROVISIONS -- ELECTION TO CONTINUE COVERAGE UPON DEATH OF  
35 POLICYHOLDER.

1 1. An association policy shall contain provisions under  
2 which the association is obligated to renew the contract until  
3 the day on which the individual in whose name the contract is  
4 issued first becomes eligible for Medicare coverage, except  
5 that in a family policy covering both husband and wife, the  
6 age of the younger spouse shall be used as the basis for  
7 meeting the durational requirements of this subsection.  
8 However, when the individual in whose name the contract is  
9 issued becomes eligible for Medicare coverage, the person  
10 shall be eligible for the Medicare supplement plan offered by  
11 the association.

12 2. The association shall not change the rates for  
13 association policies except on a class basis with a clear  
14 disclosure in the policy of the association's right to do so.

15 3. An association policy shall provide that upon the death  
16 of the individual in whose name the policy is issued, every  
17 other individual then covered under the contract may elect,  
18 within a period specified in the policy, to continue coverage  
19 under the same or a different policy until such time as the  
20 person would have ceased to be entitled to coverage had the  
21 individual in whose name the policy was issued lived.

22 Sec. 9. NEW SECTION. 514E.9 RULES.

23 Pursuant to chapter 17A, the commissioner shall adopt rules  
24 to provide for disclosure by carriers of the availability of  
25 insurance coverage from the association, and to otherwise  
26 implement this chapter.

27 Sec. 10. NEW SECTION. 514E.10 COLLECTIVE ACTION.

28 Neither the participation by carriers or members in the  
29 association, the establishment of rates, forms, or procedures  
30 for coverage issued by the association, nor any joint or  
31 collective action required by this chapter shall be the basis  
32 of any legal civil action, or criminal liability against the  
33 association or members of it either jointly or separately.

34 Sec. 11. NEW SECTION. 514E.11 NOTICE OF ASSOCIATION  
35 POLICY.

1 Commencing July 1, 1986, every carrier, including a health  
2 maintenance organization subject to chapter 514B, authorized  
3 to provide health care insurance or coverage for health care  
4 services in Iowa, shall provide a notice and an application  
5 for coverage by the association to any person who receives a  
6 rejection of coverage for health insurance or health care  
7 services, or a notice to any person who is informed that a  
8 rate for health insurance or coverage for health care services  
9 will exceed the rate of an association policy, that effective  
10 January 1, 1987, that person is eligible to apply for health  
11 insurance provided by the association. Application for the  
12 health insurance shall be on forms prescribed by the board and  
13 made available to the carriers.

14 Sec. 12. 1985 Iowa Acts, chapter 239, section 8, is  
15 amended to read as follows:

16 SEC. 8. For each fiscal year beginning July 1, 1985,  
17 except for the amount appropriated in section 7 of this Act,  
18 the entire increase, as determined by the commissioner of  
19 insurance and certified to the comptroller of state, or taxes  
20 paid under chapter 432 on premiums and payments on individual  
21 and group accident and health insurance policies and  
22 certificates and individual and group subscriber contracts  
23 under chapter 514 shall be set aside in a separate account  
24 within the general fund and reserved solely for the purposes  
25 of implementing the programs to be studied as provided in  
26 section 9 of this Act. The balance of the account shall be  
27 considered part of the balance of the general fund of the  
28 state except for purposes of determining the annual inflation  
29 factor under section 422.4, subsection 17. The funds within  
30 the account shall not be expended except as otherwise provided  
31 by the general assembly. Interest accruing on the funds  
32 within the account shall remain in the account unless other-  
33 wise provided by the general assembly.

34 Sec. 13. Health insurance coverage provided under this Act  
35 shall not be effective until January 1 following the effective

1 date of this Act.

2

EXPLANATION

3 This bill establishes the Iowa comprehensive health  
4 association, the purpose of which is to provide accident and  
5 health insurance for persons who might otherwise not be  
6 eligible for the coverage or who cannot obtain it at a  
7 reasonable cost. The association shall offer a Medicare  
8 supplement plan. Carriers who write accident and health  
9 insurance in Iowa and who are subject to the insurance premium  
10 tax are required to be members of the association. Self-  
11 insurers would not be members of the association. When  
12 premiums and payments from the health insurance trust fund  
13 created by this Act are insufficient to provide financing for  
14 the association, members of the association must be assessed  
15 amounts sufficient to finance the association and coverages  
16 provided by it. Credit against certain premium taxes is  
17 provided to offset the assessment. The coverage limitations  
18 are specified as well as the duties of the commissioner of  
19 insurance and the association. The bill also provides that  
20 interest accruing on the moneys collected pursuant to 1985  
21 Iowa Acts, chapter 239, section 8, shall remain a part of the  
22 fund created in that Act. A portion of those funds are used  
23 in the health insurance trust fund created by this Act. The  
24 balance of funds in the health insurance trust fund shall not  
25 exceed ten million dollars.

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SENATE/HOUSE FILE \_\_\_\_\_  
BY (PROPOSED COMMITTEE ON  
COMMERCE BILL BY INSURANCE  
GUARANTY FUND AND RISK-  
SHARING STUDY COMMITTEE)

Passed Senate, Date \_\_\_\_\_ Passed House, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

**A BILL FOR**

1 An Act relating to insurance guaranty associations by creating an  
2 Iowa life and health insurance guaranty association.  
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

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1 Section 1. NEW SECTION. 508C.1 TITLE.

2 This chapter shall be cited as the "Iowa Life and Health  
3 Insurance Guaranty Association Act".

4 Sec. 2. NEW SECTION. 508C.2 PURPOSE.

5 1. The purpose of this chapter is to protect, subject to  
6 certain limitations, the persons specified in section 508C.3,  
7 subsection 1, against failure in the performance of  
8 contractual obligations under life and health insurance  
9 policies and annuity contracts specified in section 508C.3,  
10 subsection 2, because of the impairment or insolvency of the  
11 member insurer that issued the policies or contracts.

12 2. To provide this protection, an association of insurers  
13 is created to enable the guaranty of payments of benefits and  
14 of continuation of coverages as limited in this chapter.  
15 Members of the association are subject to assessment to  
16 provide funds to carry out the purpose of this chapter.

17 Sec. 3. NEW SECTION. 508C.3 SCOPE.

18 1. This chapter shall provide coverage under the policies  
19 and contracts specified in subsection 2 to all of the  
20 following:

21 a. Except for nonresident certificate holders under group  
22 policies or contracts, persons who are the beneficiaries,  
23 assignees or payees of the persons covered under paragraph  
24 "b".

25 b. Persons who are owners of the policies or contracts  
26 specified in subsection 2, or are insureds or annuitants under  
27 the policies or contracts, and who are either of the  
28 following:

29 (1) Residents of this state.

30 (2) Nonresidents of this state if all of the following  
31 conditions are met:

32 (a) The state in which the person resides has an  
33 association similar to the association created in this  
34 chapter.

35 (b) The person is not eligible for coverage by an

1 association described in subparagraph part (a).

2 (c) The insurer which issued the policy or contract never  
3 held a license or certificate of authority in the state in  
4 which the person resides.

5 (d) The insurer is domiciled in this state.

6 2. This chapter shall provide coverage to the persons  
7 specified in subsection 1 under direct life insurance  
8 policies, health insurance policies, annuity contracts,  
9 supplemental contracts, and certificates under group policies  
10 or contracts issued by member insurers.

11 3. This chapter does not apply to:

12 a. Any portion of a life, health or annuity benefit  
13 payment liability arising on or after the date of insolvency  
14 to the extent that it is based upon a rate of interest which  
15 exceeds the lesser of the following:

16 (1) The minimum rate of interest guaranteed under the  
17 policy or contract.

18 (2) The rate of interest calculated as prescribed in the  
19 standard valuation law of this state for determining the  
20 minimum standard for the valuation of life insurance policies  
21 issued during the year of insolvency which have an interest-  
22 guaranteed duration of ten or fewer years.

23 b. That portion or part of a policy or contract under  
24 which the risk is borne by the policyholder.

25 c. A policy or contract or part of a policy or contract  
26 assumed by the impaired or insolvent insurer under a contract  
27 of reinsurance, other than reinsurance for which assumption  
28 certificates have been issued.

29 d. With respect to annuities, a benefit payment liability  
30 under a policy or contract which is not subject to standard  
31 nonforfeiture law, not annuitized, and does not provide  
32 annuity purchase rates contractually guaranteed for ten or  
33 more years.

34 e. A policy or contract issued by a company which is  
35 licensed under chapters 509A, 510, 512, 512A, 514, 514B, 518,

1 518A, or 520.

2 f. Except for a policy issued pursuant to section 515.48,  
3 subsection 5, paragraph "a", a policy or contract issued by a  
4 company which is licensed under chapter 515.

5 g. An insurer which was placed under an order of  
6 liquidation, rehabilitation, or conservation by a court prior  
7 to the effective date of this Act is not an impaired insurer  
8 or an insolvent insurer for the purposes of this chapter.

9 Sec. 4. NEW SECTION. 508C.4 CONSTRUCTION.

10 This chapter shall be liberally construed to effect its  
11 purpose as provided under section 508C.2.

12 Sec. 5. NEW SECTION. 508C.5 DEFINITIONS.

13 As used in this chapter unless the context otherwise  
14 requires:

15 1. "Account" means any of the three accounts created under  
16 section 508C.6.

17 2. "Association" means the Iowa life and health insurance  
18 guaranty association created in section 508C.6.

19 3. "Commissioner" means the commissioner of insurance.

20 4. "Contractual obligation" means an obligation under a  
21 covered policy.

22 5. "Covered policy" means a policy or contract within the  
23 scope of this chapter as provided under section 508C.3.

24 6. "Impaired insurer" means a member insurer domiciled in  
25 this state which, after the effective date of this Act, is  
26 either of the following:

27 a. Deemed by the commissioner to be potentially unable to  
28 fulfill its contractual obligations but is not an insolvent  
29 insurer.

30 b. Placed under an order of rehabilitation or conservation  
31 by a court of competent jurisdiction.

32 7. "Insolvent insurer" means a member insurer which after  
33 the effective date of this Act becomes insolvent and is placed  
34 under a final order of liquidation, rehabilitation or  
35 conservation by a court of competent jurisdiction.

1 8. "Member insurer" means a person licensed or who holds a  
2 certificate of authority to transact in this state any kind of  
3 insurance to which this chapter applies under section 508C.3,  
4 including a person whose license or certificate of authority  
5 has been suspended, revoked, not renewed, or voluntarily  
6 withdrawn.

7 9. "Person" means an individual, corporation, partnership,  
8 association or voluntary organization.

9 10. "Premiums" means direct gross insurance premiums and  
10 annuity considerations received on covered policies, less  
11 return insurance premiums and annuity considerations and  
12 dividends paid or credited to policyholders on the direct  
13 business. "Premiums" do not include premiums and  
14 considerations on contracts between insurers and reinsurers,  
15 or amounts received and held by a member insurer in an account  
16 or fund unless and until the amounts are applied by the member  
17 insurer to the purchase of an annuity or other benefit for a  
18 specific person.

19 11. "Resident" means a person who resides in this state,  
20 or if a corporation has its principal place of business in  
21 this state, at the time a member insurer is determined to be  
22 an impaired or insolvent insurer, and to whom contractual  
23 obligations are owed.

24 12. "Supplemental contract" means an agreement entered  
25 into for the distribution of policy or contract proceeds.

26 **Sec. 6. NEW SECTION. 508C.6 CREATION OF THE ASSOCIATION.**

27 1. A nonprofit legal entity is created to be known as the  
28 Iowa life and health insurance guaranty association. All  
29 member insurers shall be and shall remain members of the  
30 association as a condition of their authority to transact  
31 insurance business in this state. The association shall  
32 perform its functions under the plan of operation established  
33 and approved under section 508C.10 and shall exercise its  
34 powers through the board of directors established in section  
35 508C.7. For purposes of administration and assessment, the

1 association shall maintain all of the following accounts:

2 a. A health insurance account.

3 b. A life insurance account.

4 c. An annuity account.

5 2. The association is subject to the immediate supervision  
6 of the commissioner and the applicable provisions of the  
7 insurance laws of this state.

8 Sec. 7. NEW SECTION. 508C.7 BOARD OF DIRECTORS.

9 1. The board of directors of the association shall consist  
10 of not less than five nor more than nine member insurers  
11 serving terms as established in the plan of operation. The  
12 members of the board shall be selected by member insurers,  
13 subject to the approval of the commissioner. Vacancies on the  
14 board shall be filled for the remaining period of the term by  
15 a majority vote of the remaining board members, subject to the  
16 approval of the commissioner. To select the initial board of  
17 directors, and initially organize the association, the  
18 commissioner shall give notice to all member insurers of the  
19 time and place of the organizational meeting. In determining  
20 voting rights at the organizational meeting each member  
21 insurer is entitled to one vote in person or by proxy. If the  
22 board of directors is not selected within sixty days after  
23 notice of the organizational meeting, the commissioner may  
24 appoint the initial members.

25 2. In approving selections or in appointing members to the  
26 board, the commissioner shall consider, among other factors,  
27 whether all member insurers are fairly represented.

28 3. At the option of the association, members of the board  
29 may be reimbursed from the assets of the association for  
30 expenses incurred by them as members of the board of  
31 directors. However, members of the board shall not otherwise  
32 be compensated by the association for their services.

33 Sec. 8. NEW SECTION. 508C.8 POWERS AND DUTIES OF THE  
34 ASSOCIATION.

35 1. If a domestic insurer is an impaired insurer, the

1 association, subject to conditions imposed by the association  
2 and approved by the impaired insurer and the commissioner,  
3 may:

4 a. Guarantee, assume, reinsure, or cause to be guaranteed,  
5 assumed, or reinsured, any or all of the covered policies of  
6 the impaired insurer.

7 b. Provide moneys, pledges, notes, guarantees, or other  
8 means as proper to effectuate paragraph "a" and assure payment  
9 of the contractual obligations of the impaired insurer pending  
10 action under paragraph "a".

11 c. Loan money to the impaired insurer and guarantee  
12 borrowings by the impaired insurer, provided the association  
13 has concluded, based on reasonable assumptions, that there is  
14 a likelihood of repayment of the loan and a probability that  
15 unless a loan is made the association would incur substantial  
16 liabilities under subsection 2.

17 2. If a domestic, foreign, or alien insurer is an  
18 insolvent insurer, subject to the approval of the commissioner  
19 the association shall:

20 a. Guarantee, assume, or reinsure, or cause to be  
21 guaranteed, assumed, or reinsured the covered policies of the  
22 insolvent insurer.

23 b. Assure payment of the contractual obligations of the  
24 insolvent insurer.

25 c. Provide moneys, pledges, notes, guarantees, or other  
26 means as reasonably necessary to discharge the duties  
27 described in this subsection.

28 3. a. In carrying out its duties under subsection 2,  
29 permanent policy liens or contract liens may be imposed in  
30 connection with a guarantee, assumption or reinsurance  
31 agreement, if the court does both of the following:

32 (1) Finds either that the amounts which can be assessed  
33 under this chapter are less than the amounts needed to assure  
34 full and prompt performance of the insolvent insurer's  
35 contractual obligations, or that the economic or financial

1 conditions as they affect member insurers are sufficiently  
2 adverse to the public interest to justify the imposition of  
3 policy or contract liens.

4 (2) Approves the specific policy liens or contract liens  
5 to be used.

6 b. Before being obligated under subsection 2, the  
7 association may request the imposition of a temporary  
8 moratorium, not exceeding three years, or liens on payments of  
9 cash values, termination values and policy loans in addition  
10 to any contractual provisions for deferral of cash values,  
11 termination values or policy loans. The temporary moratoriums  
12 and liens may be imposed by the court as a condition of the  
13 association's liability with respect to the insolvent insurer.

14 c. The obligations of the association under subsection 2  
15 regarding a covered policy shall be reduced to the extent that  
16 the person entitled to the obligations has received payment of  
17 all or any part of the contractual benefits payable under the  
18 covered policy from any other source.

19 d. The association may offer modifications to the owners  
20 of policies or contracts or classes of policies or contracts  
21 issued by the insolvent insurer, if the association finds that  
22 under the policies or contracts the benefits provided,  
23 provisions pertaining to renewal, or the premiums charged or  
24 which may be charged are not reasonable. If the owner of a  
25 policy or contract to be modified fails or refuses to accept  
26 the modification as approved by the court, the association may  
27 terminate the policy or contract as of a date not less than  
28 one hundred eighty days after the modification is sent to the  
29 owner. The association shall have no liability under the  
30 policy or contract for any claim incurred or continuing beyond  
31 the termination date.

32 4. If the association fails to act within a reasonable  
33 period of time as provided in subsection 2, the commissioner  
34 shall have the powers and duties of the association under this  
35 chapter with respect to insolvent insurers.

1 5. Upon request the association may give assistance and  
2 advice to the commissioner concerning the rehabilitation,  
3 payment of claims, continuance of coverage, or the performance  
4 of other contractual obligations of an impaired or insolvent  
5 insurer.

6 6. The association has standing to appear before any court  
7 in this state with jurisdiction over an impaired or insolvent  
8 insurer concerning which the association is or may become  
9 obligated under this chapter. Standing shall extend to all  
10 matters germane to the powers and duties of the association  
11 including, but not limited to, proposals for reinsuring or  
12 guaranteeing the covered policies of the impaired or insolvent  
13 insurer and the determination of the covered policies and  
14 contractual obligations.

15 7. a. A person receiving benefits under this chapter is  
16 deemed to have assigned the rights under the covered policy to  
17 the association to the extent of the benefits received under  
18 this chapter whether the benefits are payments of contractual  
19 obligations or a continuation of coverage. The association  
20 may require an assignment to it of the rights by a payee,  
21 policyholder or contract owner, beneficiary, insured or  
22 annuitant as a condition precedent to the receipt of any  
23 rights or benefits conferred by this chapter upon the person.  
24 The association shall be subrogated to these rights against  
25 the assets of the insolvent insurer.

26 b. The subrogation rights of the association under this  
27 subsection have the same priority against the assets of the  
28 insolvent insurer as that possessed by the person entitled to  
29 receive benefits under this chapter.

30 c. In addition to the rights pursuant to subsection 3,  
31 paragraphs "a" and "b", the association shall have all common  
32 law rights of subrogation and any other equitable or legal  
33 remedy which would have been available to the insolvent  
34 insurer or holder of a policy or contract.

35 8. The contractual obligations of the insolvent insurer

1 for which the association becomes or may become liable are as  
2 great as but not greater than the contractual obligations of  
3 the insolvent insurer would have been in the absence of an  
4 insolvency, unless the obligations are reduced as permitted in  
5 this chapter. However, with respect to any one life, the  
6 aggregate liability of the association shall not exceed one  
7 hundred thousand dollars in cash and termination values, or  
8 three hundred thousand dollars for all benefits, including  
9 cash and termination values, death benefits, annuity payments,  
10 accident and health benefits and all other amounts payable  
11 under all policies or contracts of the insolvent insurer.

12 9. The association has no obligation for either of the  
13 following:

14 a. To continue coverage, or to pay a claim for benefits to  
15 any person under an individual accident, health or disability  
16 policy accruing more than three years following the date the  
17 member insurer is adjudicated to be insolvent.

18 b. To issue a group conversion policy of any nature to a  
19 person or to continue a group coverage in force for more than  
20 sixty days following the date the member insurer was  
21 adjudicated to be insolvent.

22 10. The association may do any of the following:

23 a. Enter into contracts as necessary or proper to carry  
24 out this chapter.

25 b. Sue or be sued, including taking any legal actions  
26 necessary or proper for recovery of any unpaid assessments  
27 under section 508C.9.

28 c. Borrow money to effect the purposes of this chapter.  
29 Any notes or other evidence of indebtedness of the association  
30 held by domestic insurers and not in default qualify as  
31 investments eligible for deposit under section 511.8,  
32 subsection 16.

33 d. Employ or retain persons as necessary to handle the  
34 financial transactions of the association, and to perform  
35 other functions as necessary or proper under this chapter.

1 e. Negotiate and contract with a liquidator,  
2 rehabilitator, conservator, or ancillary receiver to carry out  
3 the powers and duties of the association.

4 f. Take legal action as necessary to avoid payment of  
5 improper claims.

6 g. For the purposes of this chapter and to the extent  
7 approved by the commissioner, exercise the powers of a  
8 domestic life or health insurer. However, the association  
9 shall not issue insurance policies or annuity contracts other  
10 than those issued to perform the contractual obligations of  
11 the impaired or insolvent insurer.

12 h. Join an organization of one or more other state  
13 associations of similar purposes to further the purposes and  
14 administer the powers and duties of the association.

15 Sec. 9. NEW SECTION. 508C.9 ASSESSMENTS.

16 1. For the purpose of providing the funds necessary to  
17 carry out the powers and duties of the association, the board  
18 of directors shall assess the member insurers, separately for  
19 each account established pursuant to section 508C.6, at the  
20 time and for the amounts the board finds necessary. An  
21 assessment is due not less than thirty days after prior  
22 written notice has been sent to the member insurers and  
23 accrues interest at ten percent per annum commencing on the  
24 due date.

25 2. There are two classes of assessments as follows:

26 a. Class A assessments shall be made for the purpose of  
27 meeting administrative costs and other general expenses and  
28 examinations conducted under section 508C.12, subsection 5,  
29 not related to a particular impaired or insolvent insurer.

30 b. Class B assessments shall be made to the extent  
31 necessary to carry out the powers and duties of the  
32 association under section 508C.8 with regard to an impaired  
33 domestic insurer or an insolvent domestic, foreign, or alien  
34 insurer.

35 3. a. The amount of a class A assessment shall be

1 determined by the board and to the extent that class A  
2 assessments do not exceed one hundred dollars per company in  
3 any one calendar year may be made on a per capita basis. The  
4 assessment shall be credited against future insolvency  
5 assessments. The amount of a class B assessment shall be  
6 allocated for assessment purposes among the accounts as the  
7 liabilities and expenses of the association, either  
8 experienced or reasonably expected, are attributable to those  
9 accounts, all as determined by the association and on as  
10 equitable a basis as is reasonably practical.

11 b. Class A assessments in excess of one hundred dollars  
12 per company per calendar year and class B assessments against  
13 member insurers for each account shall be in the proportion  
14 that the aggregate premiums received on business in this state  
15 by each assessed member insurer on policies or contracts  
16 related to that account for the three calendar years preceding  
17 the year of impairment or insolvency, bear to the aggregate  
18 premiums received on business in this state by all assessed  
19 member insurers on policies related to that account for the  
20 three calendar years preceding the assessment.

21 c. Assessments for funds to meet the requirements of the  
22 association with respect to an impaired or insolvent insurer  
23 shall not be made until necessary to implement the purposes of  
24 this chapter. Classification of assessments under this  
25 subsection shall be made with a reasonable degree of accuracy,  
26 recognizing that exact determinations may not always be  
27 possible.

28 4. The association may abate or defer, in whole or in  
29 part, the assessment of a member insurer if in the opinion of  
30 the board payment of the assessment would endanger the ability  
31 of the member insurer to fulfill its contractual obligations.  
32 If an assessment against a member insurer is abated or  
33 deferred, in whole or in part, the amount by which the  
34 assessment is abated or deferred may be assessed against the  
35 other member insurers in a manner consistent with the basis

1 for assessments set forth in this section.

2 5. The total of all assessments upon a member insurer for  
3 each account shall not in any one calendar year exceed two  
4 percent of the insurer's premiums received in this state  
5 during the calendar year preceding the assessment on the  
6 policies related to that account. If the maximum assessment,  
7 together with the other assets of the association in either  
8 account, does not provide in any one year in either account an  
9 amount sufficient to carry out the responsibilities of the  
10 association, the necessary additional funds shall be assessed  
11 as soon as permitted by this chapter.

12 6. By an equitable method as established in the plan of  
13 operation, the board may refund to member insurers, in  
14 proportion to the contribution of each insurer to that  
15 account, the amount by which the assets of the account,  
16 including assets accruing from net realized gains and income  
17 from investments, exceed the amount the board finds is  
18 necessary to carry out during the coming year the obligations  
19 of the association with regard to that account. A reasonable  
20 amount may be retained in any account to provide funds for the  
21 continuing expenses of the association and for future losses  
22 if refunds are impractical.

23

24 7. In determining its premium rates and policyowner  
25 dividends - as  
26 to any kind of insurance within the scope of this chapter, it  
27 is proper for a member insurer to consider the amount  
28 reasonably necessary to meet its assessment obligations under  
29 this chapter.

30 8. The association shall issue to each insurer paying a  
31 class B assessment under this chapter, a certificate of  
32 contribution in a form prescribed by the commissioner for the  
33 amount of the assessment so paid. All outstanding  
34 certificates shall be of equal dignity and priority without  
35 reference to amounts or dates of issue. A certificate of

1 contribution may be shown by the insurer in its financial  
2 statement as an asset in the form, for the amount and for a  
3 period of time as the commissioner may approve.

4 Sec. 10. NEW SECTION. 508C.10 PLAN OF OPERATION.

5 1. a. The association shall submit to the commissioner a  
6 plan of operation and any amendments to the plan of operation  
7 necessary or suitable to assure the fair, reasonable, and  
8 equitable administration of the association. The plan of  
9 operation and any amendments to the plan are effective upon  
10 the commissioner's written approval.

11 b. If the association fails to submit a suitable plan of  
12 operation within one hundred eighty days following the  
13 effective date of this Act or if at any time the association  
14 fails to submit suitable amendments to the plan, the  
15 commissioner shall, after notice and hearing, adopt rules  
16 pursuant to chapter 17A as necessary or advisable to  
17 effectuate this chapter. The rules shall continue in force  
18 until modified by the commissioner or superseded by a plan  
19 submitted by the association and approved by the commissioner.

20 2. All member insurers shall comply with the plan of  
21 operation.

22 3. In addition to other requirements established in this  
23 chapter the plan of operation shall establish all of the fol-  
24 lowing:

25 a. Procedures for handling the assets of the association.

26 b. The amount and method of reimbursing members of the  
27 board of directors under section 508C.7.

28 c. Regular places and times for meetings of the board of  
29 directors.

30 d. Procedures for records to be kept of all financial  
31 transactions of the association, its agents, and the board of  
32 directors.

33 e. Procedures for selecting the board of directors and  
34 submitting the selections to the commissioner.

35 f. Any additional procedures for assessments under section

1 508C.9.

2 g. Additional provisions necessary or proper for the ex-  
3 ecution of the powers and duties of the association.

4 4. The plan of operation may provide that any powers and  
5 duties of the association, except those under section 508C.8,  
6 subsection 10, paragraph "c" and section 508C.9 are delegated  
7 to a corporation, association, or other organization which  
8 performs or will perform functions similar to those of this  
9 association, or its equivalent, in two or more states. Such a  
10 corporation, association, or organization shall be reimbursed  
11 for any payments made on behalf of the association and shall  
12 be paid for its performance of any function of the  
13 association. A delegation under this subsection shall take  
14 effect only with the approval of both the board of directors  
15 and the commissioner. The delegation shall be made only to a  
16 corporation, association, or organization which extends  
17 protection at least as favorable and effective as that  
18 provided by this chapter.

19 Sec. 11. NEW SECTION. 508C.11 DUTIES AND POWERS OF THE  
20 COMMISSIONER.

21 1. The commissioner shall:

22 a. Upon request of the board of directors, provide the  
23 association with a statement of the premiums for each member  
24 insurer.

25 b. When an impairment is declared and the amount of the  
26 impairment is determined, serve a demand upon the impaired  
27 insurer to make good the impairment within a reasonable time.  
28 Notice to the impaired insurer constitutes notice to its  
29 shareholders, if any. The failure of the insurer to promptly  
30 comply with the demand shall not excuse the association from  
31 the performance of its powers and duties under this chapter.

32 c. In a liquidation or rehabilitation proceeding involving  
33 a domestic insurer, be appointed as the liquidator or  
34 rehabilitator. If a foreign or alien member insurer is  
35 subject to a liquidation proceeding in its domiciliary

1 jurisdiction or state of entry, the commissioner shall be  
2 appointed conservator.

3 2. After notice and hearing, the commissioner may suspend  
4 or revoke the certificate of authority to transact insurance  
5 in this state of a member insurer which fails to pay an  
6 assessment when due or fails to comply with the plan of  
7 operation. As an alternative, the commissioner may levy an  
8 administrative penalty on any member insurer which fails to  
9 pay an assessment when due. The administrative penalty shall  
10 not exceed five percent of the unpaid assessment per month.  
11 However, an administrative penalty shall not be less than one  
12 hundred dollars per month.

13 3. An action of the board of directors or the association  
14 may be appealed to the commissioner by a member insurer if the  
15 appeal is taken within thirty days of the action being  
16 appealed. A final action or order of the commissioner is  
17 subject to judicial review pursuant to chapter 17A in a court  
18 of competent jurisdiction.

19 4. The liquidator, rehabilitator, or conservator of an  
20 impaired insurer may notify all interested persons of the  
21 effect of this chapter.

22 Sec. 12. NEW SECTION. 508C.12 PREVENTION OF  
23 INSOLVENCIES.

24 1. To aid in the detection and prevention of insurer  
25 insolvencies or impairments the commissioner shall:

26 a. Notify the commissioners or insurance departments of  
27 other states or territories of the United States and the  
28 District of Columbia when any of the following actions against  
29 a member insurer is taken:

30 (1) A license is revoked.

31 (2) A license is suspended.

32 (3) A formal order is made that a company restrict its  
33 premium writing, obtain additional contributions to surplus,  
34 withdraw from the state, reinsure all or any part of its  
35 business, or increase capital, surplus, or any other account

1 for the security of policyholders or creditors.

2 Notice shall be mailed to the commissioners or departments  
3 within thirty days following the earlier of when the action  
4 was taken or the date on which the action occurs. This  
5 subparagraph does not supersede section 507C.9, subsection 5.

6 b. Report to the board of directors when the commissioner  
7 has taken any of the actions set forth in paragraph "a" or has  
8 received a report from any other commissioner indicating that  
9 any such action has been taken in another state. Reports to  
10 the board of directors shall contain all significant details  
11 of the action taken or the report received from another  
12 commissioner.

13 c. Report to the board of directors when there is reason-  
14 able cause to believe from an examination, whether completed  
15 or in process, of a member company that the company may be an  
16 impaired or insolvent insurer.

17 d. Furnish to the board of directors the national asso-  
18 ciation of insurance commissioners' early warning tests. The  
19 board may use the information in carrying out its duties and  
20 responsibilities under this section. The report and the  
21 information contained in the report shall be kept confidential  
22 by the board of directors until such time as it is made public  
23 by the commissioner or other lawful authority.

24 2. The commissioner may seek the advice and recommenda-  
25 tions of the board of directors concerning any matter  
26 affecting the commissioner's duties and responsibilities  
27 regarding the financial condition of member companies and  
28 companies seeking admission to transact insurance business in  
29 this state.

30 3. The board of directors may upon majority vote make  
31 reports and recommendations to the commissioner upon any mat-  
32 ter germane to the solvency, liquidation, rehabilitation or  
33 conservation of a member insurer or germane to the solvency of  
34 a company seeking to transact insurance business in this  
35 state. These reports and recommendations are not public

1 records pursuant to chapter 22.

2 4. Upon majority vote, the board of directors shall notify  
3 the commissioner of any information indicating that a member  
4 insurer may be an impaired or insolvent insurer.

5 5. Upon majority vote, the board of directors may request  
6 that the commissioner order an examination of a member insurer  
7 which the board in good faith believes may be an impaired or  
8 insolvent insurer. The examination may be conducted as a na-  
9 tional association of insurance commissioners examination or  
10 may be conducted by persons designated by the commissioner.  
11 The cost of the examination shall be paid by the association  
12 and the examination report shall be treated as are other  
13 examination reports. The examination report shall not be  
14 released to the board of directors prior to its release to the  
15 public, but this shall not preclude the commissioner from  
16 complying with subsection 1. The commissioner shall notify  
17 the board of directors when the examination is completed. The  
18 request for an examination shall be kept on file by the  
19 commissioner but it is not a public record pursuant to chapter  
20 22 until the release of the examination report to the public.

21 6. Upon majority vote, the board of directors may make  
22 recommendations to the commissioner for the detection and pre-  
23 vention of insurer insolvencies.

24 7. At the conclusion of an insurer insolvency in which the  
25 association was obligated to pay covered claims, the board of  
26 directors shall prepare a report to the commissioner contain-  
27 ing information as the board may have in its possession  
28 bearing on the history and causes of the insolvency. The  
29 board shall cooperate with the boards of directors of guaranty  
30 associations in other states in preparing a report on the  
31 history and causes of insolvency of a particular insurer, and  
32 may adopt by reference any report prepared by other  
33 associations.

34 Sec. 13. NEW SECTION. 508C.13 MISCELLANEOUS PROVISIONS.

35 1. This chapter does not reduce the liability for unpaid

1 assessments of the insureds on an impaired or insolvent  
2 insurer operating under a plan with assessment liability other  
3 than the plan of this chapter.

4 2. Records shall be kept of all negotiations and meetings  
5 in which the association or its representatives are involved  
6 to discuss the activities of the association in carrying out  
7 its powers and duties under section 508C.8. Records of the  
8 negotiations or meetings shall be made public pursuant to  
9 chapter 22 only upon the termination of a liquidation,  
10 rehabilitation, or conservation proceeding involving the  
11 impaired or insolvent insurer, upon the termination of the  
12 impairment or insolvency of the insurer, or upon the order of  
13 a court of competent jurisdiction. This subsection does not  
14 limit the duty of the association to render a report of its  
15 activities under section 508C.15.

16 3. For the purpose of carrying out its obligations under  
17 this chapter, the association shall be deemed to be a creditor  
18 of the impaired or insolvent insurer to the extent of assets  
19 attributable to covered policies reduced by any amounts to  
20 which the association is entitled pursuant to its subrogation  
21 rights under section 508C.8, subsection 7. Assets of the  
22 impaired or insolvent insurer attributable to covered policies  
23 shall be used to continue all covered policies and pay all  
24 contractual obligations of the impaired or insolvent insurer  
25 as required by this chapter. As used in this subsection,  
26 "assets attributable to covered policies" means that  
27 proportion of the assets which the reserves that should have  
28 been established for the policies bear to the reserves that  
29 should have been established for all policies of insurance  
30 written by the impaired or insolvent insurer.

31 4. a. Prior to the termination of a liquidation,  
32 rehabilitation, or conservation proceeding, the court may take  
33 into consideration the contributions of the respective  
34 parties, including the association, similar associations of  
35 other states, the shareholders and policyowners of the

1 insolvent insurer, and any other party with a bona fide  
2 interest, in making an equitable distribution of the ownership  
3 rights of the insolvent insurer. When considering the  
4 contributions, consideration shall be given to the welfare of  
5 the policyholders of the continuing or successor insurer.

6 b. A distribution to stockholders, if any, of an impaired  
7 or insolvent insurer shall not be made until the total amount  
8 of valid claims of the association and of similar associations  
9 of other states for funds expended in carrying out its powers  
10 and duties under section 508C.8 with respect to the insurer  
11 have been fully recovered by the association and the similar  
12 associations.

13 5. a. Subject to the limitations of paragraphs "b," "c,"  
14 and "d," if an order for liquidation or rehabilitation of an  
15 insurer domiciled in this state has been entered, the receiver  
16 appointed under the order may recover, on behalf of the  
17 insurer, from any affiliate that controlled it, the amount of  
18 distributions other than stock dividends paid by the insurer  
19 on its capital stock made at any time during the five years  
20 preceding the petition for liquidation or rehabilitation.

21 b. Stock dividends are not recoverable if the insurer  
22 shows that when paid the distribution was lawful and  
23 reasonable and that the insurer did not know and could not  
24 reasonably have known that the distribution might adversely  
25 affect the ability of the insurer to fulfill its contractual  
26 obligations.

27 c. A person who was an affiliate that controlled the  
28 insurer at the time the distributions were paid is liable up  
29 to the amount of distributions received. A person who was an  
30 affiliate that controlled the insurer at the time the  
31 distributions were declared is liable up to the amount of  
32 distributions that would have been received if they had been  
33 paid immediately. If two persons are liable with respect to  
34 the same distributions, they are jointly and severally liable.

35 d. The maximum amount recoverable under this subsection is

1 the amount needed in excess of all other available assets of  
2 the insolvent insurer to pay the contractual obligations of  
3 the insolvent insurer.

4 e. If a person liable under paragraph "c" is insolvent,  
5 all its affiliates that controlled it at the time the dividend  
6 was paid are jointly and severally liable for a resulting  
7 deficiency in the amount recovered from the insolvent  
8 affiliate.

9 Sec. 14. NEW SECTION. 508C.14 EXAMINATION OF THE  
10 ASSOCIATION -- ANNUAL REPORT.

11 The association is subject to examination and regulation by  
12 the commissioner. The board of directors shall submit to the  
13 commissioner by May 1 of each year, a financial report for the  
14 preceding calendar year and a report of its activities during  
15 the preceding calendar year. The financial report shall be in  
16 a form approved by the commissioner.

17 Sec. 15. NEW SECTION. 508C.15 TAX EXEMPTIONS.

18 The association is exempt from payment of all fees and all  
19 taxes levied by this state or any of its subdivisions except  
20 taxes levied on the association's real property.

21 Sec. 16. NEW SECTION. 508C.16 IMMUNITY.

22 A member insurer and its agents and employees, the  
23 association and its agents and employees, members of the board  
24 of directors, and the commissioner and the commissioner's  
25 representatives are not liable for any action taken by them or  
26 omission by them while acting within the scope of their  
27 employment and in the performance of their powers and duties  
28 under this chapter.

29 Sec. 17. NEW SECTION. 508C.17 STAY OF PROCEEDINGS --  
30 REOPENING DEFAULT JUDGMENTS.

31 Proceedings in which the insolvent insurer is a party in a  
32 court in this state shall be stayed sixty days from the date  
33 an order of liquidation, rehabilitation, or conservation is  
34 final to permit proper legal action by the association on  
35 matters germane to its powers or duties. The association may

1 apply to have a judgment under a decision, order, verdict, or  
2 finding based on default, set aside by the same court that  
3 entered the judgment, and shall be permitted to defend against  
4 the suit on the merits.

5 Sec. 18. NEW SECTION. 508C.18 PROHIBITED ADVERTISEMENTS.

6 A person, including an insurer, agent or affiliate of an  
7 insurer shall not make, publish, disseminate, circulate, or  
8 place before the public, or cause directly or indirectly, to  
9 be made, published, disseminated, circulated or placed before  
10 the public in a newspaper, magazine or other publication, or  
11 in the form of a notice, circular, pamphlet, letter or poster,  
12 or over a radio station or television station, or in any other  
13 way, an advertisement, announcement or statement which uses  
14 the existence of the insurance guaranty association of this  
15 state for the purpose of sales, solicitation, or inducement to  
16 purchase any form of insurance covered by this chapter.  
17 However, this section does not apply to the association or any  
18 other entity which does not sell or solicit insurance.

19 Sec. 19. Section 22.7, Code Supplement 1985, is amended by  
20 adding the following new subsection:

21 NEW SUBSECTION. 21. Information or reports collected or  
22 submitted pursuant to section 508C.12, subsections 3 and 5,  
23 and section 508C.13, subsection 2, except to the extent that  
24 release is permitted under those sections.

25 EXPLANATION

26 This bill relates to insurance guaranty associations. It  
27 creates an Iowa life and health insurance guaranty  
28 association. The association shall exercise powers to protect  
29 policyholders of life and health insurance policies and  
30 annuity contracts because of the impairment or insolvency of a  
31 member insurer that issued the policies or contracts. The  
32 association may make assessments to cover the administrative  
33 costs and to cover losses resulting from impairments or  
34 insolvencies.

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SENATE/HOUSE FILE \_\_\_\_\_  
BY (PROPOSED COMMITTEE ON COM-  
MERCE BILL BY THE INSURANCE  
GUARANTY FUND AND RISK SHAR-  
ING STUDY COMMITTEE)

Passed Senate, Date \_\_\_\_\_ Passed House, Date \_\_\_\_\_  
Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_ Vote: Ayes \_\_\_\_\_ Nays \_\_\_\_\_  
Approved \_\_\_\_\_

A BILL FOR

1 An Act permitting an individual who is covered by a group health  
2 plan to continue coverage under the plan for up to twelve  
3 months.

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

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1 Section 1. Section 509.3, Code 1985, is amended by adding  
2 the following new subsection 3 and renumbering the subsequent  
3 subsections:

4 NEW SUBSECTION. 3. A provision that if the insurance on a  
5 person or insurance on a person and the person's dependents  
6 covered by the policy would cease because of termination of  
7 employment or membership in the class or classes eligible for  
8 coverage under the policy, the person may continue coverage  
9 under the group plan for the person or the person and the  
10 person's dependents for up to twelve months from that date of  
11 the termination of employment or membership. To continue  
12 coverage under this subsection, the person making the election  
13 shall provide written notice of the election and payment of  
14 the first premium within thirty days of receiving written  
15 notification from the group carrier of the person's  
16 eligibility to continue coverage after employment or  
17 membership in the group is terminated. Unless there is a  
18 written agreement to the contrary, the person is liable for  
19 the full premium under the group if the person elects to  
20 continue coverage.

21 The continuation provision shall also be available in  
22 either of the following cases:

23 a. Upon the death of the employee or member, to the  
24 surviving spouse with respect to such of the spouse and  
25 children as are then covered by the group policy, and to a  
26 child solely with respect to the child upon the child's  
27 attaining the limiting age of coverage under the group policy  
28 while covered as a dependent under the policy.

29 b. Upon the divorce or annulment of the marriage of the  
30 employee or member, to the divorced spouse, or former spouse  
31 in the event of annulment, of the employee or member.

32 The continuation rights under this subsection are in  
33 addition to and not in lieu of any coverage rights a person  
34 may have under this subsection.

35 Sec. 2. NEW SECTION. 514.24 CONTINUATION POLICIES RE-

1 QUIRED.

2 The requirements of section 509.3, subsection 3, regarding  
3 continuation rights under group accident and health plans also  
4 apply to group contracts written pursuant to this chapter.

5 Sec. 3. NEW SECTION. 514B.33 CONTINUATION POLICIES RE-  
6 QUIRED.

7 The requirements of section 509.3, subsection 3, regarding  
8 continuation rights under group accident and health plans also  
9 apply to group contracts written pursuant to this chapter.

10 EXPLANATION

11 This bill provides that a person whose group accident and  
12 health coverage would be terminated because of termination of  
13 the person's employment or membership in a class eligible for  
14 coverage under the policy, may elect to continue the person's  
15 or the person's and the person's dependents' coverage under  
16 the group for up to twelve months. The person must make an  
17 election in writing to continue the coverage. The  
18 continuation rights also may be exercised by a surviving  
19 spouse or a former or divorced spouse. The rights are in  
20 addition to mandatory conversion rights. The rights also  
21 apply to group contracts with a mutual service corporation or  
22 a health maintenance organization.

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COMMITTEE RESOLUTION NO. \_\_\_\_\_

BY INSURANCE GUARANTY FUND AND RISK SHARING STUDY  
COMMITTEE

A Committee Resolution recommending increased funding for the state insurance department.

WHEREAS, The Committee has been studying the issue of how to increase safeguards for Iowa insurance policyholders; and

WHEREAS, One method of increasing the security of policyholders is to adequately supervise and regulate insurance companies doing business in Iowa, and

WHEREAS, The insurance department takes in much more in licensing and filing fees than it is appropriated to spend.

WHEREAS, While the insurance department currently does a good job supervising and regulating insurance companies doing business in the state in light of the department's budgetary constraints, an increase in funding by \$750,000 would permit the department to maximize supervision and protection for Iowa policyholders; NOW THEREFORE,

BE IT RESOLVED BY THE INSURANCE GUARANTY FUND AND RISK SHARING STUDY COMMITTEE, That the senate and house committees on appropriation should increase the appropriation for the fiscal year beginning July 1, 1986 for the state insurance department by an amount of \$750,000 over the amount appropriated for the fiscal year beginning July 1, 1985.