State of Iowa

Iowa Administrative Code Supplement

Biweekly
May 27, 2015

STEPHANIE A. HOFF
ADMINISTRATIVE CODE EDITOR

Published by the
STATE OF IOWA
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

Agency names and numbers in bold below correspond to the divider tabs in the IAC binders. New and replacement chapters included in this Supplement are listed below. Carefully remove and insert chapters accordingly.

Editor's telephone (515)281-3355 or (515)242-6873

Administrative Services Department[11]

Replace Chapter 54
Replace Chapter 61
Replace Chapters 63 to 65

Insurance Division[191]

Replace Analysis
Replace Chapter 20
Replace Chapter 30
Replace Chapter 35
Replace Chapters 39 and 40

Iowa Finance Authority[265]

Replace Analysis
Replace Chapter 15
Replace Chapter 23
Replace Chapter 26
Replace Chapter 29
Replace Chapter 31
Replace Chapter 33
Remove Reserved Chapter 34 and Chapter 35
Insert Reserved Chapters 34 and 35
Replace Chapters 43 and 44

Inspections and Appeals Department[481]

Replace Analysis
Replace Chapters 10 and 11
Replace Chapter 67

Dental Board[650]

Replace Chapter 27

CHAPTER 54
RECRUITMENT, APPLICATION AND EXAMINATION

[Prior to 11/5/86, Merit Employment Department [570]]
[Prior to 2/18/04, see 581—Ch 5]

11—54.1(8A) Recruitment. Classes are closed to application unless specifically opened for recruitment.

54.1(1) *Open recruitment announcements.* The director shall give public notice of positions opened for recruitment for a minimum of ten calendar days following the announcement date. Recruitment may be limited to a specific geographic area or a specific selective background area or both. Recruitment announcements shall be posted publicly. Copies may also be sent to newspapers, radio stations, educational institutions, professional and vocational associations, and other recruitment sources. Recruitment announcements may be posted as promotional opportunities for current permanent state employees only.

54.1(2) *Content of announcements.* Announcements shall specify the job title, vacancy number, salary range, location, method for making application, closing date for receiving applications, minimum qualifications, and any selective requirements. All announcements must include a statement indicating that the state of Iowa is an affirmative action and equal employment opportunity employer. Announcements for continuous recruitment shall include a statement indicating that applications will be accepted until further notice.

54.1(3) *Advertising.* The appointing authority shall send to the director copies of all advertisements announcing employment opportunities that are to be placed in any publication, and any additional information required by the director. The appointing authority shall comply with any policies established by the director regarding advertising.

11—54.2(8A) Applications.

54.2(1) *Applicant information.* Applicant information shall be on forms prescribed by the director unless an alternate method has been authorized. Applicants must supply at least their name, current mailing address, signature and social security number; however, if an applicant requests, a nine-digit number will be assigned by the department to be used in lieu of the social security number. If other than the social security number is requested, it shall be the applicant's responsibility to ensure that all future correspondence directed to the department regarding the applicant's records contains the assigned nine-digit number. All other information requested on the application will assist the department in accurately and completely processing and evaluating the application. Applications that are not complete may not be regarded as an official application and may not be processed. The director may require an applicant to submit documented proof of the possession of any license, certificate, degree, or other evidence of eligibility or qualification to satisfactorily perform the essential duties of the job with or without a reasonable accommodation.

54.2(2) *Verifying applicant information.* The director may at any time verify statements contained in an application and seek further information concerning an applicant's qualifications. If information is obtained which affects or would have affected an applicant's qualifications, standing on an eligible list, or status if already employed, the director may make the necessary adjustment or take other appropriate action, including termination if the applicant has already been employed.

54.2(3) *Applicant files.* Applications accepted for processing and necessary related materials will be placed in the applicant files in the department and retained for no less than one year. Applications for jobs which result in the hire of the applicant will be placed in the employee files in the department and retained for no less than the period of employment.

54.2(4) *Application for eligible lists.* Persons may apply to be on eligible lists as follows:

a. *Promotional lists.* Promotional applicants shall meet the minimum qualifications. Promotional applicants may be subject to keyboard examinations, background checks, psychological examinations, and other examinations used for further screening. The following persons may apply to be on promotional eligible lists:

(1) Persons who have attained permanent employee status, including permanent employees of the board of regents and community-based corrections;

(2) Persons enrolled in work experience programs who have successfully completed at least 480 hours in the program are eligible to apply for promotional vacancies for a period of one year from the date of the successful completion of the work experience program;

(3) Persons who have been formally enrolled in the department's intern development program for a period of at least 480 hours are eligible to apply for promotional vacancies for a period of one year from the date of the successful completion of the work experience program;

(4) Disabled veterans who are enrolled in a job training program in accordance with the provisions of rule 11—57.9(8A) and have worked a minimum of 160 hours up to a maximum of 780 hours are eligible to apply for promotional vacancies for a period of one year from the date of successful completion of the job training program; and

(5) Noncontract employees who have been laid off are eligible to apply for promotional vacancies for a period of one year from the date of layoff.

b. *All-applicant lists.* The following persons may apply to be on all-applicant lists:

(1) Persons laid off and eligible for recall;

(2) Judicial branch employees;

(3) Legislative branch employees;

(4) Probationary or provisional probationary employees;

(5) Permanent employees, including permanent employees of the board of regents and community-based corrections;

(6) Temporary employees not on the promotional list and volunteers (including persons enrolled in work experience programs who are not on the promotional list) following 60 calendar days' service with the state;

(7) Nonpermanent employees of the board of regents and community-based corrections; and

(8) Former permanent employees who resigned or retired from state employment in good standing.

54.2(5) *Application pending license or graduation.* An applicant who does not meet the minimum education or license requirements, but who is currently enrolled in an education program that will result in meeting such requirements, may be placed on the eligible list with a "pending graduation" or "pending license" status provided the applicant will meet or has a reasonable expectation of meeting, the requirements within the following nine months. The applicant may be selected for employment, but may not be appointed until all qualification requirements are met.

54.2(6) *Disqualification or removal of applicants.* The director may refuse to place an applicant on a list of eligibles, refuse to refer an applicant for a vacancy, refuse to approve the appointment of an applicant, or remove an applicant from a list of eligibles for a position if it is found that the applicant:

a. Does not meet the minimum qualifications or selective requirements for the job class or position as specified in the job class description, vacancy announcement, administrative rules, or law.

b. Is incapable of performing the essential functions of the job classification or position and a reasonable accommodation cannot be provided.

c. Has knowingly misrepresented the facts when submitting information relative to an application, examination, certification, appeal, or any other facet of the selection process.

d. Has used or attempted to use coercion, bribery or other illegal means to secure an advantage in the application, examination, appeal or selection process.

e. Has obtained screening information to which applicants are not entitled.

f. Has failed to submit the application within the designated time limits.

g. Was previously discharged from a position in state government.

h. Has resigned in lieu of discharge for cause.

i. Has been convicted of a crime that is shown to have a direct relationship to the duties of a job class or position.

j. Is proven to be an unrehabilitated substance abuser who would be unable to perform the duties of the job class or who would constitute a threat to state property or to the safety of others.

k. Is not a United States citizen and does not have a valid permit to work in the United States under regulations issued by the U.S. Immigration and Naturalization Service.

Applicants disqualified or removed under this subrule shall be notified in writing by the director within five workdays following removal. Applicants may informally request that the director reconsider their disqualification or removal by submitting additional written evidence of their qualifications or reasons why they should not be removed in accordance with rule 11—61.3(8A). Formal appeal of disqualification or removal shall be in accordance with 11—subrule 61.2(4).

54.2(7) *Qualifications.* Applicants must meet the qualifications for the class as well as any selective requirements associated with a particular class or position as indicated in the class description. The director shall determine whether or not an applicant meets such qualifications and requirements.

Applicants and employees may, as a condition of the job, be required to have a current license, certificate, or other evidence of eligibility or qualification. Employees who fail to meet and maintain this requirement shall be subject to discharge in accordance with rule 11—57.10(8A) or 11—subrule 60.2(4).

Any fees associated with obtaining or renewing a license, certificate, or other evidence of eligibility or qualification shall be the responsibility of the applicant or employee unless otherwise provided by statute.

[**ARC 0401C**, IAB 10/17/12, effective 11/21/12; **ARC 1568C**, IAB 8/6/14, effective 9/10/14; **ARC 2000C**, IAB 5/27/15, effective 7/1/15]

11—54.3(8A) Examinations.

54.3(1) *Purpose of examinations.* The director or appointing authority may conduct examinations to assess the qualifications of applicants. Possession of a valid license, certificate, registration, or work permit required by the Iowa Code or the Iowa Administrative Code in order to practice a trade or profession may qualify as evidence of an applicant's basic qualifications.

54.3(2) *Types of examinations.* Examinations may include, but are not limited to, written, oral, physical, or keyboard tests, and may screen for such factors as education, experience, aptitude, psychological traits, knowledge, character, physical fitness, or other standards related to job requirements.

54.3(3) *Background checks.* Background checks and investigations, including, but not limited to, checks of arrest or conviction records, fingerprint records, driving records, financial or credit records, and child or dependent adult abuse records, constitute an examination or test within the meaning of this subrule and Iowa Code chapter 8A. Confidential documents provided to the director by other agencies in conjunction with the administration of this rule shall continue to be maintained in the documents' confidential status. The director is subject to the same policies and penalties regarding the confidentiality of the documents as any employee of the agency providing the documents.

Background checks shall be conducted only after receiving approval from the director concerning the areas to be checked and the standards to be applied in evaluating the information gathered. Background checks are subject to the following limitations and requirements:

a. Arrest record information, unless otherwise required by law, shall not be considered in the selection of persons for employment unless expressly authorized by the director.

b. The appointing authority shall notify the director of each job class or position that requires applicants to undergo any type of background check. The notification shall document the clear business necessity for the background check and the job relatedness of each topic covered in the inquiry.

c. The appointing authority shall provide a statement that shall be presented to each applicant who is to be investigated under this subrule. This statement shall inform the applicant that the applicant is subject to a background check as a condition of employment and the topics to be covered in the background check. It shall also inform the applicant that all information gathered will be treated as confidential within the meaning of Iowa Code section 22.7, but that all such information gathered shall be available to the applicant upon request through the agency authorized to release such information, unless otherwise specifically provided by law. The statement shall be signed and dated by the applicant and shall include authorization from the applicant for the appointing authority to conduct the background check as part of the application and selection process.

[**ARC 0401C**, IAB 10/17/12, effective 11/21/12]

11—54.4(8A) Development and administration of examinations.

54.4(1) *Examination development.* The director shall oversee the development, purchase, and use of examination materials, forms, procedures, and instructions.

54.4(2) *Examination administration.* The director or appointing authority shall arrange for suitable locations and conditions to conduct examinations. Locations in various areas of the state and out of state may be used. Examinations may be postponed, canceled, or rescheduled.

a. Examination of persons with disabilities. Persons with disabilities may request specific examination accommodations. Reasonable accommodations will be granted in accordance with policies for accommodations established by the department.

b. Retaking examinations. Applicants may not retake aptitude, psychological, video-based or other examinations for 60 calendar days following the last date the examination was taken except as provided for in rule 11—54.6(8A). Violation of the waiting period for an examination shall result in the voiding of the current examination score and the imposition of an additional 60-calendar-day waiting period.

Keyboard examinations, such as typing, may be retaken at any time without a waiting period.

The most recent examination score shall determine the applicant's qualification for the corresponding eligible lists.

Applicants who are required to take examinations covered by the rules or procedures of other agencies are subject to applicable rules or procedures on retakes for such examinations of that agency.

54.4(3) *Examination materials.*

a. All examination materials, including working papers, test booklets, test answer sheets and test answer keys are not public records under Iowa Code chapter 22. All examination materials are the property of the department and shall not be released without the consent of the director.

b. Removing examination material. Any unauthorized person who removes examination material from an examination site, who participates in unauthorized distribution of examination materials, who is in unauthorized possession of examination material or who otherwise compromises the integrity of the examination process shall be subject to discipline, up to and including discharge if employed by the state, as well as prosecution.

[**ARC 0401C**, IAB 10/17/12, effective 11/21/12]

11—54.5(8A) Scoring examinations. All applicants shall be given uniform treatment in all phases of the examination scoring process applicable to the job class or position and status of the applicant. Applicants may be required to obtain at least a minimum score in any or all parts of the examination process in order to receive a final score or to be allowed to participate in the remaining parts of an examination.

54.5(1) *Adjustment of errors.* Examination scoring errors will be corrected. A correction shall not, however, invalidate any list already issued or any appointment already made and shall not extend the life of the score.

54.5(2) *Points for veterans.* Veterans' points shall be applied to veterans as defined in Iowa Code section 35C.1.

a. "Veteran" means a resident of this state who served in the armed forces of the United States at any time during the following dates and who was discharged under honorable conditions:

(1) World War I from April 6, 1917, through November 11, 1918.

(2) Occupation of Germany from November 12, 1918, through July 11, 1923.

(3) American expeditionary forces in Siberia from November 12, 1918, through April 30, 1920.

(4) Second Haitian suppression of insurrections from 1919 through 1920.

(5) Second Nicaragua campaign with marines or navy in Nicaragua or on combatant ships from 1926 through 1933.

(6) Yangtze service with navy and marines in Shanghai or in the Yangtze valley from 1926 through 1927 and 1930 through 1932.

(7) China service with navy and marines from 1937 through 1939.

(8) World War II from December 7, 1941, through December 31, 1946.

(9) Korean conflict from June 25, 1950, through January 31, 1955.

(10) Vietnam conflict from February 28, 1961, through May 7, 1975.

(11) Lebanon or Grenada service from August 24, 1982, through July 31, 1984.

(12) Panama service from December 20, 1989, through January 31, 1990.

(13) Persian Gulf conflict from August 2, 1990, through the date the President or the Congress of the United States declares a cessation of hostilities. However, if the United States Congress enacts a date different from August 2, 1990, as the beginning of the Persian Gulf conflict for purposes of determining whether a veteran is entitled to receive military benefits as a veteran of the Persian Gulf conflict, that date shall be substituted for August 2, 1990.

b. "Veteran" also includes the following:

(1) Former members of the reserve forces of the United States who served at least 20 years in the reserve forces after January 28, 1973, and who were discharged under honorable conditions. However, a member of the reserve forces of the United States who completed a minimum aggregate of 90 days of active federal service, other than training, and was discharged under honorable conditions or was retired under Title X of the United States Code shall be included as a veteran.

(2) Former members of the Iowa national guard who served at least 20 years in the Iowa national guard after January 28, 1973, and who were discharged under honorable conditions. However, a member of the Iowa national guard who was activated for federal duty, other than training, for a minimum aggregate of 90 days and was discharged under honorable conditions or was retired under Title X of the United States Code shall be included as a veteran.

(3) Former members of the active, oceangoing merchant marine who served during World War II at any time between December 7, 1941, and December 31, 1946, both dates inclusive, who were discharged under honorable conditions.

(4) Former members of the women's air force service pilots and other persons who have been conferred veteran status based on their civilian duties during World War II in accordance with federal Pub. L. No. 95-202, 38 U.S.C. Section 106.

c. Proof of eligibility for points must be provided by the applicant in the form of a certified photocopy of a DD214 Form (Armed Forces Report of Transfer or Discharge) or other official document containing dates of service or a listing of service medals and campaign badges.

d. Applicants who were awarded a Purple Heart, or who have a service-connected disability, or who are receiving disability compensation or pension under laws administered by the U.S. Veterans Administration may request to have a maximum of ten points added to examination scores. Proof of current disability dated within the last 24 months and updated every 24 months after initial application must be submitted for continued eligibility.

11—54.6(8A) Review of written examination questions. Applicants may request to review their incorrectly answered questions on department-administered written examinations except that aptitude, psychological, and video-based examinations are not subject to review. An applicant who reviews written examination questions may not retake that examination or an examination with the same or similar content for 60 calendar days following the review. Violation of this waiting period shall result in the voiding of the current examination score and the imposition of an additional 60-calendar-day waiting period.

[**ARC 0401C**, IAB 10/17/12, effective 11/21/12]

11—54.7(8A) Drug use and drug tests.

54.7(1) *Policy.* Employees shall not report to work while under the influence of alcohol or illegal drugs. The unauthorized use, possession, sale, purchase, manufacture, distribution, or transfer of any illegal drug or alcoholic beverage while engaged in state business or on state property is prohibited. Employees who violate this policy are subject to disciplinary action up to and including discharge.

54.7(2) *Definition and applicability.*

a. "Drug test" means any blood, urine, saliva, chemical, or skin tissue test conducted for the purpose of detecting the presence of a chemical substance in an individual. These rules authorize only the use of urinalysis tests for this purpose. Other methods of drug testing are prohibited.

b. These rules do not apply to drug tests required under federal statutes, drug tests conducted pursuant to a nuclear regulatory commission policy statement, or drug tests conducted to determine if an employee is ineligible to receive workers' compensation under Iowa Code section 85.16, subsection 2.

54.7(3) *Preemployment drug tests.* A urinalysis drug test may be performed as part of a preemployment physical only for department of corrections correctional officer positions. Application materials for these positions shall include clear notice that a drug test is part of the preemployment physical. Requirements for these tests are as follows:

a. A urine sample will be collected during the preemployment physical examination.

b. The sample container will include identification for chain of custody purposes that does not include any part of the applicant's name or social security number.

c. The container will be transported directly from the site of the physical examination to a laboratory or other testing facility. Samples may be transported via certified mail or courier service.

d. The sample will be tested and retained by the laboratory or other testing facility for a minimum of 30 days. The applicant may have the sample analyzed, at the applicant's expense, by a laboratory or other testing facility approved in accordance with the administrative rules of the department of public health.

e. Each drug test will include an initial screen and a confirmation of positive results. The initial screening test may utilize immunoassay, thin layer, high performance liquid or gas chromatography, or an equivalent technology. If the initial test utilizes immunoassay, the test kit must meet the requirements of the Food and Drug Administration. All confirmation tests will be done by Gas Chromatography - Mass Spectrometry (GC-MS) at a laboratory or other testing facility approved in accordance with the administrative rules of the department of public health.

f. At a minimum, tests will screen for marijuana, cocaine, and amphetamines.

g. Procedures for obtaining, sealing, identifying, transporting, storing, and retention of samples shall protect the chain of custody and the viability of the sample, and shall comply with department of public health administrative rules.

h. The laboratory or other testing facility shall report the results of the drug tests to the appointing authority. The confidentiality of the information shall be protected by all parties.

i. The appointing authority shall provide an applicant an opportunity to rebut or explain the results of a positive drug test by administering a pretest questionnaire or arranging a posttest conference with the applicant.

j. A positive confirmation drug test will disqualify an applicant from further consideration and hire for department of corrections correctional officer positions.

54.7(4) *Employee drug tests.* Drug testing of employees is prohibited except as provided in subrule 54.7(2), paragraph *"b."*

These rules are intended to implement Iowa Code chapter 8A, subchapter IV.

[Filed 5/1/69; amended 5/13/70, 9/17/70, 4/14/71]
[Filed 6/28/76, Notice 5/17/76—published 7/12/76, effective 8/2/76]
[Filed without notice 7/22/76—published 8/9/76, effective 9/13/76]
[Filed emergency 9/7/76—published 9/22/76, effective 9/7/76]
[Filed 10/13/76, Notice 9/8/76—published 11/3/76, effective 12/8/76]
[Filed 4/11/79, Notice 3/7/79—published 5/2/79, effective 6/6/79]
[Filed 1/30/81, Notice 11/26/80—published 2/18/81, effective 3/25/81]
[Filed 12/3/82, Notice 10/13/82—published 12/22/82, effective 1/26/83][1]
[Filed 3/22/85, Notice 10/24/84—published 4/10/85, effective 5/15/85]
[Filed 4/4/86, Notice 1/15/86—published 4/23/86, effective 5/28/86]
[Filed emergency 7/1/86—published 7/30/86, effective 7/1/86][2]
[Filed 10/17/86, Notice 8/13/86—published 11/5/86, effective 12/10/86]
[Filed 7/24/87, Notice 6/17/87—published 8/12/87, effective 9/16/87]
[Filed 2/18/88, Notice 1/13/88—published 3/9/88, effective 4/13/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 10/26/88]
[Filed 10/27/88, Notice 9/21/88—published 11/16/88, effective 12/21/88]

[Filed 7/7/89, Notice 5/17/89—published 7/26/89, effective 9/1/89]
[Filed 9/29/89, Notice 8/23/89—published 10/18/89, effective 11/24/89]
[Filed 2/1/90, Notice 12/13/89—published 2/21/90, effective 3/30/90]
[Filed 5/25/90, Notice 4/18/90—published 6/13/90, effective 7/20/90]
[Filed 2/1/91, Notice 12/12/90—published 2/20/91, effective 3/29/91]
[Filed 5/23/91, Notice 4/17/91—published 6/12/91, effective 7/19/91][3]
[Filed emergency 9/13/91—published 10/2/91, effective 9/13/91]
[Filed 11/20/91, Notice 8/21/91—published 12/11/91, effective 1/17/92]
[Filed 11/21/91, Notice 10/2/91—published 12/11/91, effective 1/17/92]
[Filed 3/26/93, Notice 2/17/93—published 4/14/93, effective 5/19/93]
[Filed 12/12/96, Notice 10/23/96—published 1/15/97, effective 2/19/97]
[Filed 8/12/99, Notice 6/16/99—published 9/8/99, effective 10/13/99]
[Filed emergency 6/29/00—published 7/26/00, effective 7/1/00]
[Filed 1/28/04, Notice 12/24/03—published 2/18/04, effective 3/24/04]
[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]
[Filed ARC 0401C (Notice ARC 0180C, IAB 6/27/12), IAB 10/17/12, effective 11/21/12]
[Filed ARC 1568C (Notice ARC 1503C, IAB 6/11/14), IAB 8/6/14, effective 9/10/14]
[Filed ARC 2000C (Notice ARC 1936C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[1] Effective date of amendments to 5.11 and 54.12(1/26/83) delayed 70 days by the Administrative Rules Review Committee. Delay lifted by Committee on 2/8/83. See details following chapter analysis.

[2] See IAB Personnel Department

[3] Effective date (7/19/91) of subrule 5.3(3) delayed 70 days by the Administrative Rules Review Committee at its meeting held 7/12/91.

CHAPTER 61
GRIEVANCES AND APPEALS

[Prior to IAB 3/14/84, subject appeared in Chs 12 and 15]
[Prior to 11/5/86, Merit Employment Department[570]]
[Prior to 1986, see Executive Council[420]Ch 10]
[Prior to 1/21/04, see 581—Ch 12]

11—61.1(8A) Grievances. The grievance procedure is an informal process. It is not a contested case. All employees shall have the right to file grievances. The right to file a grievance and the grievance procedure provided for in these rules shall be made known and available to employees throughout the agency by the appointing authority through well-publicized means. Employees covered by a collective bargaining agreement may use this grievance procedure for issues that are not covered by their respective collective bargaining agreements.

Grievances shall state the issues involved, the relief sought, the date the incident or violation took place and any rules involved and shall be filed on forms prescribed by the director. Grievances involving suspension, reduction in pay within the same pay grade, disciplinary demotion, or discharge may be filed as appeals in accordance with subrule 61.2(6) and commence with Step 3 of the grievance procedure described in subrule 61.1(1).

61.1(1) *Grievance procedure.*

a. Step 1. The grievant shall initiate the grievance by submitting it in writing to the immediate supervisor, or to a supervisor designated by the appointing authority, within 14 calendar days following the day the grievant first became aware of, or should have through the exercise of reasonable diligence become aware of, the grievance issue. The immediate supervisor shall, within seven calendar days after the day the grievance is received, attempt to resolve the grievance within the bounds of these rules and give a decision in writing to the grievant with a copy to the director.

b. Step 2. If the grievant is not satisfied with the decision obtained at the first step, the grievant may, within seven calendar days after the day the written decision at the first step is received or should have been received, file the grievance in writing with the appointing authority. The appointing authority shall, within seven calendar days after the day the grievance is received, attempt to resolve the grievance within the bounds of these rules, by affirming, modifying, or reversing the decision made at the first step, or otherwise grant appropriate relief. The decision shall be given to the grievant in writing with a copy to the director.

c. Step 3. If the grievant is not satisfied with the decision obtained at the second step, the grievant may, within 7 calendar days after the day the written decision at the second step was received, or should have been received, file the grievance in writing with the director. The director shall, within 30 calendar days after the day the grievance is received, attempt to resolve the grievance and send a decision in writing to the grievant with a copy to the appointing authority. The director may affirm, modify, or reverse the decision made at the second step or otherwise grant appropriate relief. If the relief sought by the grievant is not granted, the director's response shall inform the grievant of the appeal rights in subrule 61.2(5).

d. If the grievant is not satisfied with the decision obtained from the third step the grievant may file an appeal in accordance with subrule 61.2(5).

61.1(2) *Exceptions to time limits.*

a. If the grievant fails to proceed to the next available step in the grievance procedure within the prescribed time limits, the grievant shall have waived any right to proceed further in the grievance procedure and the grievance shall be considered settled.

b. If any management representative fails to comply with the prescribed time limits at any step in the grievance procedure, the grievant may proceed to the next available step.

c. The maximum time periods at any of the three steps in the grievance procedure may be extended when mutually agreed to in writing by both parties.

61.1(3) *Group grievances.* When the appointing authority or the director determines that two or more grievances or grievants address the same or similar issues, they shall be processed and decided as a group grievance.

61.1(4) *Grievance meetings.*

a. When it is determined by a designated management representative or the director that a meeting with the grievant will be held, all reasonable attempts will be made to hold the meeting during the grievant's regularly scheduled hours of work.

b. The grievant may be represented at a grievance meeting by an employee of the grievant's choosing except where that would constitute a conflict of interest. A grievant who wishes to be represented and whose class is covered by a collective bargaining agreement may only be represented by an appointed or elected union representative from the same employee organization as the grievant. A grievant who wishes to be represented and whose class is not covered by a collective bargaining agreement may only be represented by an employee with the same bargaining status as the grievant.

c. The grievant, an employee who is the grievant's representative, and employees authorized to attend the grievance meeting by the appointing authority or the director shall be in paid status for that time spent at and traveling to and from the grievance meeting during their regularly scheduled hours of work. In addition, employees shall, if eligible for overtime compensation, be in paid status for that time spent at and traveling to and from the grievance meeting outside of their regularly scheduled hours of work.

d. The appointing authority shall not authorize mileage, or the use of a state vehicle for employees to attend or participate in a grievance meeting, except for those employees who are required to attend or participate in the meeting by the appointing authority or the director. In the case of group grievances, only one of the grievants shall be in paid status.

61.1(5) *Bypassing steps for discrimination grievances.* A grievance step may be bypassed by the grievant when the grievance alleges discrimination and the respondent at the step is the person against whom the grievance has been filed.

[**ARC 0401C**, IAB 10/17/12, effective 11/21/12; **ARC 2000C**, IAB 5/27/15, effective 7/1/15]

11—61.2(8A) Appeals.

61.2(1) *Appeal of position classification decisions.*

a. Appeal of a position classification decision shall be in accordance with rule 11—52.5(8A) and the contested case provisions of Iowa Code chapter 17A.

b. The appellant (including all appellants in the case of a group hearing), an employee who is the appellant's representative, and employees directed by the appointing authority to attend the classification appeal hearing by the appointing authority or the director shall be in paid status for the time spent at and traveling to and from the hearing during their regularly scheduled hours of work. In addition, only employees directed by management to attend the hearing shall, if eligible for overtime compensation, be in paid status for the time spent at and traveling to and from the hearing outside of their regularly scheduled hours of work.

c. The appointing authority shall not authorize mileage or the use of a state vehicle for employees to attend or participate in a classification appeal hearing, except for those employees who are directed to attend the hearing by the appointing authority or the director.

61.2(2) Reserved.

61.2(3) *Appeal of examination rating.* Following examination, an applicant may file a written appeal to the employment appeal board in the department of inspections and appeals for a review of the rating received on the examination for the sole purpose of assuring that uniform rating procedures were applied consistently and fairly. Right of appeal shall expire unless filed with the board within 30 calendar days following the notice of the examination results.

A rating on an examination may be corrected if it is found by the employment appeal board that a substantial error has been made by the department. The correction of a rating shall not, however, affect any certifications or appointments already made.

61.2(4) *Appeal of disqualification, restriction, or removal from eligible lists.* An applicant who has been disqualified or whose name has been restricted or removed from an eligible list in accordance with rule 11—54.2(8A) or 11—55.2(8A), or who has been restricted from certification in accordance with rule 11—56.7(8A) may file a written appeal to the employment appeal board in the department of inspections

and appeals for a review of that action. The written appeal must be filed with the board within 30 calendar days following the notice of disqualification, removal from the eligible list, or restriction from certification. The burden of proof to establish eligibility shall rest with the appellant.

When an appeal is generated as the result of an action initiated by the department, the department shall be responsible for representation. When an appeal is generated as the result of an action initiated by an appointing authority through the department, the appointing authority shall pay the costs of the appeal assessed to the department and shall participate in representation as requested by the department.

If the applicant's name is restored to an eligible list, that decision shall not affect any certifications or appointments already made.

61.2(5) *Appeal of grievance decisions.* An employee who has alleged a violation of Iowa Code sections 8A.401 to 8A.458or the rules adopted to implement Iowa Code sections 8A.401 to 8A.458 may, within 30 calendar days after the date the director's response at the third step of the grievance procedure was issued or should have been issued, file an appeal with the public employment relations board. A nontemporary, noncontract employee covered by merit system provisions who is suspended, reduced in pay within the same pay grade, disciplinarily demoted, or discharged, except during the employee's period of probationary status, may, if not satisfied with the decision of the director, request an appeal hearing before the public employment relations board within 30 calendar days after the date the director's decision was issued or should have been issued. However, when the grievance concerns allegations of discrimination within the meaning of Iowa Code chapter 216, the Iowa civil rights commission procedures shall be the exclusive remedy for appeal and shall, in such instances, constitute final agency action. In all other instances, decisions by the public employment relations board constitute final agency action.

61.2(6) *Appeal of disciplinary actions.* Any nontemporary, noncontract employee covered by merit system provisions who is suspended, reduced in pay within the same pay grade, disciplinarily demoted, or discharged, except during the employee's period of probationary status, may bypass steps one and two of the grievance procedure provided for in rule 11—61.1(8A) and may file an appeal in writing to the director for a review of the action within 7 calendar days after the effective date of the action. The appeal shall be on the forms prescribed by the director. The director shall affirm, modify or reverse the action and shall give a written decision to the employee within 30 calendar days after the receipt of the appeal. The time may be extended by mutual agreement of the parties. If not satisfied with the decision of the director, the employee may request an appeal hearing before the public employment relations board as provided in subrule 61.2(5).

61.2(7) *Appeal of reduction in force.* An employee who is to be or has been laid off or who has changed classes in lieu of layoff, and who alleges that the reduction in force was used to circumvent the rights of appeal provided for in subrule 61.2(6) or subrule 61.2(1), paragraph *"a"* or *"d,"* may file an appeal with the director within 30 calendar days following receipt of the notice of reduction in force to the employee from the appointing authority.

61.2(8) *Remedies.* All remedies provided in rule 11—61.2(8A) must be exhausted pursuant to Iowa Code section 17A.19, subsection 1, prior to petition for judicial review.

[**ARC 0401C**, IAB 10/17/12, effective 11/21/12; **ARC 2000C**, IAB 5/27/15, effective 7/1/15]

11—61.3(8A) Informal settlement. The director or an appellant may request that an informal conference be held to determine if a dispute can be resolved in a manner agreeable to all parties prior to a contested case hearing. If the director and the appellant agree to negotiate a settlement, the various points of the proposed settlement shall be included in a written statement of facts. Negotiations for a settlement shall be completed at least five workdays prior to the date of the contested case hearing, unless additional time is agreed to by the director, the appellant and the public employment relations board, the department of inspections and appeals, or the classification appeal committee, as applicable. The settlement shall be binding when approved and signed by both the director and the appellant.

These rules are intended to implement 2003 Iowa Code Supplement section 8A.413.

[Filed 9/17/70, amended 4/4/71][1]

[Filed 7/14/79, amended 9/17/70, 11/28/73]

[Filed 9/16/76, Notice 8/9/76—published 10/6/76, effective 11/10/76][1]
[Filed 3/22/77, Notice 1/12/77—published 4/20/77, effective 5/25/77]
[Filed 8/17/77, Notice 7/13/77—published 9/7/77, effective 10/12/77][1]
[Filed 8/30/79, Notice 5/30/79—published 9/19/79, effective 10/24/79][1]
[Filed 2/13/81, Notice 11/26/80—published 3/4/81, effective 4/8/81][1]
[Filed emergency 4/9/82—published 4/28/82, effective 4/9/82][1]
[Filed 6/16/82, Notice 4/28/82—published 7/7/82, effective 8/11/82][1]
[Filed 12/3/82, Notice 10/13/82—published 12/22/82, effective 1/26/83][2]
[Filed emergency 3/28/83—published 4/13/83, effective 3/28/83]
[Filed 2/24/84, Notice 1/4/84—published 3/14/84, effective 4/18/84]
[Filed 3/22/85, Notice 10/24/84—published 4/10/85, effective 5/15/85]
[Filed 7/26/85, Notice 5/22/85—published 8/14/85, effective 9/18/85]
[Filed 12/3/85, Notice 10/9/85—published 12/18/85, effective 1/22/86]
[Filed emergency 7/1/86—published 7/30/86, effective 7/1/86][3]
[Filed 10/17/86, Notice 8/13/86—published 11/5/86, effective 12/10/86]
[Filed emergency 11/7/86—published 12/3/86, effective 12/10/86]
[Filed 7/24/87, Notice 6/17/87—published 8/12/87, effective 9/16/87]
[Filed 2/18/88, Notice 1/13/88—published 3/9/88, effective 4/13/88]
[Filed 4/29/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
[Filed emergency 6/24/88—published 7/13/88, effective 7/1/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 10/26/88]
[Filed 10/27/88, Notice 9/21/88—published 11/16/88, effective 12/21/88]
[Filed 7/7/89, Notice 5/17/89—published 7/26/89, effective 9/1/89]
[Filed 9/29/89, Notice 8/23/89—published 10/18/89, effective 11/24/89]
[Filed 2/1/90, Notice 12/13/89—published 2/21/90, effective 3/30/90]
[Filed 5/25/90, Notice 4/18/90—published 6/13/90, effective 7/20/90]
[Filed 9/28/90, Notice 7/11/90—published 10/17/90, effective 11/23/90]
[Filed 2/1/91, Notice 12/12/90—published 2/20/91, effective 3/29/91]
[Filed 5/23/91, Notice 4/17/91—published 6/12/91, effective 7/19/91]
[Filed 11/20/91, Notice 8/21/91—published 12/11/91, effective 1/17/92]
[Filed 12/12/96, Notice 10/23/96—published 1/15/97, effective 2/19/97]
[Filed 8/12/99, Notice 6/16/99—published 9/8/99, effective 10/13/99]
[Filed 12/31/03, Notice 11/26/03—published 1/21/04, effective 2/25/04]
[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]
[Filed ARC 0401C (Notice ARC 0180C, IAB 6/27/12), IAB 10/17/12, effective 11/21/12]
[Filed ARC 2000C (Notice ARC 1936C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[1] History relating also to "Grievances and Complaints", Ch 15, prior to IAB 3/14/84.

[2] Effective date of amendments to 12.4(19A) delayed 70 days by Administrative Rules Review Committee. Delay lifted by Committee on 2/8/83. See details following chapter analysis.

[3] See IAB Personnel Department

CHAPTER 63
LEAVE

[Prior to 11/5/86, Merit Employment Department[570]]
[Prior to 1/7/04, see 581—Ch 14]

11—63.1(8A) Attendance. Appointing authorities shall establish the working schedules, regulations, and required hours of work for employees under their direction. All regulations and schedules shall be made known to the affected employees by appointing authorities. All absences of probationary and permanent employees shall be charged to one of the leave categories provided for in this chapter.

11—63.2(8A) Vacation leave.

63.2(1) Nontemporary employees shall earn vacation for continuous state employment as follows:

a. Two unscheduled holidays to be added to the vacation accrual each year.

b. Two weeks of vacation during the first and through the fourth year of employment.

c. Three weeks of vacation during the fifth and through the eleventh year of employment.

d. Four weeks of vacation during the twelfth year and through the nineteenth year of employment.

e. Four and four-tenths weeks of vacation during the twentieth year and through the twenty-fourth year of employment.

f. Five weeks of vacation during the twenty-fifth and all subsequent years of employment.

63.2(2) Vacation is subject to the following conditions:

a. Vacation shall be subject to the approval of the appointing authority. The appointing authority shall approve vacation so as to maintain the efficient operation of the agency; take into consideration the vacation preferences and needs of the employee; and make every reasonable effort to provide vacation to prevent any loss of vacation accrual.

b. Probationary and permanent part-time employees shall accrue vacation in an amount proportionate to that which would be accrued under full-time employment.

c. Vacation shall not accrue during any absence without pay.

d. An employee who is transferred, promoted, or demoted from one state agency to another shall be credited with the vacation accrued.

e. Employees, including employees who are paid from a pay plan having annual salary rates, who leave state employment for any reason shall be paid, or have payment made according to law, for all accrued vacation. Payment shall be included with the employee's final paycheck and shall be based on the employee's total biweekly regular rate of pay at the time of separation. When other pay is to be included in the calculation, that other pay must have been in effect for at least three pay periods. Vacation shall not be granted after the employee's last day of work.

f. An employee may, at the appointing authority's discretion, be required to use all accrued vacation before being granted any leave without pay, except as otherwise provided in these rules.

g. Vacation shall be charged on the employee's workday basis. Officially designated holidays occurring during an employee's vacation shall not be counted against the employee's accrued vacation.

h. In the event of an illness or disability while on vacation, that portion of the vacation spent under the care of a physician shall be switched retroactively to and charged against the employee's accrued sick leave upon satisfactory proof from the physician of the illness or disability and its duration.

i. Vacation shall not be used in excess of the amount accrued, and shall not be used until the pay period after it is accrued.

j. Vacation shall be cumulative to a maximum of twice the employee's annual rate of accrual, including sick leave conversion. An appointing authority may require an employee to take vacation whenever it would be in the best interests of the agency. The employee shall be given reasonable notice of the appointing authority's decision to require the use of accrued vacation. However, an employee shall not be required to reduce accrued vacation to less than 80 hours.

k. One week of vacation shall be equal to the number of hours in the employee's normal, regular workweek.

l. Any employee who is laid off, or an employee who separated due to qualification for long-term disability benefits or an on-the-job injury or illness and subsequently returns to state employment within

two years following the date of separation, shall have previous continuous service and the period of separation counted toward the vacation accrual rate.

m. Reserved.

n. Time spent in military service, within the specified time limits of the military training and service Act, shall be considered continuous service for the purpose of computing vacation accrual, provided the employee returns to state service within 90 calendar days following discharge from military duty. Vacation shall not accrue to an employee while on military leave without pay.

o. If on June 1 an employee has a balance of 160 or more hours of accrued leave, the employer may, with the approval of the employee, pay the employee for up to 40 hours of the accrued annual leave. This amount will be paid on a separate warrant on the payday which represents the last pay period of the fiscal year. Decisions regarding these payments will be made by each department director and are not subject to the grievance procedure provided for in these rules. This paragraph applies only to employees not covered by a collective bargaining agreement.

11—63.3(8A) Sick leave with pay. Probationary and permanent full-time employees, except peace officer employees of the department of natural resources and the department of public safety, shall accrue sick leave as set forth in this paragraph. If the employee's accrued sick leave balance is 750 hours or less, the employee shall accrue one and one-half days of sick leave per month, which is 5.538462 hours per pay period. If the employee's accrued sick leave balance is 1500 hours or less but more than 750 hours, the employee shall accrue one day of sick leave per month, which is 3.692308 hours per pay period. If the employee's accrued sick leave balance is more than 1500 hours, the employee shall accrue one-half day of sick leave per month, which is 1.846154 hours per pay period. Peace officer employees of the department of natural resources and department of public safety shall accrue sick leave at the same rate as the rate provided under the State Police Officers Council collective bargaining agreement. The use of sick leave with pay shall be subject to the following conditions:

63.3(1) Accrued sick leave may be used during a period when an employee is unable to work because of medically related disabilities; for physical or mental illness; medical, dental or optical examination, surgery or treatment; or when performance of assigned duties would jeopardize the employee's health or recovery. Medically related disabilities caused by pregnancy or recovery from childbirth shall be covered by sick leave.

63.3(2) Sick leave shall not be used as vacation.

63.3(3) Sick leave shall not be granted in excess of the amount accrued.

63.3(4) There is no limit on the accumulation of sick leave. An employee who has accrued at least 240 hours of sick leave may elect to accrue additional vacation in lieu of the normal sick leave accrual. An employee who has made an election to convert sick leave to vacation will be credited with four hours of vacation for each full month when sick leave is not used during that month. A conversion shall not be made if the accrued sick leave is less than 240 hours in the pay period in which the conversion would be made. The conversion of sick leave shall be prorated for employees who are normally scheduled to work less than full-time (40 hours per week). An employee's maximum vacation accrual may be increased under this subrule up to 96 hours.

63.3(5) In all cases when an employee has been absent on sick leave, the employee shall immediately upon return to work submit a statement that the absence was due to illness or other reasons stated in this rule. Where absence exceeds three working days, the reasons for the absence shall be verified by a physician or other authorized practitioner if required by the appointing authority. An appointing authority may require verification for lesser periods of absence and at any time during an absence. In all cases, sick leave shall not be deducted from that accrued until authorized by the appointing authority.

63.3(6) Sick leave shall be charged on the employee's workday basis. Officially designated holidays occurring during an employee's sick leave shall not be counted against the employee's accrued sick leave.

63.3(7) Sick leave shall not accrue during any absence without pay.

63.3(8) Probationary and permanent part-time employees shall accrue sick leave in an amount proportionate to that which would be accrued under full-time employment.

63.3(9) An employee who is transferred, promoted, or demoted from one agency to another shall be credited with the sick leave accrued.

63.3(10) All accrued sick leave shall be canceled on the date of separation, and no employee shall be reimbursed for accrued sick leave unused at the time of separation except as provided for in Iowa Code section 70A.23, or the applicable collective bargaining agreement. However, if an employee is laid off and is reemployed by any state agency within two years following the date of layoff, or an employee is separated due to an on-the-job injury or illness and is reemployed by any state agency within two years following the date of medical release, the employee's unused accrued sick leave shall be restored, except to the extent that the sick leave hours have been credited to a sick leave bank pursuant to Iowa Code section 70A.23 and the provisions of 11—64.16(8A). Employees participating in the sick leave insurance program who return to permanent employment will not have prior sick leave amounts restored.

63.3(11) Employees may also use accrued sick leave, not to exceed a total of 40 hours per fiscal year, for the following purposes:

a. When a death occurs in the immediate family;

b. For the temporary care of, or necessary attention to, members of the immediate family.

For purposes of this subrule, "immediate family" means the employee's spouse, children, grandchildren, foster children, stepchildren, legal wards, parents, grandparents, foster parents, stepparents, brothers, foster brothers, stepbrothers, sons-in-law, brothers-in-law, sisters, foster sisters, stepsisters, daughters-in-law, sisters-in-law, aunts, uncles, nieces, nephews, first cousins, corresponding relatives of the employee's spouse and other persons who are members of the employee's household.

This leave shall be granted at the convenience of the employee whenever possible and consistent with the staffing needs of the appointing authority.

63.3(12) If an absence because of illness, injury or other proper reason for using sick leave provided for in this rule extends beyond the employee's accrued sick leave, the appointing authority may require or permit additional time off to be charged to any other accrued leave. Employees shall, upon request, be paid accrued compensatory leave in a lump sum. When all accrued sick leave has been used, the employee may be granted leave without pay or terminated except as provided in subrule 63.5(4).

[**ARC 8265B**, IAB 11/4/09, effective 12/9/09; **ARC 0401C**, IAB 10/17/12, effective 11/21/12; **ARC 1568C**, IAB 8/6/14, effective 9/10/14]

11—63.4(8A) Family and Medical Leave Act leave. An employee who has been employed for a cumulative total of 12 months or more in the most recent seven-year period and who has worked at least 1,250 hours during the 12-month period immediately preceding the date leave is to begin shall be eligible for family and medical leave in accordance with the federal Family and Medical Leave Act (FMLA) and 29 CFR Part 825, these rules, and the policies of the department. Eligibility determinations shall be made as of the date that the FMLA leave is to begin. The FMLA leave year begins on the first day of each fiscal year. Eligible employees are entitled to FMLA leave subject to the following conditions:

63.4(1) It is the appointing authority's responsibility to designate leave as FMLA leave. The appointing authority shall designate leave as FMLA leave when the leave qualifies for FMLA leave, even if the employee makes no request for FMLA leave or does not want the leave to be counted as FMLA leave. When both spouses are employed by the state, they shall be limited to a combined total of 12 weeks of FMLA leave taken in accordance with paragraph *"a"* or *"c"* below. The hourly equivalent for part-time employees shall be prorated based upon the average number of hours worked during the previous 12 months. Leave may be for one or more of the following reasons:

a. The birth or placement with the employee of a son or daughter (biological child, adopted child, foster child, stepchild, legal ward or a child to whom the employee stands in loco parentis) for adoption or foster care provided the leave is taken within 12 months following any such birth, adoption or foster placement;

b. The care of a son or daughter under 18 years of age, or older if incapable of self-care because of a mental or physical disability, or spouse with a serious health condition;

c. The care of a parent or person who stood in loco parentis to the employee, with a serious health condition;

d. A serious health condition that makes an employee unable to work at all or perform any one of the essential functions of the employee's position within the meaning of the Americans with Disabilities Act (ADA), as amended, 42 U.S.C. Section 12101 et seq., and the regulations at 29 CFR Section 1630.2(n).

e. A qualifying exigency, as defined in federal FMLA regulations, arising out of the fact that the employee's spouse, son, daughter or parent is a covered servicemember on covered active duty, or has been notified of an impending call or order to covered active duty, in a foreign country.

f. To care for a covered servicemember with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the servicemember, pursuant to the FMLA regulations.

63.4(2) Leave may be taken on an intermittent basis or on a reduced work schedule basis where this type of leave is medically necessary. The use of intermittent or reduced work schedule leave for circumstances described in paragraph *"a"* of subrule 63.4(1) shall be at the discretion of the appointing authority. Approval of intermittent or reduced schedule leave for circumstances described in paragraph *"b," "c," "d," "e,"* or *"f"* of subrule 63.4(1) is mandatory if certified by a health care provider or proper military authority.

63.4(3) Use of sick leave shall be in accordance with rule 11—63.3(8A). When FMLA leave is taken pursuant to paragraph *"a," "b," "c," "e,"* or *"f"* of subrule 63.4(1), an employee must exhaust all paid vacation before unpaid leave is granted. However, sick leave may be used to the extent authorized by subrule 63.3(11). When an employee takes FMLA leave after the birth of a child and the employee has not received a medical release to return to work, the employee must exhaust all accrued sick leave and vacation before unpaid leave is granted. When the employee's medical provider releases the employee to return to work, the employee is no longer eligible to use paid sick leave; however, the employee may use leave as authorized by subrule 63.3(11) and accrued vacation.

When FMLA leave is taken pursuant to paragraph *"d"* of subrule 63.4(1), an employee must exhaust all paid sick leave, compensatory leave, and vacation before unpaid leave is granted.

63.4(4) An employee shall submit a written request, using forms prescribed by the department, to the appointing authority within 30 calendar days prior to the need for FMLA leave when the need for the leave is foreseeable. In situations involving unforeseeable need for leave and leave involving a birth, adoption, foster placement, or planned medical treatment for an illness, the employee must provide notice as soon as practicable after the employee learns of the need for the leave. Notice may be made orally or in writing. Untimely requests or failure to provide notice or mandatory information to the appointing authority may result in delay or denial of the FMLA leave. The failure to follow mandatory leave policies may result in discipline of the employee.

The appointing authority shall provide the employee with all notices required by the federal Family and Medical Leave Act and the policies of the department. Notices shall be provided to employees within the time frames prescribed by the federal regulations and the policies of the department. The appointing authority shall notify the employee using forms prescribed by the department, or verbally when circumstances prevent delivery of the forms. If verbal notification is made, the appointing authority shall take reasonable steps to deliver written notification to the employee within five workdays.

63.4(5) The appointing authority may, at the agency's expense, require a second opinion. The appointing authority will designate the health care provider to furnish the second opinion. In making the designation, the appointing authority shall select a provider that is not employed on a regular basis by the appointing authority. If the second opinion differs from the first, the appointing authority may, at the agency's expense, require a third opinion from a health care provider agreeable to both the employee and the appointing authority. The third opinion shall be final and binding on both parties.

63.4(6) During the period of leave, the appointing authority shall pay the state's share of the employee's health, dental, basic life, and long-term disability benefit insurance premiums. Failure by the employee to pay the employee's share of the premiums will result in a loss of coverage. The appointing authority shall provide notice to the employee 15 calendar days prior to any retroactive or prospective cancellation of benefits coverage. Upon return from FMLA leave, employees who have

dropped or canceled their health, dental, or life insurance benefits while on FMLA leave will be restored to the same level of benefits as prior to the commencement of leave upon completion of the necessary insurance applications and other forms required by the department.

63.4(7) Upon returning from FMLA leave, an employee is entitled to no more rights or benefits than the employee would have received had the leave not been taken. If an employee does not return from leave because of the continuation, reoccurrence or onset of a serious health condition, the appointing authority shall require written certification from the health care provider. If the reason for the employee's failure to return is not a certified serious health condition or other circumstances beyond the control of the employee, the state may recover its share of health and dental benefit insurance premiums paid during the period of leave.

63.4(8) The appointing authority may request periodic reports concerning the employee's medical status, and the date the employee may return to work. Requests for periodic reports will be made no more often than necessary depending on the facts and circumstances of each case and shall not exceed one request every 30 days absent extenuating circumstances.

The appointing authority shall require written certification from the health care provider that the employee is able to resume work before allowing an employee with a serious health condition to return from FMLA leave. Upon return from FMLA leave, the employee shall be placed in a position in the same class held prior to the leave, or a class in the same pay grade for which the employee qualifies, with the same pay, benefits, terms and conditions of employment, and geographical proximate location, except that:

a. If a reduction in force occurs while the employee is on leave, the employee's right to a position shall be established in accordance with 11—Chapter 60.

b. The employee's pay increase eligibility date shall be adjusted for absences of more than 30 calendar days.

63.4(9) If an employee unequivocally advises the employer that the employee does not intend to return to work, the employee's entitlement to FMLA leave and associated benefits cease. The failure to return to work upon the expiration of FMLA leave may be considered to be job abandonment.

63.4(10) If the employee is unable to perform an essential function of the position because of a physical or mental condition, including the continuation of a serious health condition, the employee has no right to restoration to another position under the FMLA. The appointing authority's obligations may be governed by the Americans with Disabilities Act.

63.4(11) An employee remains a participant in the deferred compensation and dependent care programs while on FMLA leave as authorized by these rules and the policies of the department.

63.4(12) FMLA leave runs concurrently with other leave programs administered by the department to the extent the leave qualifies as FMLA leave.

63.4(13) FMLA leave runs concurrently with a workers' compensation absence when the workers' compensation absence is one that meets the FMLA criteria.

An employee can be offered "restricted light duty," and if such restricted duty is refused, it may result in the loss of workers' compensation benefits. Under the FMLA, the appointing authority may offer restricted duty; however, if the employee refuses, the employee shall lose workers' compensation benefits but is still protected by the FMLA.

Employees on workers' compensation who are on FMLA leave concurrently and who are unable to return to work after the exhaustion of FMLA leave are subject to state workers' compensation laws and will have no job restoration rights under the FMLA.

63.4(14) Retention of vacation leave. Notwithstanding subrule 63.4(3), non-contract-covered employees who qualify for FMLA leave are eligible to retain up to two weeks (80 hours) of accrued vacation leave in each fiscal year. An employee must elect, using forms prescribed by the department, to retain vacation by submitting the form to the employer no later than seven calendar days from the date it is determined that the employee's leave is covered by FMLA. An employee will not be permitted to retain more vacation than is in the employee's vacation bank at the time of election. Once the election is made, it cannot be increased; however, it may be reduced, at any time, to less than 80 hours. An employee will not be eligible to retain any donated leave.

For employees covered by a collective bargaining agreement, the retention of vacation leave will be governed by the collective bargaining agreement.
[**ARC 8265B**, IAB 11/4/09, effective 12/9/09; **ARC 8979B**, IAB 8/11/10, effective 9/15/10; **ARC 0401C**, IAB 10/17/12, effective 11/21/12]

11—63.5(8A) Leave without pay. A permanent or probationary employee, on written request and written approval by the appointing authority, may be granted leave without pay for any reason deemed satisfactory to the appointing authority, subject to the following conditions:

63.5(1) Leave without pay shall not originally be granted for more than 12 consecutive months. Accrued leave need not be exhausted before leave without pay is granted except that accrued sick leave must be exhausted if the reason for leave without pay is due to a medically related disability. The determination to require the exhaustion of any or all accrued leave shall rest with the appointing authority except as provided in subrule 63.5(4). On written request, prior to the expiration of a granted leave, the appointing authority may, in writing, grant an extension of the leave without pay. The approved leave without pay extension may not be for more than an additional 12 consecutive months, unless otherwise approved by the director.

63.5(2) Failure by the employee to report back to work on the date specified in the written request shall be considered a voluntary resignation unless otherwise approved by the appointing authority. A written statement accepting the resignation shall be sent to the employee by the appointing authority and a copy sent to the director.

63.5(3) Employees who do not supplement workers' compensation with sick leave, vacation or compensatory leave, and who are kept on the payroll in a nonpay status for more than 30 calendar days, shall be placed on leave without pay for purposes of probationary periods, pay increase eligibility, and other benefits. A written statement to this effect shall be sent to the employee within three days following the action by the appointing authority.

63.5(4) When requested in writing and verified by the employee's physician or other licensed practitioner, an employee shall be granted sick leave for at least an eight-week period when the purpose is to provide recovery from a medically related disability. If the employee's accrued sick leave is exhausted prior to completion of the eight-week period, the employee shall be granted additional leave, paid or unpaid, for the remainder of the period, in accordance with these rules. The appointing authority may grant leave in excess of the eight-week period. Paid leave shall not be granted in excess of that accrued. At any time during the period of leave, the appointing authority may require that the employee submit written verification of continuing disability from the employee's physician or other licensed practitioner. In addition to the reason listed, subrule 63.5(2) shall also apply under the following circumstances:

a. The employee fails or refuses to supply the requested verification of continued disability.

b. The verification does not clearly show sufficient continuing reason that would prevent the performance of the employee's regular work duties.

c. The employee is shown to be performing work which is incompatible with the purpose for which the leave without pay was granted.

63.5(5) If an employee applies for leave under the Family and Medical Leave Act, any leave without pay under the Family and Medical Leave Act shall run concurrently with the leave granted under this rule.
[**ARC 0401C**, IAB 10/17/12, effective 11/21/12]

11—63.6(8A) Rights upon return from leave.

63.6(1) An employee who is on approved leave without pay, disaster service volunteer leave or educational leave must notify the appointing authority from which the employee is on leave of the intent to exercise return from leave rights. Upon return from leave, the employee shall have the right to return to a vacant position in the class held prior to the leave or to a class in the same pay grade for which the employee qualifies. If a vacant position is not available, the reduction in force provisions of 11—Chapter 60 shall apply. An employee on leave without pay, disaster service volunteer leave, or educational leave may request permission from the appointing authority to return to work sooner than the original

approved leave expiration date. Employees on leave without pay for more than 30 calendar days, except for military leave, shall have their pay increase eligibility date adjusted to a later date which reflects the period of leave without pay.

63.6(2) An employee who elects to separate from employment for purposes of induction into military service shall have the right to return to employment in accordance with 38 U.S.C. Sections 4301-4334. Upon return, the employee's pay increase eligibility date and unused sick leave at the time of separation shall be restored.

63.6(3) At the conclusion of a period of military service, an employee who is on approved military service leave must notify the appointing authority of the intent to return to employment. Upon return from military leave, the employee shall have the right to return to employment in accordance with 38 U.S.C. Sections 4301-4334.

[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—63.7(8A) Compensatory leave. Compensatory leave accrued in accordance with 11—subrule 53.11(5) shall be granted at the request of the employee whenever possible. However, the appointing authority need not grant a request for compensatory leave if granting the leave would cause an undue disruption.

11—63.8(8A) Holiday leave. Holidays shall be granted in accordance with statutory provisions to employees who are eligible to accrue vacation and sick leave.

63.8(1) The value of a holiday for full-time employees shall be eight hours or the number of hours the employee is scheduled to work on that day, whichever is greater. The value of a holiday that falls on a full-time employee's scheduled day off shall be eight hours. Employees who are normally scheduled to work full-time shall not have their holiday compensation prorated for time on leave without pay during the pay period if the employee meets the conditions of subrule 63.8(3).

Compensation for holidays shall be prorated for employees who are normally scheduled to work less than 80 hours in a pay period. Compensation shall be based on the number of hours in pay status during the pay period in which the holiday falls plus the hours that would normally be scheduled for the holiday which shall be included when determining the number of pro-rata holiday hours.

Leave accrued under Iowa Code section 1C.2 as vacation shall be based on the employee's hours in pay status.

Compensation for holidays under this rule shall be either in pay or compensatory leave. The decision to pay or grant compensatory leave shall be made by the appointing authority.

63.8(2) For employees who work Monday through Friday, a holiday falling on Sunday shall be observed on the following Monday and a holiday falling on Saturday shall be observed on the preceding Friday. For all other employees, the designated holiday shall be observed on the day it occurs.

63.8(3) To be eligible for holiday compensation an employee must be in pay status the last scheduled workday before and the first scheduled workday after the holiday.

An employee who separates from employment and whose last day in pay status precedes a holiday shall not be eligible for payment for that holiday.

63.8(4) When the holiday falls on an overtime-covered employee's scheduled workday, and the employee does not get the day off, the employee shall be compensated for the holiday in accordance with subrule 63.8(1) in addition to a premium rate for time worked. The premium rate shall be paid for hours worked during the 24-hour period from 12 a.m. through 11:59 p.m. on the holiday. However, hours compensated at the premium rate shall not be counted as part of the 40 hours when calculating overtime pay.

When the holiday falls on an overtime-covered employee's day off, the employee shall be compensated for the holiday to a maximum of eight hours.

63.8(5) When an overtime exempt employee is required to work on a holiday, the employee may be compensated for the time worked in addition to regular holiday pay at the discretion of the appointing authority. When granted, compensation shall be at the employee's regular rate of pay for all hours worked.

11—63.9(8A) Military leave.

63.9(1) A nontemporary employee who is a member of the uniformed services, when ordered by proper authority to serve in the uniformed services, shall be granted leave without loss of pay for 30 days each calendar year. Absences required for military service shall be in accordance with the rules on vacation, compensatory leave, or leave without pay, 38 U.S.C. Sections 4301-4333, and 20 CFR Part 1002. Military leave may be utilized for up to 30 days in each calendar year. Any amount of military leave taken during any part of an employee's scheduled workday, regardless of the number of hours actually taken, shall count as one day toward the 30 paid day maximum. If the employee's work shift crosses two calendar days, only one day shall count toward the 30 paid day maximum. Work schedule changes shall not be made for the purpose of avoiding payment for military leave.

63.9(2) A nontemporary employee who is ordered by proper authority to military duty as defined in Iowa Code section 29A.28 may elect to be placed on leave without pay or be separated and removed from the payroll.

63.9(3) Nontemporary employees who elect to separate from employment when ordered by proper authority to military duty shall be given 30 days of regular pay in a lump sum with their last paycheck. Any previous paid leave days granted for military service in the current calendar year shall be deducted from this 30 days.

Employees who elect to be placed on leave without pay when ordered by proper authority to military duty shall continue to receive regular pay and benefits for 30 days. Any previous paid leave days granted for military service in the current calendar year shall be deducted from this 30 days.

63.9(4) At the conclusion of military service, the employee must notify the employee's appointing authority of the intent to exercise return rights pursuant to 38 U.S.C. Sections 4301-4344.

63.9(5) An employee taking military leave may use any vacation or compensatory leave that was accrued prior to service. Employees who elect to use vacation or compensatory leave shall continue to receive benefits in accordance with the state of Iowa's benefits program policies and procedures. Upon return to employment, the employee's accrual rate for vacation shall be at the same rate as if the employee had not taken military leave.

63.9(6) An employee may maintain health and dental insurance coverage while on military leave for up to 24 months. The employee is responsible for paying the employee's share of the health and dental insurance premiums if the period of military service is less than 31 days. If more than 30 days, the employee shall be required to pay 102 percent of the full premium under the plan to maintain coverage. Upon return to employment, the employee may elect to have health and dental insurance coverage become effective either on the first day of the month the employee returns to employment or the first day of the month following the month in which the employee returned to employment. Coverage under the plans will not have an exclusion or waiting period upon return to employment. An exclusion or waiting period may be imposed, however, in connection with any illness or injury determined by the Secretary of the U.S. Department of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

63.9(7) A person reemployed under this rule shall be treated as not having incurred a break in service with the employer by reason of such person's period of service in the uniformed services.

[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—63.10(8A) Educational leave. Educational leave, with or without pay, may be granted at the discretion of the appointing authority for the purpose of assisting state employees to develop skills that will improve their ability to perform their present job responsibilities or to provide training and developmental opportunities for employees that will enable the agency to better meet staffing needs. Education financial assistance shall be in accordance with rule 11—64.10(8A).

63.10(1) *Length of leave.* Educational leave shall be requested for a period not to exceed 12 consecutive months. Accrued vacation or compensatory leave need not be exhausted before educational leave is granted. The determination to require the exhaustion of any or all accrued leave shall rest with the appointing authority. The appointing authority may grant an extension of the original leave for an additional 12 months.

63.10(2) *Selection of applicants.* While the selection of applicants is at the discretion of the appointing authority, it is the express policy of the state to offer all qualified employees an equal opportunity to be considered for educational leave within the limitations imposed by agency staffing requirements.

63.10(3) *Educational institutions.* An employee on educational leave may take course work at any accredited educational institution within the state. Attendance at out-of-state institutions may be approved provided there are geographical or educational considerations which make attendance at institutions within the state impractical.

63.10(4) *Agency report.* Rescinded IAB 5/27/15, effective 7/1/15.

[**ARC 8265B**, IAB 11/4/09, effective 12/9/09; **ARC 2000C**, IAB 5/27/15, effective 7/1/15]

11—63.11(8A) Election leave. An employee who is not covered by the federal Hatch Act and who becomes a candidate for paid, partisan elective office shall, upon the employee's request, be granted leave 30 calendar days before a contested primary, special, or general election. The employee may choose to use accrued vacation or compensatory leave, or leave without pay to cover these periods.

An employee who is elected to a paid, partisan office or appointed to an elective paid, partisan office shall, upon written request to the appointing authority, be granted leave to serve in that office, except where prohibited by federal law. The use of accrued vacation or compensatory leave, or leave without pay to cover this period shall be at the discretion of the employee. The leave provided for in this rule need not exceed six years. An employee shall not be prohibited from returning to employment before the expiration of the period for which the leave was granted.

11—63.12(8A) Court appearances and jury duty. When in obedience to a subpoena, summons, or direction by proper authority, an employee appears as a witness or a jury member in any public or private litigation in which the employee is not a party to the proceedings, the employee shall be entitled to time off during regularly scheduled work hours with regular compensation, provided the employee gives to the appointing authority any payments received for court appearance or jury service, other than reimbursement for necessary travel or personal expenses. If the employee is directed to appear as a witness by the appointing authority, all time spent shall be considered to be worktime.

63.12(1) Hours spent on court or jury leave by an employee outside the employee's scheduled work hours are not subject to this rule, nor shall any payments received for court appearance or jury service be remitted to the appointing authority.

63.12(2) The employee shall notify the appointing authority immediately upon receipt of a subpoena, summons, or direction by proper authority to appear.

63.12(3) An employee may be required to report to work if there will be at least two hours in the workday, following necessary travel time, during which the employee is not needed for jury service or as a witness.

63.12(4) Upon return to work, the employee shall present evidence to the appointing authority of any payments received for court appearance or jury service.

11—63.13(8A) Voting leave. An employee who is eligible to vote in a public election in the state of Iowa may request time off from work with regular pay for a period not to exceed three hours for the purpose of voting. Leave shall be granted only to the extent that the employee's work hours do not allow a period of three consecutive hours outside the employee's scheduled work hours during which the voting polls are open.

A request for voting leave must be made to the appointing authority on or before the employee's last scheduled shift prior to election day. The time to be taken off shall be designated by the appointing authority.

11—63.14(8A) Disaster service volunteer leave. Subject to the approval of the appointing authority, an employee who is a certified disaster service volunteer for the American Red Cross may, at the request of the American Red Cross, be granted leave with pay to participate in disaster relief services relating to a disaster in the state of Iowa. Such leave shall be only for hours regularly scheduled to work and shall

not be for more than 15 workdays in a fiscal year. Employees granted such leave shall not lose any rights or benefits of employment while on such leave. An employee while on leave under this rule shall not be deemed to be an employee of the state for the purposes of workers' compensation or for the purposes of the Iowa tort claims Act.

11—63.15(8A) Absences due to emergency conditions. When a proper management authority closes a state office or building or directs employees to vacate a state office or building premises, employees may elect to use compensatory leave, vacation, or leave without pay to cover the absence. Employees may, with the approval of the appointing authority, elect to work their scheduled hours even though the state office or building is closed to the general public. Employees may, with the approval of the appointing authority, be permitted to make up lost time within the same workweek.

Employees who are unable to report to work as scheduled or who choose to leave work due to severe weather or other emergency conditions may, with the approval of the appointing authority, use compensatory leave, vacation, or leave without pay to cover the absence.

11—63.16(8A) Particular contracts governing. Where provisions of collective bargaining agreements differ from the provisions of this chapter, the provisions of the collective bargaining agreements shall prevail for the employees covered by those agreements.

11—63.17(8A) Examination and interviewing leave.

63.17(1) Employees may be granted leave to take examinations for positions covered by merit system provisions. Employees may elect to use vacation leave, compensatory leave, or leave without pay at the discretion of the appointing authority.

63.17(2) Employees may be granted the use of paid work time to attend interviews during scheduled work hours for jobs within their agency. For agencies that have statewide operations, the appointing authority may restrict the use of paid time to interviews within the central office, institution, county, region, or district office. A reasonable time limit for interviews may be designated by the appointing authority. Employees may be granted leave for interviews outside the agency, central office, institution, county, region, or district office in which case they may elect to use vacation leave, compensatory leave, or leave without pay at the discretion of the appointing authority.

63.17(3) Appointing authorities shall post and make known to employees the provisions of this rule.

11—63.18(8A) Service on committees, boards, and commissions. State employees who are appointed to serve on committees, boards, commissions, or similar appointments for Iowa state government shall be entitled to regular compensation for such service. Employees shall be paid in accordance with these rules for time spent.

Pursuant to Iowa Code section 70A.1, employees shall not be entitled to additional compensation for such service.

Employees shall have actual and necessary expenses paid.

Employees shall notify the appointing authority at the time of the appointment.

11—63.19(8A) Donated leave for catastrophic illnesses of employees and family members. Employees are eligible to donate or receive donated leave hours for catastrophic illnesses of the employee or an immediate family member. Contributions shall be designated as "donated leave" and shall be subject to the rules, policies and procedures of the department.

63.19(1) *Definitions:*

"Catastrophic illness" means a physical or mental illness or injury of the employee, as certified by a licensed physician, that will result in the inability of the employee to work for more than 30 workdays on a consecutive or intermittent basis; or that will result in the inability of the employee to report to work for more than 30 workdays due to the need to attend to an immediate family member on a consecutive or intermittent basis.

"Donated leave" means vacation leave (hours) donated to employees as a monetary benefit only. Recipient employees will not accrue vacation or sick leave benefits on donated leave hours.

"Employee" means a full-time or part-time executive branch employee who is eligible to accrue vacation.

"Immediate family member" means the employee's spouse, parent, son, or daughter, as defined in the federal Family and Medical Leave Act.

63.19(2) *Program eligibility for employee illness.* In order to receive donated leave for a catastrophic illness, an employee must:

a. Have a catastrophic illness as defined by subrule 63.19(1); and

b. Have exhausted all paid leave; and

c. Not be supplementing workers' compensation to the extent that it exceeds more than 100 percent of the employee's pay for the employee's regularly scheduled work hours on a pay-period-by-pay-period basis; and

d. Not be receiving long-term disability benefits; and

e. Be approved for and using or have exhausted Family and Medical Leave Act (FMLA) leave hours if eligible; and

f. Be on approved leave without pay for medical reasons during any hours for which the employee will receive donated leave.

63.19(3) *Program eligibility for immediate family member illness.* In order to receive donated leave for a catastrophic illness of an immediate family member, the immediate family member must have a catastrophic illness as defined in subrule 63.19(1). The employee must:

a. Have exhausted all paid leave for which eligible; and

b. Be approved for and using or have exhausted Family and Medical Leave Act leave hours if eligible; and

c. Be on approved leave without pay for the medical reasons of an immediate family member during any hours for which the employee will receive donated leave.

63.19(4) *Certification requirements.* The employee shall submit an application for donated leave on forms developed by the department. Appointing authorities may, at their department's expense, seek second medical opinions or updates from physicians regarding the status of an employee's or employee's immediate family member's illness or injury. If the employee is receiving FMLA leave, a second opinion must be obtained from a physician who is not regularly employed by the state.

63.19(5) *Program requirements.*

a. Vacation hours shall be donated in whole-hour increments; however, they may be credited to the recipient in other than whole-hour increments. All of the recipient's accrued leave must be used before donations will be credited to the recipient. Hours will be credited in increments not to exceed the employee's regularly scheduled work hours on a pay-period-by-pay-period basis. Recipients will not accrue vacation and sick leave on donated leave hours.

b. Approval of use of donated leave shall be for a period not to exceed one year either on an intermittent or continuous basis for each occurrence.

c. Donated leave shall be irrevocable after it is credited to the recipient. Donated hours not credited to the recipient will not be deducted from the donor's vacation leave balance. Donated leave shall be credited on a first-in/first-out basis.

d. Donated leave for catastrophic illness will not restrict the right to terminate probationary employees. The period of probationary status and the pay increase eligibility date, if in excess of 30 days, will be extended by the amount of time the employee received donated leave.

e. Appointing authorities shall post a form developed by the department indicating that the employee is eligible to receive donated leave and the name of the person to contact for the donation. The appointing authority is not responsible for posting outside the employing department; however, donated leave hours can be received from executive branch employees outside the employing department.

f. Leave without pay rules and procedures shall apply to the following benefits: health, dental, life, and long-term disability insurances; pretax; deferred compensation; holiday pay, sick leave and vacation leave accrual, shift differential pay, longevity pay and cash payments. In addition, employees receiving donated leave for catastrophic illness for themselves or their immediate family member will not be eligible for leadworker pay, extraordinary duty pay or special duty pay. If FMLA leave and donated

leave for a catastrophic illness are used concurrently, the state is obligated to pay its share of health and dental insurance premiums. The state also maintains an employee's basic life and long-term disability insurances during periods of FMLA leave.

g. Employees may choose to continue or terminate optional deductions (e.g., miscellaneous insurance, savings bonds, charitable contributions, or credit union deductions) while using donated leave. Mandatory deductions are taken from gross pay first, then optional deductions as funds are available and as authorized by the employee. Union dues deductions will continue as long as the employee has sufficient earnings to cover the dollar amount certified to the employer after deductions for social security, federal taxes, state taxes, retirement, health and dental insurance, and life insurance.

h. Contributions to the employee's dependent care account will not be allowed during a period of leave without pay. Claims will not be paid for dependent care while an employee is on leave without pay.

i. If an employee applies for and is approved to receive long-term disability, the employee may continue to receive leave contributions for up to one year on an intermittent or continuous basis or the effective date of the employee's long-term disability, whichever comes first. Donated leave hours not used are not credited to the recipient and are not deducted from the donor's vacation leave balance.

11—63.20(8A,70A) Bone marrow and organ donation leave. Employees, excluding employees covered by a collective bargaining agreement that provides otherwise, shall be granted leave pursuant to Iowa Code section 70A.39. An employee who is granted a leave of absence under Iowa Code section 70A.39 shall receive leave without loss of seniority, pay, vacation time, personal days, sick leave, insurance and health coverage benefits, or earned overtime accumulation. The employee shall be compensated at the employee's regular rate of pay for those regular work hours during which the employee is absent from work. An employee deemed to be on leave under Iowa Code section 70A.39 shall not be deemed to be an employee of the state for purposes of workers' compensation or for purposes of the Iowa tort claims Act.

[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

These rules are intended to implement Iowa Code section 8A.413 and Iowa Code chapter 70A.

[Filed 11/5/70; amended 4/14/71, 5/1/71, 8/18/71, 12/23/71, 5/10/72, 9/13/72, 10/11/72, 8/16/73, 7/26/74, 5/19/75]

[Amendment filed 9/4/75, Notice 7/28/75—published 9/22/75, effective 10/27/75; emergency amendment filed and effective 10/20/75—published 11/3/75]

[Emergency amendment filed and effective 11/4/75—published 11/3/75]

[Filed 1/19/76, Notice 11/17/75—published 2/9/76, effective 3/15/76]

[Filed 4/23/76, Notice 3/8/76—published 5/17/76, effective 6/21/76]

[Filed 8/2/76, Notice 6/28/76—published 8/9/76, effective 9/13/76]

[Filed 9/16/76, Notice 8/9/76—published 10/6/76, effective 11/10/76]

[Filed 2/1/78, Notice 12/28/77—published 2/22/78, effective 3/29/78]

[Filed 8/2/78, Notice 6/28/78—published 8/23/78, effective 9/27/78]

[Filed 10/17/78, Notice 8/9/78—published 11/15/78, effective 12/20/78]

[Filed 8/1/79, Notice 6/13/79—published 8/22/79, effective 9/26/79]

[Filed 10/12/79, Notice 8/22/79—published 10/31/79, effective 12/5/79]

[Filed 10/26/79, Notice 9/19/79—published 11/14/79, effective 12/20/79]

[Filed 7/6/81, Notice 4/15/81—published 7/22/81, effective 8/26/81]

[Filed 12/3/82, Notice 10/13/82—published 12/22/82, effective 1/26/83][1]

[Filed emergency 6/29/84—published 7/18/84, effective 7/1/84]

[Filed 8/24/84, Notice 7/18/84—published 9/12/84, effective 10/17/84]

[Filed 11/30/84, Notice 9/26/84—published 12/19/84, effective 1/23/85]

[Filed 3/22/85, Notice 10/24/84—published 4/10/85, effective 5/15/85]

[Filed 7/26/85, Notice 5/22/85—published 8/14/85, effective 9/18/85]

[Filed 12/3/85, Notice 10/9/85—published 12/18/85, effective 1/22/86]

[Filed 12/13/85, Notice 10/9/85—published 1/1/86, effective 2/5/86]

[Filed 10/17/86, Notice 8/13/86—published 11/5/86, effective 12/10/86]
[Filed 7/24/87, Notice 6/17/87—published 8/12/87, effective 9/16/87]
[Filed 2/18/88, Notice 1/13/88—published 3/9/88, effective 4/13/88]
[Filed 4/29/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 10/26/88]
[Filed 10/27/88, Notice 9/21/88—published 11/16/88, effective 12/21/88]
[Filed 3/29/89, Notice 2/8/89—published 4/19/89, effective 5/26/89]
[Filed 7/7/89, Notice 5/17/89—published 7/26/89, effective 9/1/89]
[Filed 9/29/89, Notice 8/23/89—published 10/18/89, effective 11/24/89]
[Filed 2/1/90, Notice 12/13/89—published 2/21/90, effective 3/30/90]
[Filed 2/1/91, Notice 12/12/90—published 2/20/91, effective 3/29/91]
[Filed 5/23/91, Notice 4/17/91—published 6/12/91, effective 7/19/91]
[Filed 3/26/93, Notice 2/17/93—published 4/14/93, effective 5/19/93]
[Filed emergency 8/5/93—published 9/1/93, effective 8/5/93]
[Filed emergency 7/18/95—published 8/16/95, effective 7/18/95]
[Filed 12/12/96, Notice 10/23/96—published 1/15/97, effective 2/19/97]
[Filed 8/12/99, Notice 6/16/99—published 9/8/99, effective 10/13/99]
[Filed emergency 6/21/01 after Notice 5/16/01—published 7/11/01, effective 6/22/01]
[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]
[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]
[Filed 5/20/05, Notice 4/13/05—published 6/22/05, effective 7/27/05]
[Filed without Notice 5/5/06—published 5/24/06, effective 7/1/06]
[Filed ARC 8265B (Notice ARC 8115B, IAB 9/9/09), IAB 11/4/09, effective 12/9/09]
[Filed ARC 8979B (Notice ARC 8781B, IAB 6/2/10), IAB 8/11/10, effective 9/15/10]
[Filed ARC 0401C (Notice ARC 0180C, IAB 6/27/12), IAB 10/17/12, effective 11/21/12]
[Filed ARC 1568C (Notice ARC 1503C, IAB 6/11/14), IAB 8/6/14, effective 9/10/14]
[Filed ARC 2000C (Notice ARC 1936C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[1] Effective date of subrule 14.2(12) delayed 70 days by Administrative Rules Review Committee. Delay lifted by Committee on 2/8/83.

CHAPTER 64
BENEFITS

[Prior to 8/15/86; See Deferred Compensation Program, 270—Ch 4]
[Prior to 1/7/04, see 581—Ch 15]

11—64.1(8A) Health benefits. The director is authorized by the executive council of Iowa to administer health benefit programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A. The executive council of Iowa shall determine the amount of the state's contribution toward each individual non-contract-covered employee's premium cost and shall authorize the remaining premium cost to be deducted from the employee's pay. The state's contribution for each contract-covered employee shall be as provided for in collective bargaining agreements negotiated in accordance with Iowa Code chapter 20.
[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—64.2(8A) Dental insurance. The director is authorized by the executive council of Iowa to administer dental insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A.
[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—64.3(8A) Life insurance. The director is authorized by the executive council of Iowa to administer life insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A, except for employees of the board of regents.
[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—64.4(8A) Long-term disability insurance. The director is authorized by the executive council of Iowa to administer long-term disability insurance programs for employees of the state of Iowa who are covered under Iowa Code chapter 509A, except for employees of the board of regents.

Employees who receive loss of time benefits under the state workers' compensation program shall have those benefits, except for benefits designated as medical costs pursuant to Iowa Code section 85.27 and that portion of benefits paid as attorneys' fees approved pursuant to Iowa Code section 86.39, deducted from any state long-term disability benefits received where the workers' compensation injury or illness was a substantial contributing factor to the award of long-term disability benefits. Disability benefit payments will be further reduced by primary and family social security payments as determined at the time social security disability payments commence, railroad retirement disability income, and any other state-sponsored sickness or disability benefits payable.
[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—64.5(8A) Health benefit appeals. A member who disagrees with a group health benefit company's decision on the application of group contract benefits may:

1. File a written appeal with the respective company as defined in the group contract, or
2. File a written appeal with the commissioner of insurance at the department of commerce.

11—64.6(8A) Deferred compensation.

64.6(1) *Definitions.* The following definitions shall apply when used in this rule:

"Account" means any fixed annuity contract, variable annuity contract, life insurance contract, documents evidencing mutual funds, variable or guaranteed investments, or combination thereof provided for in the plan.

"Beneficiary" means the person or estate entitled to receive benefits under the plan following the death of the participant.

"Director" means the director of the Iowa department of administrative services.

"Employee" means a nontemporary (permanent full-time or permanent part-time) employee of the employer, including full-time elected officials and members of the general assembly, except employees of the board of regents. For the purposes of enrollment, elected officials-elect and members-elect of

the general assembly shall be considered employees. Persons in a joint employee relationship with the employer shall not be considered employees eligible to participate in the plan.

"Employer" means the state of Iowa and any other governmental employer that participates in the plan. Effective July 1, 2003, "employer" shall also include any governmental entity located within the state of Iowa that enters into an agreement to allow its employees to participate in the plan.

"Fiduciary" means a person or company that manages money or property for another and that must exercise the standard of care imposed by law or contract. For the purpose of these rules, "fiduciary" means the trustee, the plan administrator, investment providers, and the persons they designate to carry out or help carry out their duties or responsibilities as fiduciaries under the plan.

"Governing body" means the executive council of the state of Iowa.

"Group" means one or more employees.

"Investment provider" means a company authorized under this rule to issue an account or administer the records of such an account or accounts under the deferred compensation plan authorized by Iowa Code section 509A.12 and 2003 Iowa Code Supplement section 8A.402.

"Normal retirement age" means 65 years of age, unless an employee declares a different age pursuant to the plan's catch-up provision. The age cannot be earlier than a year in which the employee is eligible to receive retirement benefits without an age reduction penalty from the employer-sponsored retirement plan.

"Participating employee" or *"participant"* means any employee or former employee of the employer who is currently deferring or who has previously deferred compensation under the plan and who retains the right to benefits under the plan.

"Plan" means the state of Iowa employee contribution plan for deferred compensation as authorized by Internal Revenue Code Section 457, Iowa Code section 509A.12, and 2003 Iowa Code Supplement section 8A.434.

"Plan administrator" means the designee of the director who is authorized to administer the plan.

"Plan year" means a calendar year.

"Retirement investors' club" means the voluntary retirement savings program for employees designed to increase personal long-term savings. The program contains three plans, the 457 employee contributions plan, the 401(a) employer contribution plan, and the 403(b) tax-sheltered annuity plan.

"Trust" means the Iowa state employee deferred compensation trust fund created in the state treasury and under the control of the department.

"Trustee" means the director of the Iowa department of administrative services.

64.6(2) *Plan administration.*

a. Director's authorization. The director is authorized by the governing body to administer a deferred compensation program for eligible employees and to enter into contracts and service agreements with deferred compensation investment providers for the benefit of eligible employees and on behalf of the state of Iowa and other eligible employers. This rule shall govern all investment options and participant activity for the funds placed in the program.

b. Plan modification. The trustee may at any time amend, modify, or terminate the plan without the consent of the participant (or any beneficiary thereof). The plan administrator shall provide to participating employees and investment providers sufficient notice of all amendments to the plan. No amendment shall deprive participants of any of the benefits to which they are entitled under the plan with respect to deferred amounts credited to their accounts before the effective date of the amendment. If the plan is curtailed or terminated, or the acceptance of additional deferred amounts is suspended permanently, the plan administrator shall nonetheless be responsible for the supervision of the payment of benefits resulting from amounts deferred before the amendment, modification, or termination. Payment of benefits will be deferred until the participant would otherwise have been entitled to a distribution pursuant to the provisions of the plan.

c. Location of account documentation. The investment providers shall send the original annuity policies, contracts or account forms to the plan administrator. Failure to do so may result in termination of an investment provider's contract or service agreement. The plan administrator shall keep all such original documents. Participating employees may review their own documentation during normal work

hours at the department, but may not under any circumstances remove the documentation from the premises.

d. Not an employment contract. Participation in this plan by an employee shall not be construed to give a contract of employment to the participant or to alter or amend an existing employment contract of the participant, nor shall participation in this plan be construed as affording to the participant any representation or guarantee regarding the participant's continued employment.

e. Tax relief not guaranteed. The employer, trustee, and the investment providers do not represent or guarantee that any particular federal or state of Iowa income, payroll, personal property or other tax consequences will result because of the participant's participation in the plan. The participant is obligated to consult with the participant's own tax representative regarding all questions of federal or state of Iowa income, payroll, personal property or other tax consequences arising from participation in the plan.

f. Investment agents. The investment providers shall, subject to the trustee's consent, have the power to appoint agents to act for the investment providers in the administration of accounts according to the terms, conditions, and provisions of their contracts or service agreements with the plan. Investment providers are responsible for the conduct of their agents, including their adherence to the plan document and administrative rules. The plan administrator may require an investment provider to remove the authority of any agent to provide services to the plan or plan participants when cause has been shown that the agent has violated these rules or state or federal law or regulation related to the governance of the plan or agent conduct.

g. Plan expenses. Expenses incurred by the plan administrator while administering the plan, including fees and expenses approved by the plan trustee for investment advisory, custodial, record-keeping, and other plan administration and communication services, and any other reasonable and necessary expenses or charges allocable to the plan that have been incurred for the exclusive benefit of plan participants and that have been approved by the plan trustee may be charged to the short-term interest that has accrued in the deferred compensation trust fund created by Iowa Code section 8A.434 prior to the allocation of funds to a participant's chosen investment provider. Such expenses may also be funded from fees assessed to eligible employers who choose to offer the plan to their employees.

h. Time periods. As necessary or desirable to facilitate the proper administration of the plan and consistent with the requirements of Section 457 of the Internal Revenue Code (IRC), the plan administrator may modify the time periods during which a participating employee or beneficiary is required to make any election under the plan, and the time periods for processing these elections by the plan administrator, including the making or amending of a deferral agreement, the making or amending of investment provider selections, the election of distribution commencement dates or distribution methods.

i. Supplementary information and procedures. Any explanatory brochures, pamphlets, or notices distributed by the plan shall be distributed for information purposes only and shall not override any provision of the plan or give any person any claim or right not provided for under the plan. In the event any form or other document used in administering the plan, including but not limited to enrollment forms and marketing materials, conflicts with the terms of the plan, the terms of the plan shall prevail.

j. Binding plan. The plan, and any properly adopted amendments, shall be binding on the parties and their respective heirs, administrators, trustees, successors and assignees and on all beneficiaries of the participant.

64.6(3) *Rights of participating employees.*

a. Exclusive benefit. The trustee shall hold the assets and income of the plan for the exclusive benefit of the participating employee or the participating employee's beneficiary.

b. Creditors. The accounts of a participating employee under the plan shall not be subject to creditors of the participating employee or the participant's beneficiary and shall be exempt from execution, attachment, prior assignment, or any other judicial relief, or order for the benefit of creditors or other third persons.

c. Designation of beneficiary. Upon enrollment, a participating employee must designate a beneficiary or beneficiaries. An employee who has an open account with an investment provider that is no longer able to open new accounts may change the employee's designated beneficiary or beneficiaries

at any time thereafter by providing the plan administrator with written notice of the change on the form prescribed by the plan administrator. An employee who has an open account with an investment provider that is able to open new accounts may change the employee's designated beneficiary or beneficiaries at any time thereafter by completing the investment provider's beneficiary change form.

d. Assignment. Neither a participating employee, nor the participating employee's beneficiary, nor any other designee shall have the right to commute, sell, assign, transfer, borrow, alienate, use as collateral or otherwise convey the right to receive any payments.

64.6(4) *Trust provisions.*

a. Investment options. The trustee shall adopt various investment options for the investment of deferred amounts by participating employees or their beneficiaries and shall monitor and evaluate the appropriateness of the investment options offered by the plan.

b. Designation of fiduciaries. The trustee, the plan administrator, and the persons they designate to carry out or help carry out their duties or responsibilities are fiduciaries under the plan. Each fiduciary has only those duties or responsibilities specifically assigned to fiduciaries under the plan, contractual relationship, trust, or as delegated to fiduciaries by another fiduciary. Each fiduciary may assume that any direction, information, or action of another fiduciary is proper and need not inquire into the propriety of any such action, direction, or information. No fiduciary will be responsible for the malfeasance, misfeasance, or nonfeasance of any other fiduciary, except where the fiduciary participated in such conduct, or knew or should have known of such conduct in the discharge of the fiduciary's duties under the plan and did not take reasonable steps to compel the cofiduciary to redress the wrong.

c. Fiduciary standards.

(1) All fiduciaries shall discharge their duties with respect to the plan and trust solely in the interest of the participating employees and their beneficiaries and in accordance with Iowa Code section 633.123. Such duties shall be discharged for the exclusive purpose of providing benefits to the participating employees and beneficiaries and, if determined applicable, defraying expenses of the plan.

(2) The investment providers shall discharge their duties with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims and as defined by applicable Iowa law.

d. Trustee powers and duties. The trustee may exercise all rights or privileges granted by the provisions of the plan and trust and may agree to any alteration, modification or amendment of the plan. The trustee may take any action respecting the plan or the benefits provided under the plan that the trustee deems necessary or advisable. Persons dealing with the trustee shall not be required to inquire into the authority of the trustee with regard to any dealing in connection with the plan. The trustee may employ persons, including attorneys, auditors, investment advisors or agents, even if they are associated with the trustee, to advise or assist, and may act without independent investigation upon their recommendations. Instead of acting personally, the trustee may employ one or more agents to perform any act of administration, whether or not discretionary.

e. Trust exemption. This trust is intended to be exempt from taxation under IRC Section 501(a) and is intended to comply with IRC Section 457(g). The trustee shall be empowered to submit or designate appropriate agents to submit the plan and trust to the IRS for a determination of the eligibility of the plan under IRC Section 457, and the exempt status of the trust under IRC Section 501(a), if the trustee concludes that such a determination is desirable.

f. Held in trust. Notwithstanding any contrary provision of the plan, in accordance with IRC Section 457(g), all amounts of compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in trust for the exclusive benefit of participants and beneficiaries under the plan. Any trust under the plan shall be established pursuant to a written agreement that constitutes a valid trust under the law of the state of Iowa. All plan assets shall be held under one or more of the following methods:

(1) Compensation deferred under the plan shall be transferred to a trust established under the plan within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, compensation deferred under the plan shall be transferred

to a trust established under the plan not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

(2) Notwithstanding any contrary provision of the plan, including any annuity contract issued under the plan, in accordance with IRC Section 457(g), compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in one or more annuity contracts, as defined in IRC Section 401(g), issued by an insurance company qualified to do business in the state where the contract was issued, for the exclusive benefit of participants and beneficiaries under the plan or held in a custodial account as described in subparagraph (3) below. For this purpose, the term "annuity contract" does not include a life, health or accident, property, casualty, or liability insurance contract. Amounts of compensation deferred under the plan shall be transferred to an annuity contract described in IRC Section 401(f) within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, amounts of compensation deferred under the plan shall be transferred to a contract described in IRC Section 401(f) not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

(3) Notwithstanding any contrary provision of the plan, in accordance with IRC Section 457(g), compensation deferred pursuant to the plan, all property and rights purchased with such amounts, and all income attributable to such amounts, property, or rights shall be held in one or more custodial accounts for the exclusive benefit of participants and beneficiaries under the plan or held in an annuity contract as described in subparagraph (2) above. For purposes of this subparagraph, the custodian of any custodial account created pursuant to the plan must be a bank, as described in IRC Section 408(n), or a person who meets the nonbank trustee requirements of Treasury Regulations Section 1.408-2(e)(2) to (6) relating to the use of nonbank trustees.

Amounts of compensation deferred under the plan shall be transferred to a custodial account described in IRC Section 401(f) within a period that is not longer than is reasonable for the proper administration of the accounts of participants. To comply with this requirement, amounts of compensation deferred under the plan shall be transferred to a custodial account described in IRC Section 401(f) not later than 15 business days after the end of the month in which the compensation would otherwise have been paid to the employee.

64.6(5) *Absolute safeguards of the employer, trustee, their employees, and agents.*

a. Questions of fact. The trustee and the plan administrator are authorized to resolve any questions of fact necessary to decide the participating employee's rights under the plan. An appeal of a decision of the plan administrator shall be made to the trustee, or the trustee's designee, who shall render a final decision on behalf of the plan.

b. Plan construction. The trustee and the plan administrator are authorized to construe the plan and to resolve any ambiguity in the plan and to apply reasonable and fair procedures for the administration of the plan. An appeal of a decision of the plan administrator shall be made to the trustee, or the trustee's designee, within 30 days of the plan administrator's decision. The trustee, or the trustee's designee, shall render a final decision on behalf of the plan.

c. No liability for loss. The participating employee specifically agrees that the employer, the plan, the trustee, the plan administrator, or any other employee or agent of the employer shall not be liable for any loss sustained by the participating employee or the participating employee's beneficiary for the nonperformance of duties, negligence, or any other misconduct of the above-named persons except that this paragraph shall not excuse malicious or wanton misconduct.

d. Payments suspended. The trustee, plan administrator, investment providers, their employees and agents, if in doubt concerning the correctness of their actions in making a payment of a benefit, may suspend the payment until satisfied as to the correctness of the payment or the identity of the person to receive the payment, or until the filing of an administrative appeal under Iowa Code chapter 17A, and thereafter in any state court of competent jurisdiction, a suit in such form as they consider appropriate for a legal determination of the benefits to be paid and the persons to receive them.

e. Court costs. The employer, the plan, the trustee, the plan administrator, their employees and agents are hereby held harmless from all court costs and all claims for the attorneys' fees arising from

any action brought by the participating employee, or any beneficiary thereof, under the plan or to enforce their rights under the plan, including any amendments of the plan.

64.6(6) *Eligibility.* Except employees of the board of regents, any nontemporary executive, judicial or legislative branch employee, or employee of a governmental employer that enters into an agreement to join the plan, who is regularly scheduled for 20 or more hours of work per week or who has a fixed annual salary is eligible to defer compensation under this rule. An elected official-elect and elected members-elect of the general assembly are also eligible provided that deductions meet the requirements set forth in the plan. Final determination on eligibility shall rest with the plan administrator.

64.6(7) *Communications.*

a. Forms. All enrollments, elections, designations, applications and other communications by or from an employee, participant, beneficiary, or legal representative of any such person regarding that person's rights under the plan shall be made in the form and manner established by the plan administrator and shall be deemed to have been made and delivered only upon actual receipt by the person designated to receive such communication. The employer or the plan shall not be required to give effect to any such communication that is not made on the prescribed form and in the prescribed manner and that does not contain all information called for on the prescribed form.

b. Notices mailed. All notices, statements, reports, and other communications from the plan to any employee, participant, beneficiary, or legal representative of any such person shall be deemed to have been duly given when delivered to, or when mailed by first-class mail to, such person at that person's last mailing address appearing on the plan records.

64.6(8) *Disposition of funds while employed.*

a. Unforeseeable emergency. A participating employee may request that the plan administrator allow the withdrawal of some or all of the funds held in the participating employee's account based on an unforeseeable emergency. Forms must be completed and returned to the plan administrator for review in order to consider a withdrawal request. The plan administrator shall determine whether the participating employee's request meets the definition of an unforeseeable emergency as provided for in federal regulations. In addition to being extraordinary and unforeseeable, an unforeseeable emergency must not be reimbursable:

(1) By insurance or otherwise;

(2) By liquidation of the participating employee's assets, to the extent the liquidation of such assets would not itself cause severe financial hardship; or

(3) By cessation of deferrals under the plan.

Upon the plan administrator's approval of an unforeseeable emergency distribution, the participating employee will be required to stop current deferrals for a period of no less than six months.

A participating employee who disagrees with the initial denial of a request to withdraw funds on the basis of an unforeseeable emergency may request that the trustee or the trustee's designee reconsider the request by submitting additional written evidence of qualification or reasons why the request for withdrawal of funds from the plan should be approved. All such requests must be in writing and be received by the trustee, or the trustee's designee, within 30 calendar days of the date of the initial denial. Requests received after 30 days will be rejected as untimely, and the initial denial shall become final agency action.

b. Voluntary in-service distribution. A participant who is an active employee of an eligible employer shall receive a distribution of the total amount payable to the participant under the plan if the following requirements are met:

(1) The total amount payable to the participant under the plan does not exceed $5,000 (or the dollar limit under IRC Section 411(a)(11), if greater);

(2) The participant has not previously received an in-service distribution of the total amount payable to the participant under the plan;

(3) No amount has been deferred under the plan with respect to the participant during the two-year period ending on the date of the in-service distribution; and

(4) The participant elects to receive the distribution.

The plan administrator may also elect to distribute the accumulated account value of a participant's account without consent, if the above criteria are met.

This provision is available only once in the lifetime of the participating employee. If funds are distributed under this provision, the participating employee is not eligible under the plan to utilize this provision at any other time in the future.

c. Transfers under domestic relations orders.

(1) To the extent required under a final judgment, decree, or order (including approval of a property settlement agreement) made pursuant to a state domestic relations law, any portion of a participating employee's account may be paid or set aside for payment to a spouse, former spouse, or child of the participating employee. The plan will determine whether the judgment, decree, or order is valid and binding on the plan and whether it is issued by a court or agency with jurisdiction over the plan. The judgment, decree or order must specify which of the participating employee's accounts are to be paid or set aside, the valuation date of the accounts and, to the extent possible, the exact value of the accounts. Where necessary to carry out the terms of such an order, a separate account shall be established with respect to the spouse, former spouse, or child who shall be entitled to choose investment providers in the same manner as the participating employee. Unless otherwise subsequently suspended or altered by federal law, all applicable taxes shall be withheld and paid from this lump sum distribution. The provisions of this subparagraph shall not be construed to authorize any amount to be distributed under the plan at a time or in a form that is not permitted under IRC Section 457.

(2) A right to receive benefits under the plan shall be reduced to the extent that any portion of a participating employee's account has been paid or set aside for payment to a spouse, former spouse, or child pursuant to these rules or to the extent that the employer or the plan is otherwise subject to a binding judgment, decree, or order for the attachment, garnishment, or execution of any portion of any account or of any distributions therefrom. The participating employee shall be deemed to have released the employer and the plan from any claim with respect to such amounts in any case in which:

1. The department, the retirement investors' club, or the plan has been served with legal process or otherwise joined in a proceeding relating to such amounts,

2. The participating employee has been notified of the pendency of such proceeding in the manner prescribed by the law of the jurisdiction in which the proceeding is pending for service of process or by mail from the employer or a plan representative to the participating employee's last-known mailing address, and

3. The participating employee fails to obtain an order of the court in the proceeding relieving the employer and the plan from the obligation to comply with the judgment, decree, or order.

(3) The department, the retirement investors' club or the plan shall not be obligated to incur any cost to defend against or set aside any judgment, decree, or order relating to the division, attachment, garnishment, or execution of the participating employee's account or of any distribution therefrom.

64.6(9) *Investment providers.*

a. Participation. The investment providers under the plan are authorized to offer new accounts and investment products to employees only if awarded a contract or service agreement through a competitive bid process. A list of active investment providers shall be provided, upon request, to any employee or other interested party. Inactive investment providers shall participate to the extent necessary to fully discharge their duties under the applicable federal and state laws and regulations, the plan, their service agreements or contracts with the employer, and their investment accounts or contracts with participating employees.

b. Investment products. Investment products shall be limited to those that have been approved by the plan administrator. No new accounts shall be available to employees for life insurance under the plan.

c. Reports and consolidated statements. The investment providers will provide various reports to the plan administrator as well as consolidated statements, newsletters, and performance reports to participants as specified in the service agreements or contracts with investment providers.

d. Dividends and interest. The only dividend or interest options available on policies or funds are those where the dividend or interest remains within the account to increase the value of the account.

e. Minimum contract requirements. In addition to meeting selection requirements, an investment provider must meet and maintain the requirements set forth in its contract or service agreement with the state of Iowa.

f. Removal from participation. Failure to comply with the provisions of these rules, the investment provider contract or service agreement with the employer, or the terms and conditions of the investment provider account with the participating employee may result in termination of an investment provider contract or service agreement, and all rights therein shall be exercised by the employer.

64.6(10) *Marketing and education.*

a. Orientation and information meetings. Employers may hold orientation and information meetings for the benefit of their employees during normal work hours using materials developed and approved by the plan administrator. Active investment providers may make authorized presentations upon approval of individual agency or department authorities during nonwork hours. There shall be no solicitation of employees by investment providers at an employee's workplace during the employee's working hours, except as authorized in writing by the plan administrator.

b. General requirements for solicitation.

(1) An active investment provider may solicit business from participants and employees through representatives, the mail, or direct presentations.

(2) Active investment providers and representatives may solicit business at an employer's work site only with the prior permission of the agency director or other appropriate authority.

(3) Investment providers or representatives may not conduct any activity with respect to a registered investment option unless the appropriate license has been obtained.

(4) An investment provider or representative may not make a representation about an investment option that is contrary to any attribute of the option or that is misleading with respect to the option.

(5) An investment provider or representative may not state, represent, or imply that its investment options are endorsed or recommended by the plan administrator, the employing agency, the state of Iowa, or an employee of the foregoing.

(6) An investment provider or representative may not state, represent, or imply that its investment option is the only option available under the plan.

c. Disclosure.

(1) Enrollment. When soliciting business for an investment product, an active investment provider or representative shall provide each participating employee or eligible employee with a copy of the approved disclosure for that option. If a variable annuity product has several alternative investment choices, the participant must receive disclosures concerning all investment choices. An active investment provider shall notify the plan administrator in writing if the investment provider will be marketing its investment options through representatives. The notification must contain a complete identification of the representatives who will be marketing the options. Every representative and agent who enrolls eligible employees in the plan and is authorized by the investment provider to sign plan forms must be included on this notification.

(2) Disbursement methods and account values. When discussing distribution methods for an investment option, investment providers or representatives shall disclose to each participating employee or eligible employee all potential distribution methods and the potential income derived from each method for that option.

d. Approval of a disclosure form.

(1) An investment provider shall complete and submit to the plan administrator a disclosure form for each approved investment product. If a variable annuity product has several investment choices, the plan administrator must receive all disclosures related to those investment choices. An investment provider shall complete a disclosure form on each investment product that has participating employee funds (including those no longer offered).

(2) If changes occur during the plan year, any changes must be submitted to the plan administrator for approval prior to their implementation. Disclosure forms will be updated quarterly. Even if no changes occur, an investment provider shall resubmit its disclosure form to the plan administrator for approval every year.

(3) If an investment provider or representative materially misstates a required disclosure or fails to provide disclosure, the plan administrator may sanction the investment provider or bind the investment provider to the disclosure as stated on the form.

e. Confidentiality. The plan administrator may provide to all active investment providers any information that can be made available under the department's rules. Notwithstanding any rule of the department to the contrary, the plan administrator shall make available to all active investment providers the names and home addresses of all state employees. The plan administrator may assess reasonable costs to the active investment providers to defray the expense of producing any requested information. All information obtained under the plan shall be confidential and used exclusively for purposes relating to the plan and as expressly contemplated by the service agreement or contract entered into by the investment provider.

f. Number of investment providers. Only investment providers that are selected through a competitive bid process, that are subsequently awarded a contract or service agreement, and that are authorized to do business in the state of Iowa may sell annuities, mutual funds or other approved products under the plan, and then only if the investment providers agree to the terms, conditions, and provisions of the contract or service agreement.

64.6(11) *Investment option removal/replacement.* The plan administrator may determine that an investment option offered under the plan is no longer acceptable for inclusion in the plan. If the plan administrator decides to remove an investment option from the plan as the result of the option's failure to meet the established evaluation criteria and according to the recommendations of consultants or advisors, the option shall be removed or phased out of the plan. Employees newly enrolling in the plan shall be informed in writing that investment options that do not meet the evaluation criteria are not open to new enrollments.

a. Notice to participant. Any participating employees already deferring to the investment option being phased out shall be informed in writing that they need to redirect future deferrals from this option to an alternative investment option offered under the plan by notifying the investment provider, unless otherwise directed, of their new investment choice.

b. Automatic transfer. If any participating employee has failed to move a remaining account balance from the investment option being phased out, the plan administrator shall instruct an investment provider to automatically move that participating employee's account balance into another designated alternative investment option offered under the plan.

c. Reexamination. At any time during this process, the plan administrator may reexamine the performance of the investment option being phased out and the recommendations of consultants and advisors to determine if continued inclusion of the investment option in the plan is justified.

64.6(12) *Demutualization of investment providers.*

a. Ballots. An investment provider that is a mutual company and that provides any annuity product or life insurance product held under the plan shall provide the plan administrator with a ballot(s) for official vote registration. The ballot(s) shall be completed and returned to the company according to the specified deadline in the instructions. The ballot(s) shall include the owner's name, policy numbers of affected contracts, name of annuitant or insured, number of shares anticipated, and the control number for the group of shares.

b. Policyholder booklet. The company shall provide the plan administrator with a policyholder booklet, as well as instructions and guide information, prior to or in conjunction with the delivery of the ballot(s). Notices of progress, time frames and meetings will also be provided to the plan administrator as such information becomes available.

c. Method of compensation. Compensation will be provided in cash according to the terms of the demutualization plan. In the event that stocks are issued in lieu of cash, the company shall provide a listing which includes participants' names, social security numbers, policy numbers, and number of shares pro rata.

d. Liquidation of stock. An arrangement will be entered into between the plan administrator and a stockbroker as soon as administratively possible in order to liquidate the stock for cash. The broker

shall retain commission fees according to the arrangement entered into from the value obtained at the time of sale. The employer will not realize a tax liability nor will the participating employees.

e. Deposit of proceeds. The proceeds of the sale of the stock, less the broker commission, and any dividends issued prior to the sale of the stock, shall be made payable to the plan. Cash shall be deposited into the plan's trust fund until payment instructions are received from the participant or the participant's beneficiary.

[**ARC 8265B**, IAB 11/4/09, effective 12/9/09; **ARC 1568C**, IAB 8/6/14, effective 9/10/14]

11—64.7(8A) Dependent care. The director administers the dependent care flexible spending account plan for employees of the state of Iowa. The plan is permitted under IRC Section 125. The plan is also a dependent care assistance plan under IRC Section 129. Administration of the plan shall comply with all applicable federal regulations, the Plan Document, and the Summary Plan Description. For purposes of this rule, the plan year is a calendar year.

64.7(1) *Employee eligibility.* All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the dependent care flexible spending plan. Temporary employees are not eligible to participate in this plan.

64.7(2) *Enrollment.* An open enrollment period, as designated by the director, shall be held for employees who wish to participate in the plan. New employees may enroll within 30 calendar days following their date of hire. Employees also may enroll or change their existing dependent care deduction amounts during the plan year provided that they have a qualifying change in family status as defined in the Plan Document and the Summary Plan Description. To continue participation, employees shall reenroll each year during the open enrollment period.

64.7(3) *Termination of participation in the plan.* An employee may terminate participation in the plan provided that the employee has a qualifying change in status as defined in the Summary Plan Description. Employees who terminate state employment and are rehired within 30 days must resume their participation in the plan. Employees who terminate state employment and are rehired more than 30 days after termination may reenroll in the plan.

11—64.8(8A) Premium conversion plan (pretax program). The director administers the premium conversion plan for employees of the state of Iowa. The plan is permitted under IRC Section 125. Pursuant to IRC Section 105, the plan is also an insured health care plan to the extent that participants use salary reduction to pay for health or dental insurance premiums. In accordance with IRC Section 79, the plan is also a group term life insurance plan to the extent that salary reduction is used for life insurance premiums. Administration of the plan shall comply with all federal regulations and the Plan Document. For purposes of this rule, the plan year is January 1 to December 31 of each year.

64.8(1) *Employee eligibility.* All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the pretax conversion plan. Temporary employees are not eligible to participate in the plan.

64.8(2) *Enrollment.* An enrollment and change period, as designated by the director, shall be held for employees who wish to make changes in their current pretax status. New employees will automatically be enrolled in the plan after satisfying any waiting period requirements for group insurance unless an election form is submitted. Employees also may change their existing pretax status during the plan year if they have a qualifying change in status as defined in the Plan Document.

64.8(3) *Termination of participation in the plan.* An employee may terminate participation in the plan during an open enrollment period. Otherwise, an employee may terminate participation if the employee has a qualifying change in status as defined in the Plan Document.

[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—64.9(8A) Interviewing and moving expense reimbursement.

64.9(1) *Interviewing expenses.* If reimbursement is approved by the appointing authority, a person who interviews for state employment shall be reimbursed for expenses incurred in order to interview. Reimbursement shall be at the same rate at which an employee is reimbursed for expenses incurred during the performance of state business.

64.9(2) *Moving expenses for reassigned employees.* A state employee who is reassigned at the direction of the appointing authority shall be reimbursed for moving and related expenses in accordance with the policies of the department of administrative services or the applicable collective bargaining agreement. Eligibility for reimbursement shall occur when all of the following conditions exist:

a. The employee is reassigned at the direction of the appointing authority;

b. The reassignment requires a permanent change in duty station beyond 25 miles;

c. The employee must change the employee's place of personal residence beyond 25 miles unless the department of administrative services has given prior written approval; and

d. The reassignment is for the primary benefit of the state.

64.9(3) *Moving expenses for newly hired or promoted employees.* If reimbursement is approved by the appointing authority, a person newly hired or promoted may be reimbursed for moving and related expenses. Reimbursement shall be at the same rates used for the reimbursement of a current employee who has been reassigned. Reimbursement shall not occur until the employee is on the payroll.

64.9(4) *Temporary living expenses.* An employee may be reimbursed for up to 90 days of temporary living expenses. Such reimbursement shall be included as part of the total amount reimbursable under the relocation policy.

64.9(5) *Repayment.* As a condition of receiving reimbursement for moving expenses, the recipient must sign an agreement to continue employment with the appointing authority for a period following the date of receipt of reimbursement that is deemed by the appointing authority to be commensurate with the amount of reimbursement received. In the event that the recipient leaves the department of the appointing authority for any reason, the recipient will repay to the appointing authority a proportionate fraction of the amount received for each month remaining in the period provided for in the agreement. If the recipient continues employment with the state, then the repayment will be subject to a repayment schedule approved by the director. If the recipient leaves state government, then the repayment will be recouped out of the final paycheck. Recoupment must be coordinated with the accounting enterprise of the department of administrative services to ensure proper tax reporting.

11—64.10(8A) Education financial assistance. Education financial assistance may be granted for the purpose of assisting employees in developing skills that will improve their ability to perform job responsibilities. Assistance may be in the form of direct payment to the organization or institution or by reimbursement to the employee as provided for in subrule 64.10(4).

64.10(1) *Employee eligibility.* Any nontemporary employee may be considered for education financial assistance.

64.10(2) *Workshop, seminar, or conference attendance.* The appointing authority may approve education financial assistance for an employee attending a workshop, seminar, or conference conducted by a professional, educational, or governmental organization or institution when attendance by the employee would not require a reduction in job responsibilities.

a. Assistance may be approved for meeting continuing education requirements when necessary to maintain a professional registration, certification, or license related to the duties and responsibilities of the employee's position.

b. Payment of registration fees and other costs, such as lodging, meals, and travel, shall be in accordance with the policies and procedures of the department of administrative services.

c. If attendance is outside the state of Iowa, travel must first be authorized by the executive council pursuant to 2003 Iowa Code Supplement section 8A.512.

64.10(3) *Educational institution coursework.* Education financial assistance to an employee taking academic courses at an educational institution, with or without educational leave, shall require the preapproval of the appointing authority and the director. Requests for reimbursement shall be on forms prescribed by the director.

a. An employee may take academic courses at any accredited educational institution (university, college, area community college) within the state. Attendance at an out-of-state institution may be approved provided that there are geographical or educational considerations which make attendance within the state impractical.

b. Reimbursement requests shall be made to the director before the employee takes the courses. If the director does not approve the request, the employee shall not be reimbursed.

c. Reimbursement may be approved for courses taken to meet continuing education requirements when necessary to maintain a professional registration, certification, or license when the courses relate to the duties and responsibilities of the employee's position.

d. An employee receiving other financial assistance, such as scholarship aid or Veterans Administration assistance, shall be eligible to receive education financial assistance only to the extent that the total of all methods of reimbursement does not exceed 100 percent of the payment of expenses.

e. In order for the employee to be reimbursed, the employee's department shall submit to the department of administrative services the employee's original paid receipt from the educational institution, the approved education financial assistance form, and proof of the employee's successful completion of the courses as follows:

(1) Undergraduate courses shall require at least a "C-" grade.

(2) Graduate courses shall require at least a "B-" grade.

(3) Successful completion of vocational or correspondence courses or continuing education courses shall require an official certificate, diploma or notice.

64.10(4) *Repayment.* As a condition of applying for reimbursement for education expenses, the recipient must sign an agreement to continue employment with the appointing authority. The agreement must be signed prior to approval and will stipulate the period of time deemed by the appointing authority to be commensurate with the amount of reimbursement received. The period of time commences upon successful completion of the course. In the event that the recipient leaves the department of the appointing authority for any reason, the recipient will repay to the appointing authority an appropriate fraction of the amount received for each month remaining in the period provided for in the agreement. If the recipient continues employment with the state, then the repayment will be subject to a repayment schedule approved by the director. If the recipient leaves state government, then the repayment will be recouped out of the final paycheck. Recoupment must be coordinated with the accounting enterprise of the department of administrative services to ensure proper tax reporting.

64.10(5) *Annual report.* The appointing authority shall report to the director and legislative council, not later than October 1 of each year, the direct and indirect costs to the department for education financial assistance granted to employees during the preceding fiscal year in a manner prescribed by the director.
[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—64.11(8A) Particular contracts governing. Where provisions of collective bargaining agreements differ from the provisions of this chapter, the provisions of the collective bargaining agreement shall prevail for employees covered by the collective bargaining agreements.

11—64.12(8A) Tax-sheltered annuities (TSAs).

64.12(1) *Administration.* The director is authorized by 2003 Iowa Code Supplement section 8A.402 to administer a tax-sheltered annuity program for eligible employees.

64.12(2) *Definitions.* The following definitions shall apply when used in this rule:

"Company" means any life insurance company or mutual fund provider that issues a policy under the tax-sheltered annuity plan authorized under Iowa Code section 8A.438.

"Employee" means an employee of the state of Iowa, including employees of the board of regents administrative staff on the centralized payroll system, or an employee of a participating employer.

"Employer" means the state of Iowa, a public school district in the state of Iowa, an area education agency in the state of Iowa, or a community college in the state of Iowa.

"Participating employee" means an employee participating in the plan.

"Participating employer" means an employer that has elected to join the state's tax-sheltered annuity plan.

"Plan" means the tax-sheltered annuity plan authorized in Iowa Code section 8A.438.

"Plan administrator" means the designee of the director who is authorized to administer the tax-sheltered annuity plan.

"Plan year" means a calendar year.

"Policy" means any retirement annuity, variable annuity, family of mutual funds or combination thereof provided by IRC Section 403(b) and Iowa Code section 8A.438.

"Salary reduction form" means the tax-sheltered annuity form signed by the participating employee to begin or change payroll deductions.

64.12(3) *Eligibility.*

a. Initial eligibility. Any employee who works for the department of education, the board of regents administrative office, or a participating employer is eligible to participate in this plan. Participating employers may establish different eligibility requirements, as long as the requirements conform to IRC Section 403(b) and the applicable federal regulations. Final determination on eligibility shall rest with the plan administrator.

b. Eligibility after terminating reduction of compensation. Any employee who terminates the reduction of compensation may choose to reenroll in the plan in accordance with paragraphs 64.12(4)*"a"* and *"b"* and 64.12(6)*"a."*

64.12(4) *Enrollment and termination.*

a. Enrollment. State employees may enroll in the plan at any time. Participating employers may establish different enrollment periods, as long as the periods conform to IRC Section 403(b) and the applicable federal regulations. The salary reduction form must be submitted to the employing agency's personnel assistant or payroll office for approval.

b. Forms submission. State personnel assistants shall provide the plan administrator with the salary reduction form in a timely manner.

c. Termination of salary reductions. A participating employee may terminate salary reductions by providing to the employing agency's personnel assistant or payroll office written notification on a form required by the plan administrator.

d. Availability of forms. It is the responsibility of each employee interested in participating in the plan to obtain the necessary forms from the investment provider.

64.12(5) *Tax status.*

a. FICA and IPERS. The amount of compensation reduced under the salary reduction form shall be included in the gross wages subject to FICA and IPERS until the maximum taxable wages established by law have been reached.

b. Federal and state income taxes. The amount of earned compensation reduced under the form is exempt from federal and state income taxes until such time as the funds are paid or made available as provided in IRC Section 403(b).

64.12(6) *Reductions from earnings.*

a. Salary reduction amount changes. Participating employees may increase or decrease their salary reduction amount by providing to their personnel assistant or payroll office written notice on a form required by the plan administrator. Salary reduction amounts may be changed to permit a one-time lump sum contribution from the last paycheck due to termination of employment.

b. Maximum salary reduction limits. Employees' salary reductions may not exceed the maximum limit set forth in federal law.

c. Minimum salary reduction amount. Participating employers may establish a minimum amount as long as the minimum conforms to IRC Section 403(b) and the applicable federal regulations.

64.12(7) *Companies.*

a. Time of payment. Participating employers shall transmit amounts within 15 business days after the end of the calendar month.

b. Cooperation with third-party administrator. Companies are required to cooperate with the plan's third-party administrator, including the provision of daily account information as well as any other data or information required for administration of the plan.

c. Annual status report. Each company shall provide to the participating employee at the employee's home address an annual status report stating the value of each participant's policy. This practice shall be continued even after the participating employee terminates or stops contributions to the

plan. These annual reports are required as long as a value exists in the contract or any activity occurs during the year.

d. Crediting of accounts. Companies must minimize crediting errors and provide timely and reasonable credit resolution.

e. Solicitation. There shall be no solicitation of employees by companies at the employees' workplace during employees' work hours, except as authorized by the plan administrator or participating employer.

f. Dividends. The only dividend options available on cash value policies are those where the dividend remains with the company to increase the value of the policy.

g. Removal from participation. Failure to comply with the provisions of these rules will result in permanent removal as a participating company and may require that the monthly ongoing deferrals to existing contracts be discontinued, as determined by the director.

64.12(8) *Disposition of funds.*

a. Distribution eligibility. An employee is eligible for a distribution of funds based upon any of the following circumstances: severance of employment; reaching age 59½; becoming disabled; qualifying for a financial hardship; or becoming eligible for a reservist distribution. Distribution will be made in accordance with applicable IRS regulations.

b. Financial hardship. A participating employee may request to withdraw some or all of the salary reduction contributions to the policy, but not the income earned thereon, based on a financial hardship and in accordance with 401(k) regulations. New contributions to the plan will not be allowed after the receipt of a distribution based on financial hardship until such time as allowed by law.

c. Federal and state withholding taxes. It is the company's responsibility, when making payments to an employee, to withhold the required federal and state income tax, to timely remit the tax to the proper government agency, and to file all necessary reports as required by federal and state regulations, including IRS Form 1099-R.

d. Federal penalties. Under IRC Section 72(t), an additional tax of 10 percent of the amount includable in gross income applies to early withdrawal for qualified plans as defined in IRC Section 4974(c). An IRC Section 403(b) contract is a qualified plan for these purposes.

64.12(9) *General.*

a. Orientation and information meetings. Employers may hold orientation and information meetings for the benefit of their employees using materials developed or approved by the plan administrator, but there shall be no solicitation of employees by companies allowed at such meetings without employer approval.

b. Company changes.

(1) If a participating employee wishes to redirect contributions to another company, the employee shall submit a form to the personnel assistant or payroll office in accordance with paragraph 64.12(6)*"a."*

(2) The funds accumulated under the old policy may be transferred in total to the new policy or to another existing policy, if allowed under the participating employer's plan elections, in accordance with the plan's policies and applicable IRC Section 403(b) provisions.

c. Deferred compensation or tax-sheltered annuity participation—maximum contribution. State employees who, under the laws of the state of Iowa, are eligible for both deferred compensation and tax-sheltered annuities shall be allowed to contribute to one plan or the other, but not to both at the same time.

d. Direct transfer/rollover.

(1) Effective January 1, 2002, a former employee may request a direct transfer/rollover to an eligible retirement plan as defined in IRC Section 402(c)(8)(B). Eligible rollover amounts that are received by a former employee are subject to mandatory federal and state withholding as required by law.

(2) An employee may request a trustee-to-trustee transfer of funds to a defined benefit governmental plan for the purchase of permissive service credit.

64.12(10) *Forfeiture.* IRC Section 403(b)(1)(C) provides that an employee's interest in an IRC Section 403(b) contract is nonforfeitable, except for failure to pay future premiums.

64.12(11) *Nontransferability.* The employee's interest in the contract is nontransferable within the meaning of IRC Section 401(g). The contract may not be sold, assigned, discounted, or pledged as collateral for a loan or as security for the performance of an obligation or for any other purpose.
[**ARC 8265B**, IAB 11/4/09, effective 12/9/09]

11—64.13(8A) Health flexible spending account. The director administers the health flexible spending account plan for employees of the state of Iowa. The program is permitted under IRC Section 125. Administration of the plan shall comply with all applicable federal regulations and the Plan Document. To the extent that the provisions of the Plan Document or administrative rule conflict with IRC Section 125, the provisions of IRC Section 125 shall govern. For purposes of this rule, the plan year is a calendar year.

64.13(1) *Employee eligibility.* All nontemporary employees who work at least 1040 hours per calendar year are eligible to participate in the health flexible spending account plan. Temporary employees are not eligible to participate in this plan. Employees subject to a collective bargaining agreement shall have their eligibility determined by the collective bargaining agreement.

64.13(2) *Enrollment.* An open enrollment period, as designated by the director, shall be held for employees who wish to participate in the plan. New employees may enroll within 30 calendar days following their date of hire. Employees also may enroll or change their existing health flexible spending account salary reduction amounts during the plan year, provided they have a qualifying change in status as defined in the Plan Document, and as permitted under IRC Section 125. To continue participation, employees shall reenroll each year during the open enrollment period.

64.13(3) *Modification or termination of participation in the plan.* An employee may modify or terminate participation in the plan, provided the employee has a qualifying change in status as defined in the Plan Document, and as permitted under IRC Section 125. Employees who have terminated state employment and are rehired within 30 days must resume their participation in the plan. Employees who terminate state employment and are rehired more than 30 days after termination may reenroll in the plan.

64.13(4) *Continuation of coverage.* The health flexible spending account plan shall provide the opportunity to continue coverage as required by applicable state and federal laws.

64.13(5) *Eligible health care expenses.* The types of expenses eligible for reimbursement shall be consistent with medical expenses as defined under IRC Section 213.

64.13(6) *Acceptable proof of eligible expense.* Only those expenses for which appropriate documentation is submitted shall be eligible for reimbursement. Such documentation shall include the date upon which the expense was incurred; sufficient evidence that the expense is an eligible health care expense; evidence that the expense has been incurred and will not be reimbursed under an otherwise qualified health plan authorized by IRC Sections 105 and 106; and the amount of such expense.

64.13(7) *Appeal process.* In the event that a participant disagrees with a determination as to reimbursement from the health flexible spending account plan, a formal appeals mechanism is hereby provided. The participant may submit a formal appeal in writing to the director (or designee). Such appeal must be accompanied by a previous written request for favorable consideration to the designated administrator of the plan, along with evidence as to an unfavorable determination in response to this request. Upon receipt of a qualified appeal, the director (or designee) shall provide a written determination within 30 days of receipt. Such determination shall be final and binding. This appeal process is not a contested case proceeding as defined by Iowa Code chapter 17A.

64.13(8) *Third-party administrator.* The director may contract with a third-party administrator to perform such actions as are reasonably necessary to administer the health flexible spending account plan.

11—64.14(8A) Deferred compensation match plan. The director is authorized by the governing body to administer a deferred compensation match plan for employees of the state of Iowa and employees of other eligible participating governmental employers. The plan shall be qualified under IRC Section 401(a) and Iowa Code section 509A.12. The assets and income of the plan shall be held in trust for the exclusive benefit of the participating employee or the participating employee's beneficiary. The trustee shall be the director of the department of administrative services. The director shall adopt various

investment options for the investment of plan funds by participating employees or their beneficiaries and shall monitor and evaluate the appropriateness of the investment options offered by the plan.

The plan shall match eligible participant contributions to the deferred compensation plan with contributions by the employer. Eligibility of participants and the rate of employer matching contributions shall be subject to determination by the trustee and the governing body. The only voluntary contributions by participants that the plan shall accept are eligible rollover contributions.

11—64.15(8A) Insurance benefit eligibility.

64.15(1) Full-time and part-time employees with probationary or permanent status who work 20 or more hours a week are eligible for health and dental insurance coverage. For employees working 20 to 29 hours per week, the state's share of the premium is one-half the amount paid for full-time employees (30 to 40 hours per week). Temporary employees are not eligible for health or dental insurance.

64.15(2) Full-time employees with probationary or permanent status who work 30 or more hours a week are eligible for life and long-term disability insurance coverage. Temporary employees are not eligible for life and long-term disability insurance.

11—64.16(8A) Sick leave insurance program. The director is authorized to establish a sick leave insurance program (program) for employees not covered by a collective bargaining agreement. The program shall allow eligible employees to convert a portion of their sick leave balance at retirement into a sick leave bank with which the state will pay the state's share of retiree health insurance. Employees of the department of natural resources or department of public safety who are classified as peace officers and are not covered by a collective bargaining agreement shall receive benefits at retirement consistent with the provisions of the negotiated collective bargaining agreement with the State Police Officers Council. The benefits for sick leave banks earned by all department of public safety peace officer employees shall be administered by the department of public safety.

64.16(1) To be eligible to participate in the program, the employee must be employed on or after July 1, 2006, and must retire under a retirement system in the state maintained in whole or in part by public contributions or payment prior to reaching Medicare eligibility.

a. Participation in the program ceases when any one of the following occurs:

(1) The employee's sick leave balance is exhausted;

(2) The employee reaches Medicare eligibility;

(3) The employee terminates participation in the state's group insurance program;

(4) The employee returns to permanent employment with the state;

(5) The employee fails to pay any required amount; or

(6) The employee dies.

b. A deceased employee's sick leave bank is not transferable to another person, including a spouse.

64.16(2) Upon a participating employee's termination of employment, the employee's sick leave hours are multiplied by the employee's regular hourly wage. The employee receives up to $2,000 of this amount on the employee's final paycheck. The remainder is multiplied by a conversion factor, and that amount is placed into the employee's sick leave bank. The conversion factors are as follows: If an employee has up to 750 hours, the rate is 60 percent; if an employee has over 750 hours and up to 1,500 hours, the rate is 80 percent; and if the employee has more than 1,500 hours, the rate is 100 percent. The employee's sick leave balance before payment of up to $2,000 is used to determine the number of hours an employee has for conversion purposes. The amounts placed into the employee's sick leave bank have no cash value, other than for purposes of paying the state's share of retiree health insurance premiums under this program. The value of sick leave hours for peace officer employees of the department of natural resources and the department of public safety shall be calculated in the same manner as for those employees covered by the collective bargaining agreement with the State Police Officers Council.

64.16(3) Rescinded IAB 5/27/15, effective 7/1/15.

64.16(4) To participate in the program, an employee must complete a sick leave insurance program enrollment form upon retirement. Upon commencement of participation in the program, the employee may choose to continue the employee's current health insurance plan selection or may choose any other

state group health plan whose total cost is the same or lower than the total cost of the current plan selection. Except for employees eligible for benefits negotiated consistent with the collective bargaining agreement negotiated with the State Police Officers Council, employees may not apply the sick leave balance to a private insurance plan.
[**ARC 2000C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code sections 8A.402, 8A.433 to 8A.438, and 8A.454 and Iowa Code chapter 509A.

[Filed 6/26/75; amended 8/4/75]
[Filed 9/13/76, Notice 6/14/76—published 10/6/76, effective 11/15/76]
[Filed 8/14/80, Notice 7/9/80—published 9/3/80, effective 10/8/80]
[Filed 7/16/82, Notice 6/9/82—published 8/4/82, effective 9/30/82]
[Filed 5/19/83, Notice 4/13/83—published 6/8/83, effective 7/13/83]
[Filed 12/27/85, Notice 11/20/85—published 1/15/86, effective 2/19/86]
[Filed emergency 8/15/86—published 9/10/86, effective 8/15/86]
[Filed 10/17/86, Notice 8/13/86—published 11/5/86, effective 12/10/86]
[Filed 7/24/87, Notice 6/17/87—published 8/12/87, effective 9/16/87]
[Filed 2/18/88, Notice 1/13/88—published 3/9/88, effective 4/13/88]
[Filed 4/29/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
[Filed 10/27/88, Notice 9/21/88—published 11/16/88, effective 12/21/88]
[Filed emergency 12/14/88—published 1/11/89, effective 12/21/88]
[Filed 3/29/89, Notice 2/8/89—published 4/19/89, effective 5/26/89]
[Filed 9/29/89, Notice 8/23/89—published 10/18/89, effective 11/24/89]
[Filed 2/1/90, Notice 12/13/89—published 2/21/90, effective 3/30/90]
[Filed 11/20/91, Notice 8/21/91—published 12/11/91, effective 1/17/92]
[Filed 3/27/92, Notice 2/5/92—published 4/15/92, effective 5/20/92]
[Filed 3/26/93, Notice 2/17/93—published 4/14/93, effective 5/19/93]
[Filed emergency 12/17/93—published 1/5/94, effective 12/17/93]
[Filed emergency 6/16/95—published 7/5/95, effective 7/1/95]
[Filed emergency 3/15/96—published 4/10/96, effective 3/15/96]
[Filed 12/12/96, Notice 10/23/96—published 1/15/97, effective 2/19/97]
[Filed emergency 8/8/97—published 8/27/97, effective 8/8/97]
[Filed 3/20/98, Notices 8/27/97, 2/11/98—published 4/8/98, effective 5/13/98]
[Filed 12/23/98, Notice 11/18/98—published 1/13/99, effective 2/17/99]
[Filed emergency 8/12/99—published 9/8/99, effective 8/12/99]
[Filed emergency 10/29/99 after Notice 9/22/99—published 11/17/99, effective 11/17/99]
[Filed 10/29/99, Notice 9/8/99—published 11/17/99, effective 12/22/99]
[Filed emergency 6/29/00—published 7/26/00, effective 7/1/00]
[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]
[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]
[Filed without Notice 5/5/06—published 5/24/06, effective 7/1/06]
[Filed without Notice 12/23/08—published 1/14/09, effective 2/18/09]
[Filed ARC 8265B (Notice ARC 8115B, IAB 9/9/09), IAB 11/4/09, effective 12/9/09]
[Filed ARC 1568C (Notice ARC 1503C, IAB 6/11/14), IAB 8/6/14, effective 9/10/14]
[Filed ARC 2000C (Notice ARC 1936C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 65
POLITICAL ACTIVITY

[Prior to 11/5/86, Merit Employment Department [570]]
[Prior to 2/18/04, see 581—Ch 16]

11—65.1(8A) Political activity of employees. All employees have the right to express their opinions as individuals on political issues and candidates. Such expressions may be either verbal or demonstrative in the form of pictures, buttons, stickers, badges, pins, or posters. Employees' rights to express their opinions on political matters in this form or manner shall not be restrained while on duty unless:

65.1(1) It is a violation of the law; or

65.1(2) The display of such items would cause or constitute a real and present safety risk or would substantially and materially interfere with the efficient performance of official duties; or

65.1(3) The employee has substantial contact with the public and the level of trust and confidence associated with the employee's position is perceived to be such that political expressions in any form, while on duty, might influence the public.

11—65.2(8A) Restrictions on political activity of employees. All employees are prohibited from:

65.2(1) Using the influence of their positions, public property, or supplies to secure contributions or to influence an election for any political party or any person seeking political office.

65.2(2) Soliciting or receiving anything of value in excess of the limits in Iowa Code section 68B.5 as a political contribution or subterfuge for a contribution from any other person for any political party or any person seeking political office during scheduled working hours, while on duty, when using state equipment, or on state property.

65.2(3) Promising or using influence to secure public employment or other benefits financed from public funds as a reward for political activity.

65.2(4) Discriminating in favor of or against any employee or applicant on account of their political contributions or permitted political activities.

Employees of the alcoholic beverages division of the department of commerce, in addition to the foregoing subrules, are subject to the prohibitions set forth in Iowa Code section 123.18. All employees are further subject to the provisions of Iowa Code chapter 721.

11—65.3(8A) Application of Hatch Act. In addition to the restrictions set forth in rules 11—65.1(8A) and 11—65.2(8A), employees occupying state positions wholly funded by federal "grant-in-aid" or other specific federal funding are subject to the provisions of the federal Hatch Act. Where compliance with the political restrictions of the Hatch Act is required for the receipt of federal funds, the appointing authority shall identify those state positions so covered. The employees under those further political activity restrictions shall be made aware of the additional restrictions by posting or other written notification from the appointing authority.

Persons found by proper authority to have violated the provisions of the federal Hatch Act are subject to summary discharge.

[**ARC 2000C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code Supplement sections 8A.413, 8A.416 and 8A.418.

[Filed 10/17/70; amended 11/5/70, 7/26/74]
[Filed 2/13/81, Notice 11/26/80—published 3/4/81, effective 4/8/81]
[Filed 4/3/85, Notice 2/13/85—published 4/24/85, effective 5/29/85]
[Filed 7/26/85, Notice 5/22/85—published 8/14/85, effective 9/18/85]
[Filed 10/17/86, Notice 8/13/86—published 11/5/86, effective 12/10/86]
[Filed 3/29/89, Notice 2/8/89—published 4/19/89, effective 5/26/89]
[Filed 7/7/89, Notice 5/17/89—published 7/26/89, effective 9/1/89]
[Filed 2/1/90, Notice 12/13/89—published 2/21/90, effective 3/30/90]
[Filed 12/12/96, Notice 10/23/96—published 1/15/97, effective 2/19/97]
[Filed 1/28/04, Notice 12/24/03—published 2/18/04, effective 3/24/04]
[Filed ARC 2000C (Notice ARC 1936C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

INSURANCE DIVISION[191]

[Prior to 10/22/86, see Insurance Department[510], renamed Insurance Division[191] under the "umbrella" of Department of Commerce by the 1986 Iowa Acts, Senate File 2175]

ORGANIZATION AND PROCEDURES

CHAPTER 1
ORGANIZATION OF DIVISION

CHAPTER 2
DECLARATORY ORDERS

CHAPTER 3
CONTESTED CASES

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING AND WAIVER OF RULES

DIVISION I
AGENCY PROCEDURE FOR RULE MAKING

DIVISION II
WAIVER AND VARIANCE RULES

REGULATION OF INSURERS

CHAPTER 5
REGULATION OF INSURERS—GENERAL PROVISIONS

CHAPTER 6
ORGANIZATION OF DOMESTIC INSURANCE COMPANIES

CHAPTER 7
DOMESTIC STOCK INSURERS PROXIES

PROXY REGULATIONS

CHAPTER 8
BENEVOLENT ASSOCIATIONS

CHAPTER 9
Reserved

INSURANCE PRODUCERS

CHAPTER 10
LICENSING OF INSURANCE PRODUCERS

DIVISION I
LICENSING OF INSURANCE PRODUCERS

DIVISION II
LICENSING OF CAR RENTAL COMPANIES AND EMPLOYEES

CHAPTER 11
CONTINUING EDUCATION FOR INSURANCE PRODUCERS

CHAPTER 12
PORT OF ENTRY REQUIREMENTS

CHAPTER 13
CONSENT FOR PROHIBITED PERSONS TO ENGAGE IN THE BUSINESS OF INSURANCE

UNFAIR TRADE PRACTICES

CHAPTER 14
LIFE INSURANCE ILLUSTRATIONS MODEL REGULATION

CHAPTER 15
UNFAIR TRADE PRACTICES

DIVISION I
SALES PRACTICES

DIVISION II
CLAIMS

DIVISION III
DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

DIVISION IV
ANNUITY DISCLOSURE REQUIREMENTS

CHAPTERS 18 and 19
Reserved

PROPERTY AND CASUALTY INSURANCE

CHAPTER 20
PROPERTY AND CASUALTY INSURANCE

DIVISION I
FORM AND RATE REQUIREMENTS

DIVISION II
IOWA FAIR PLAN ACT

DIVISION III
CERTIFICATES OF INSURANCE FOR COMMERCIAL LENDING TRANSACTIONS

DIVISION IV
CANCELLATIONS, NONRENEWALS AND TERMINATIONS

CHAPTER 21
REQUIREMENTS FOR EXCESS AND SURPLUS LINES, RISK RETENTION GROUPS AND PURCHASING GROUPS

CHAPTER 22
FINANCIAL GUARANTY INSURANCE

CHAPTER 23
MOTOR VEHICLE SERVICE CONTRACTS

CHAPTER 24
IOWA RETIREMENT FACILITIES

CHAPTER 25
MILITARY SALES PRACTICES

CHAPTER 26
Reserved

CHAPTER 27
PREFERRED PROVIDER ARRANGEMENTS

CHAPTER 28
CREDIT LIFE AND CREDIT
ACCIDENT AND HEALTH INSURANCE

CHAPTER 29
CONTINUATION RIGHTS UNDER GROUP ACCIDENT AND HEALTH INSURANCE POLICIES

LIFE AND HEALTH INSURANCE

CHAPTER 30
LIFE INSURANCE POLICIES

CHAPTER 31
LIFE INSURANCE COMPANIES—VARIABLE ANNUITIES CONTRACTS

CHAPTER 32
DEPOSITS BY A DOMESTIC LIFE COMPANY IN A CUSTODIAN BANK OR CLEARING CORPORATION

CHAPTER 33
VARIABLE LIFE INSURANCE MODEL REGULATION

CHAPTER 34
NONPROFIT HEALTH SERVICE CORPORATIONS

CHAPTER 35
ACCIDENT AND HEALTH INSURANCE

BLANKET ACCIDENT AND SICKNESS INSURANCE

GENERAL ACCIDENT AND HEALTH INSURANCE REQUIREMENTS

LARGE GROUP HEALTH INSURANCE COVERAGE

CONSUMER GUIDE

CHAPTER 36
INDIVIDUAL ACCIDENT AND HEALTH—MINIMUM STANDARDS AND RATE HEARINGS

DIVISION I
MINIMUM STANDARDS

DIVISION II
RATE HEARINGS

CHAPTER 37
MEDICARE SUPPLEMENT INSURANCE

DIVISION I
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

DIVISION III
LONG-TERM CARE PARTNERSHIP PROGRAM

CHAPTER 40
HEALTH MAINTENANCE ORGANIZATIONS

(Health and Insurance—Joint Rules)

CHAPTER 41
LIMITED SERVICE ORGANIZATIONS

CHAPTER 55
LICENSING OF PUBLIC ADJUSTERS

CHAPTER 56
WORKERS' COMPENSATION GROUP SELF-INSURANCE

CHAPTER 57
WORKERS' COMPENSATION SELF-INSURANCE FOR INDIVIDUAL EMPLOYERS

CHAPTER 58
THIRD-PARTY ADMINISTRATORS

CHAPTER 59
PHARMACY BENEFITS MANAGERS

CHAPTER 60
WORKERS' COMPENSATION INSURANCE RATE FILING PROCEDURES

CHAPTERS 61 to 69
Reserved

MANAGED HEALTH CARE

CHAPTER 70
UTILIZATION REVIEW

HEALTH BENEFIT PLANS

CHAPTER 71
SMALL GROUP HEALTH BENEFIT PLANS

CHAPTER 74
HEALTH CARE ACCESS

CHAPTER 75
IOWA INDIVIDUAL HEALTH BENEFIT PLANS

CHAPTER 76
EXTERNAL REVIEW

CHAPTER 77
MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

CHAPTER 78
UNIFORM PRESCRIPTION DRUG INFORMATION CARD

CHAPTER 79
Reserved

INSURANCE COVERAGE FOR PEDIATRIC PREVENTIVE SERVICES

CHAPTER 80
WELL-CHILD CARE

CHAPTER 81
POSTDELIVERY BENEFITS AND CARE

CHAPTERS 82 to 84
Reserved

CHAPTER 85
REGULATION OF NAVIGATORS

CHAPTER 91
2001 CSO MORTALITY TABLE

CHAPTER 92
UNIVERSAL LIFE INSURANCE

CHAPTER 93
CONDUIT DERIVATIVE TRANSACTIONS

CHAPTER 94
PREFERRED MORTALITY TABLES FOR USE
IN DETERMINING MINIMUM RESERVE LIABILITIES

CHAPTER 95
DETERMINING RESERVE LIABILITIES FOR PRENEED LIFE INSURANCE

CHAPTER 96
SYNTHETIC GUARANTEED INVESTMENT CONTRACTS

CHAPTER 97
ACCOUNTING FOR CERTAIN DERIVATIVE INSTRUMENTS USED TO HEDGE THE GROWTH IN INTEREST CREDITED FOR INDEXED INSURANCE PRODUCTS AND ACCOUNTING FOR THE INDEXED INSURANCE PRODUCTS RESERVE

CHAPTER 98
ANNUAL FINANCIAL REPORTING REQUIREMENTS

CHAPTERS 111 to 139
Reserved

CHAPTER 140
BURIAL SITES AND CEMETERIES

PROPERTY AND CASUALTY INSURANCE

CHAPTER 20
PROPERTY AND CASUALTY INSURANCE

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

DIVISION I
FORM AND RATE REQUIREMENTS

191—20.1(505,509,514A,515,515A,515F) General filing requirements.

20.1(1) Insurance companies required to file rates or forms with the division shall submit required rate and form filings and any fees required for the filings electronically using the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). Insurance companies must comply with the division's requirements, including both the Iowa general instructions and the specific submission requirements for the type of insurance for which the companies are submitting forms or rates, as set out on the SERFF Web site at www.serff.org.

20.1(2) No rate filing shall include any adjustment designed to recover underwriting or operating losses incurred out of state. Upon request by the commissioner, insurers doing business in Iowa shall segregate in their rate filings data from any state identified by the commissioner, and the filings shall include a certification that no portion of any rate increase is designed to recover underwriting or operating losses incurred in another state.

191—20.2(505) Objection to filing.

20.2(1) Any insured or established organization with one or more insureds among its members that has an objection to a form filing may submit to the insurance commissioner a written request for a hearing on the filing. A request for a hearing must be filed within 20 days after the filing has been received by the commissioner.

20.2(2) Within 20 days after receipt of the request for a hearing, the commissioner will hold a hearing to consider the objection to the filing. The commissioner will provide not less than 10 days' written notice of the time and place of the hearing to the person or association filing the demand, to the filing insurer or organization, and to any other person requesting notice. The commissioner may suspend or postpone the effective date of the filing pending the hearing. Upon consideration of the information received at the hearing, the commissioner may determine whether or not to approve the filing.

191—20.3(515,515A,515C,518,518A,520) Letter of transmittal. Rescinded IAB 10/25/06, effective 11/29/06.

191—20.4(505,509,514A,515,515A,515F) Policy form filing.

20.4(1) Each policy form, endorsement, application and agreement modifying the provisions of policies must bear an identification form number. This form number must be in the lower left-hand corner unless uniform or authentic forms are used.

20.4(2) Rescinded IAB 2/19/14, effective 3/26/14.

20.4(3) A form filing which has not been previously approved, disapproved or questioned shall be deemed approved on or after 30 days from its receipt.

[**ARC 1334C**, IAB 2/19/14, effective 3/26/14]

191—20.5(515A) Rate or manual rule filing.

20.5(1) Every insurer shall determine and file its final rates with the commissioner pursuant to provisions of Iowa Code chapter 515F, except for insurers of workers' compensation who are specifically excluded by Iowa Code section 515F.5 and residual market mechanisms.

a. Advisory organizations may file on behalf of their member and subscriber companies prospective loss costs, supplementary rate information and supporting information as defined in Iowa Code section 515F.2. Advisory organization filings shall be filed and made effective in accordance with

the provisions of Iowa Code sections 515F.4 to 515F.6 or 515F.23 to 515F.25 that apply to the filing and approval of rates and supplementary rating information.

b. An insurer may satisfy its obligation to make rate filings by becoming a participating insurer of a licensed advisory organization that makes reference filings of advisory prospective loss costs and by authorizing the commissioner to accept such filings on its behalf. The insurer's rates shall be the prospective loss costs filed by the advisory organization which have been put into effect in accordance with 20.5(1)*"a,"* combined with the loss cost adjustments which are filed in accordance with this paragraph.

c. An insurer may satisfy its obligation to make filings of supplementary rating information by becoming a participating insurer of a licensed advisory organization which makes such filings and by authorizing the commissioner to accept such filings on its behalf, subject to any modifications filed by the insurer.

d. If an insurer has previously filed forms modifying coverage provided by the applicable advisory organization forms, such fact should be noted in the rate filing.

20.5(2) Rate filings shall reflect that due consideration has been given to the factors enumerated in Iowa Code section 515F.4(1), and shall be accompanied by supporting statistical exhibits. In addition, each filing shall note the date of the last revision of rates affecting this coverage and briefly describe the nature of that revision.

20.5(3) Insurers making filings in their own behalf and advisory organizations shall identify each page filed by printing, typing or stamping their own name thereon.

20.5(4) If a company filing rates used the manuals of an advisory organization in its filings, any portion of the manuals of the organization which will not be followed by the filing must be clearly shown as deleted or amended by use of an appropriately numbered exception page.

20.5(5) For residual market mechanisms, insurers making filings in their own behalf shall identify the submission as an independent filing or a deviation from the bureau filing. A deviation filing is a submission which represents modification of a form or rate or rule previously filed by an authorized rating organization or advisory organization on behalf of its member and subscriber companies. If an insurer has previously filed forms modifying coverage provided by the applicable standard or bureau forms, such fact should be noted in the rate filing.

191—20.6(515A) Exemption from filing requirement.

20.6(1) An insurer requesting, pursuant to Iowa Code section 515F.5(4), suspension or modification of the requirement of filing of a rate shall provide the commissioner with a full explanation for the proposed exemption from the filing requirement together with any actuarial data available and shall furnish the commissioner with any additional material the commissioner may desire.

20.6(2) If the commissioner finds that a proposed rate represents a classification for which credible and homogeneous statistical experience does not exist and cannot be analyzed using standard actuarial techniques to produce a statistically significant average rate for the individual risks within the classification, the commissioner may exempt the proposed rate from the filing requirement.

20.6(3) An insurer shall maintain statistical records of the experience and expenses attendant upon the risks covered by any rate exempted by the commissioner from the filing requirement. The insurer may supplement statistical information with information filed with the commissioner by an advisory organization.

This rule is intended to implement Iowa Code section 515A.4(6).

191—20.7(515E) Risk retention and purchasing groups. Rescinded IAB 11/22/06, effective 12/27/06.

191—20.8(515A) Rate filings for crop-hail insurance. Rate filings for crop-hail insurance shall be submitted on or before March 15 of each calendar year. Each company may file one set of rates per policy plan per calendar year which shall remain in effect throughout the current crop year. In the absence of a new filing, rates on file from the previous year will remain in effect. Each filing shall be accompanied by a cover letter, synopsis sheet and supporting data which justifies the filed rate.

191—20.9(515F) Licensing advisory organization. Rescinded IAB 3/28/07, effective 5/2/07.

191—20.10(515F) Exemptions. Rescinded IAB 3/28/07, effective 5/2/07.

191—20.11(515) Exemption from form and rate filing requirements.

20.11(1) The following lines of insurance shall be exempt from the form filing requirements of Iowa Code section 515.102:

Aircraft hull and aviation liability
Difference-in-conditions
Kidnap-ransom
Manuscript policies and endorsements issued to not more than two insureds in Iowa
Political risk
Reinsurance
Terrorism
War risk
Weather insurance

20.11(2) Insurers shall be exempt from filing rates for the lines of insurance exempted in 20.11(1).

20.11(3) An insurer shall within 30 days of request provide the commissioner with any of the information which is exempted from form and rate filing requirements.

[**ARC 1125C**, IAB 10/16/13, effective 11/20/13]

191—20.12(515,515F) Use of credit history in underwriting and making of rates for personal automobile and homeowners policies. Rescinded IAB 11/24/04, effective 12/29/04.

191—20.13 to **20.40** Reserved.

These rules are intended to implement Iowa Code chapter 515F and Iowa Code section 515.109.

DIVISION II
IOWA FAIR PLAN ACT

191—20.41(515,515F) Purpose. This division is intended to implement and interpret 2003 Iowa Acts, chapter 119, for the purpose of establishing procedures and requirements for a mandatory risk-sharing facility for basic property insurance coverage. This division is also intended to encourage improvement of and reasonable loss prevention measures for properties located in Iowa and to further orderly community development.

191—20.42(515,515F) Scope. This division shall apply to all insurers licensed to write property insurance in Iowa.

191—20.43(515,515F) Definitions.

"Basic property insurance" means insurance against direct loss to property as defined in the standard fire policy and extended coverage, vandalism, and malicious mischief endorsements; homeowners insurance; and such other coverage or classes of insurance as may be added to the FAIR Plan by the commissioner. Basic property insurance shall include:

1. Coverage provided in the customary fire policy and in the customary extended coverage and builders risk endorsements.
2. Coverage against loss or damage by burglary or theft, or both.
3. Coverage at least equivalent to that provided in a modified coverage form homeowners policy.

"Habitational risk" means:

1. Dwellings, permanent or seasonal, designed for occupancy by not more than four families or containing not more than four apartments.
2. Private outbuildings used in connection with any of the risks described in "1."
3. Trailer homes at a fixed location.
4. Household and personal property in risks described in "1" to "3."

5. Tenants' contents in dwellings or apartment houses.

"Iowa FAIR Plan" or *"the Plan"* means the nonprofit, unincorporated mandatory risk-sharing facility established by this division to provide for basic property insurance.

"Location" means a single building and its contents, or contiguous buildings and their contents, under one ownership.

"Manufacturing risks" means those risks eligible to be written under the customary manufacturing business interruption policy forms approved by the commissioner. The following are not considered manufacturing risks:

1. Dry cleaning and laundering—Carpet, rug, furniture, or upholstery cleaning; diaper service or infants' apparel laundries; dry cleaning; laundries; linen supply.

2. Installation, servicing and repair—Electrical equipment; electronic equipment; glazing; household furnishings and appliances; office machines; plumbing, heating and air conditioning; protective systems for premises, vaults and safes.

3. Laboratories—Blood banks; dental laboratories; medical or X-ray laboratories.

4. Duplicating or similar services—Blueprinting and photocopying services; bookbinding; electrotyping; engraving; letter service (mailing or addressing companies); linotype or hand composition; lithographing; photo engraving; photo finishing; photographers (commercial).

5. Warehousing—Cold storage (locker establishments); cold storage warehouse; furniture or general merchandise warehouse.

6. Miscellaneous—Barber shops; beauty parlors; cemeteries; dog kennels; electroplating; equipment rental (not contractors' equipment); film and tape rental; funeral directors; galvanizing, tinning, detinning; radio broadcasting, commercial wireless and television broadcasting; taxidermists; telephone or telegraph companies; textiles (bleaching, dyeing, mercerizing or finishing of property of others); veterinarians and veterinary hospitals.

"Motor vehicles" means vehicles which are self-propelled.

"Weighted premiums written" means:

1. Gross direct premiums less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits, with respect to property in this state excluding premiums on risks insured under the Plan, for basic property insurance, for homeowners multiple peril policies, for farm dwelling policies and for the basic property insurance premium components of all other multiple peril policies.

2. In addition, 100 percent of the premiums obtained for homeowners multiple peril policies shall be added to 100 percent of the premiums obtained for basic property insurance and the basic property insurance premium components of all other multiple peril policies. The basic year for the computation shall be the first preceding calendar year.

191—20.44(515,515F) Eligible risks.

20.44(1) All risks at a fixed location shall be eligible for inspection and considered for insurance under the Plan except motor vehicles, inland marine risks, and manufacturing risks as defined above.

20.44(2) The maximum limits of coverage for the type of basic property insurance for customary fire and extended coverage which may be placed under the Plan are those established by the governing committee from time to time.

20.44(3) The maximum limits of coverage for the type of basic property insurance for burglary and theft which may be placed under the Plan are those established by the governing committee from time to time.

20.44(4) The maximum limits of coverage for the type of basic property insurance for homeowners coverage which may be placed under the Plan are those established by the governing committee from time to time.

191—20.45(515,515F) Membership.

20.45(1) Every insurer licensed to write one or more components of basic property insurance shall be considered a member of the Plan. Any other insurer may, upon application to and approval by the governing committee, become a member.

20.45(2) An insurer's membership terminates when the insurer is no longer authorized to write basic property insurance in Iowa, but the effective date of termination shall be the last day of the fiscal year of the Plan in which termination occurs. Any insurer so terminated shall continue to be governed by the provisions of this division until the insurer completes all of its obligations under the Plan.

20.45(3) Any voluntary insurer member may terminate its membership only as of the last day of the fiscal year of the Plan by giving written notice to the Plan 30 days prior to the last day of the fiscal year of the Plan. The governing committee upon a majority vote may terminate the membership of a voluntary insurer. Any such terminated member shall continue to be governed by the provisions of this division until the insurer completes all of its obligations under the Plan.

20.45(4) Subject to the approval of the commissioner, the governing committee may charge a reasonable annual membership fee.

191—20.46(515,515F) Administration.

20.46(1) The Plan shall be administered by the governing committee, subject to supervision of the commissioner, and operated by a manager appointed by the governing committee.

20.46(2) The governing committee shall consist of seven members, each of whom shall serve for a period of one year or until a successor is elected or designated. Each member shall have one vote.

191—20.47(515,515F) Duties of the governing committee.

20.47(1) The governing committee shall meet as often as may be required to perform the general duties of the administration of the Plan, or on the call of the commissioner. Four members of the committee present or by proxy shall constitute a quorum. Members of the committee who choose to appoint a proxy shall give a written proxy to the person elected to act as proxy. The written proxy shall then be filed with the governing committee, thus ensuring the validity of the proxy's actions as the governing committee performs its duties.

20.47(2) The governing committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds, and perform all other duties of the Plan. The adoption of or substantive changes in pension plans or employee benefit programs for the manager and staff shall be subject to approval of the governing committee.

20.47(3) The governing committee may designate, with the approval of the commissioner, a rate service organization as defined in Iowa Code chapter 515F, to make inspections as required under the Plan and to perform such other duties as may be authorized by the governing committee.

20.47(4) The manager shall annually prepare an operating budget which shall be subject to approval of the governing committee.

20.47(5) The governing committee shall submit to the commissioner periodic reports setting forth information as the commissioner may request. On or before April 1 of each year, the governing committee shall submit a report summarizing any new programs or reforms in operation undertaken during the preceding calendar year in order to comply with any new legislation, regulations or directives affecting the Plan. This report shall contain a statistical tabulation on business written in accordance with the Plan.

20.47(6) The governing committee shall separately code all policies written by the Plan so that appropriate records may be compiled for purposes of performing loss prevention and other studies of the operation of the Plan.

20.47(7) The governing committee shall authorize the manager to file rates, surcharge schedules and forms for prior approval by the commissioner.

20.47(8) The governing committee shall prepare such agreements and contracts as may be necessary for the execution of this division consistent with its provisions.

191—20.48(515,515F) Annual and special meetings.

20.48(1) There shall be an annual meeting of the insurers on a date fixed by the governing committee at which time members may be chosen.

20.48(2) A special meeting shall be called by the governing committee within 40 days after receipt of written request from any ten insurers, not more than one of which may be in a group under the same management or ownership.

20.48(3) The time and place of all meetings shall be reasonable. Twenty days' notice of an annual or special meeting shall be given in writing by the governing committee to all insurers defined above. Four members present in person or by proxy shall constitute a quorum. Voting by proxy shall be permitted.

20.48(4) Any matter not inconsistent with the law or this division may be proposed and voted upon at any special meeting of the committee. Notice of any such proposal shall be mailed to each insurer not less than 20 days prior to the final date fixed by the committee for voting thereon.

191—20.49(515,515F) Application for insurance.

20.49(1) Any person who has an insurable interest in an eligible risk in property permitted to be written in the Plan and who has received within the last six months a notice of rejection, nonrenewal or cancellation from an insurer may apply for insurance by the Plan.

20.49(2) An inspection need not be made if the governing committee determines that insurance can be provided for specified classes of risks on the basis of representations of the applicant or insurance producer.

20.49(3) The Plan may bind coverage. The Plan may wait until receipt of the inspection report or receipt of additional underwriting information before determining whether to bind coverage. Coverage will be bound by the Plan by acknowledgement to the producer.

191—20.50(515,515F) Inspection procedure.

20.50(1) The inspection by the Plan shall be without cost to the applicant.

20.50(2) The manner and scope of the inspection shall be prescribed by the Plan with the approval of the commissioner.

20.50(3) An inspection report shall be made for each property inspected covering pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. Representative photographs may be taken during the inspection to indicate the pertinent features of building, construction, maintenance, occupancy, and surrounding property.

20.50(4) After the inspection, a copy of the completed inspection report and any relevant photographs shall be kept on file by the Plan. The report shall include a description of any deficient physical condition changes proposed by the inspector. A copy of the inspection report shall be made available to the applicant or producer upon request.

191—20.51(515,515F) Procedure after inspection and receipt of application.

20.51(1) After receipt of the application, the inspection report, and any additional underwriting information requested from the applicant, the Plan shall within five business days complete and send to the applicant an action report advising the applicant of one of the following:

a. That the risk is acceptable. If the inspection reveals substandard conditions, appropriate charges may be imposed, but the report shall specify the improvements necessary for removal of each such charge.

b. That the risk is declined unless reasonable improvements noted in the action report are made by the applicant and confirmed by reinspection.

c. That the risk is declined because it fails to meet reasonable underwriting standards as set forth in 191—20.52(515,515F). Reasonable underwriting standards as set forth in 191—20.52(515,515F) shall not include neighborhood or area location or any environment hazard beyond the control of the property owner.

20.51(2) If the risk is accepted, the action report shall advise the applicant of:

a. The amount of coverage the Plan agrees to write.

b. The amount of coverage the Plan agrees to write if specified improvements are made.

c. The amount of coverage the Plan agrees to write only if a large or special deductible is agreed to by the applicant.

20.51(3) If the risk is accepted, the Plan, upon receipt of the premium, shall deliver the policy to the applicant or to the licensed producer designated by the applicant for delivery to the applicant. The Plan shall remit the commissions to the licensed producer designated by the applicant.

191—20.52(515,515F) Reasonable underwriting standards for property coverage.

20.52(1) The following characteristics may be used in determining whether a risk is acceptable for property coverage. Where there is more than one cause for declination, all causes shall be listed and complied with before the property may be accepted for insurance purposes.

a. Physical condition of property; however, the mere fact that a property does not satisfy all current building code specifications will not, of itself, suffice as a reason for declination.

b. The property's present use as extended vacancy or extended unoccupancy of the property for 60 consecutive days. Properties that are vacant or unoccupied for more than 60 days may be insured while rehabilitation or reconstruction work is actively in process, meaning that the insured or owner should make monthly progress in order to complete the rehabilitation or reconstruction within a one-year time frame.

c. Other specific characteristics of ownership, condition, occupancy or maintenance that violate the law and that result in substantial increased exposure to loss. Any circumstance considered under this paragraph must relate to the peril insured against.

d. Physical condition of buildings which results in an outstanding order to vacate, in an outstanding demolition order or in being declared unsafe in accordance with the applicable law.

e. One or more of the conditions for nonrenewal as listed in 191—20.54(515,515F) currently exist. The Plan shall upon notice that conditions at the buildings have changed consider new application for coverage.

f. Vandalism and malicious mischief coverage shall not be provided for a dwelling or commercial property where the property has been subject to two vandalism and malicious mischief losses, each loss amounting to at least $500, in the immediately preceding 12-month period, or three or more such losses in the immediately preceding 24-month period.

g. Previous loss history or matters of public record concerning the applicant or any person defined as an insured under the policy.

h. Any other guidelines which have been approved by the commissioner.

20.52(2) Reserved.

[**ARC 8624B**, IAB 3/24/10, effective 4/28/10]

191—20.53(515,515F) Reasonable underwriting standards for liability coverage.

20.53(1) The following characteristics may be used in determining whether a risk is acceptable for liability insurance on homeowner policies:

a. Broken, cracked, uneven or otherwise faulty steps, porches, decks, sidewalks, patios and similar areas.

b. Downspouts or drains which discharge onto sidewalks or driveways.

c. Unsafe conditions including inadequate lighting of stairways.

d. Animals known to be vicious or animals that have caused a liability claim.

e. Swimming pools or private ponds not fenced in accordance with local regulations.

f. Unsafe, or the absence of, handrails.

g. Junk cars, empty refrigerators, trampolines or other potentially dangerous objects in the yard which are an attraction to children.

h. Previous loss history or matters of public record concerning the applicant or any person defined as an insured under the policy.

i. Any other guidelines which have been approved by the commissioner.

20.53(2) Liability insurance shall only be provided as contained in the Iowa FAIR Plan homeowners policy.

20.53(3) Liability insurance shall not be provided for risks with any of the deficiencies set forth in paragraphs 20.53(1)*"a"* through *"g,"* as disclosed by the application or inspection, until the deficiencies have been corrected.

20.53(4) Liability insurance may not be provided where there is a business operating at the insured location, unless the applicant has in force a business liability policy with limits of at least $100,000 per occurrence providing premises liability coverage.

20.53(5) Liability insurance shall not be provided where the applicant owns three or more horses or other riding animals, unless the applicant has in force a liability policy with limits of at least $100,000 per occurrence providing coverage for the ownership and use of the horses or other riding animals.

191—20.54(515,515F) Cancellation; nonrenewal and limitations; review of eligibility.

20.54(1) The Plan shall not cancel or refuse to renew a policy issued by the Plan except for the following reasons:

a. Facts as confirmed by inspection or investigation which would have been grounds for nonacceptance of the risk by the Plan had they been known to the Plan at the time of acceptance.

b. Changes in the physical condition of the property or other changed conditions as confirmed by inspection or investigation that make the risk uninsurable pursuant to paragraphs *"j"* and *"k."*

c. Nonpayment of premiums.

d. At least 65 percent of the rental units in the building are unoccupied, and the insured has not received prior approval from the Plan of a rehabilitation program which necessitates a high degree of unoccupancy.

e. Unrepaired damage exists and the insured has stated that repairs will not be made, or such time has elapsed as clearly indicates that the damage will not be repaired. The elapsed time under this paragraph is a length of time over 60 days where the damage remains unrepaired, unless there are known to be extenuating circumstances.

f. After a loss, permanent repairs have not been commenced within 60 days following payment of the claim, unless there are known to be extenuating circumstances. The 60-day period starts upon acceptance of payment of the claim.

g. Property has been abandoned for 90 days or more.

h. There is good cause to believe, based on reliable information, that the building will be burned for the purpose of collecting the insurance on the property. The removal of damaged salvageable items, such as normally permanent fixtures, from the building shall be considered under this paragraph when the insured can provide no reasonable explanation for such removal.

i. A named insured or loss payee or other person having a financial interest in the property being convicted of the crime of arson or a crime involving a purpose to defraud an insurance company. The fact that an appeal has been entered shall not negate the use of this paragraph.

j. The property has been subject to more than two losses, each loss amounting to at least $500 or 1 percent of the insurance in force, whichever is greater, in the immediately preceding 12-month period, or more than three such losses in the immediately preceding 24-month period, provided that the cause of such losses is due to the conditions which are the responsibility of the owner named insured or due to the actions of any person defined as an insured under the policy.

k. Theft frequency in which there have been more than two thefts, each loss amounting to at least $500, in a 12-month period.

l. Material misrepresentation in any statement to the Plan.

m. On homeowners policies, excessive theft or liability losses. If a given property has been subject to two vandalism and malicious mischief losses, each loss amounting to at least $500, in the immediately preceding 12-month period, or three or more such losses in the immediately preceding 24-month period, the Plan may convert the homeowners policy to a dwelling policy without vandalism and malicious mischief coverage.

20.54(2) The Plan shall terminate all insurance contracts in accordance with Iowa Code sections 515.125, 515.127, and 515.128.

20.54(3) At the completion of 36 months of coverage and prior to the completion of 48 months, each risk shall be reviewed for its eligibility for coverage in the voluntary market. The risk shall be submitted by the Plan to the producer of record, if any, for a search of the voluntary market. If the producer resubmits the risk to the Plan, the risk must be resubmitted with a new application and a written statement from the producer that a search of the voluntary market was performed.

[**ARC 8624B**, IAB 3/24/10, effective 4/28/10]

191—20.55(515,515F) Assessments.

20.55(1) Participation and assessments by and upon each insurer in the Plan for losses and expenses in connection with Plan business shall be levied and assessed by the governing committee of the Plan on the basis of participation factors determined annually, giving effect to the proportion which such insurer's weighted premiums written bears to the aggregate weighted premiums written by all insurers in the Plan.

20.55(2) De minimis assessments. Any assessment of less than $20 shall not be billed to an insurer, but will be accumulated as a deferred assessment until the cumulative amount deferred is at least $20.

20.55(3) Late payment fee. Assessments shall be due and payable when billed. If any member fails to pay an assessment within 60 days after it is due, the insurer shall pay interest from the billing date at the rate of 1.5 percent per month. In the event that an insurer fails to pay any applicable late payment fee with an assessment, the amount of such unpaid late payment fee will be included in the amount of the insurer's next assessment.

20.55(4) Credits for voluntary writings. The Plan may develop a voluntary writing credit policy, subject to approval by the commissioner. Credits may be used as offsets to member company assessments made by the Plan.

191—20.56(515,515F) Commission.

20.56(1) Commission to the licensed producer designated by the applicant shall be 10 percent of all policy premiums. The Plan shall not license or appoint producers.

20.56(2) In the event of cancellation of a policy, or if an endorsement is issued which requires the premium to be returned to the insured, the producer shall refund proportionally to the Plan commissions on the return premium at the same rate at which such commissions were originally paid.

191—20.57(515,515F) Public education. In cooperation with the insurance commissioner, the Plan shall undertake a continuing education program with insurers, producers and consumers about the Plan's insurance program and its availability. All insurers and producers shall cooperate fully in the continuing education program. Such continuing education program will include the publication and distribution of literature:

1. Describing the Plan and its general operation;
2. Explaining the possible cost savings of obtaining insurance in the voluntary market; and
3. Advising of the availability of rate comparison charts.

191—20.58(515,515F) Cooperation and authority of producers.

20.58(1) Each insurer shall require its licensed producers to cooperate fully in the accomplishment of the intents and purposes of the Plan.

20.58(2) Licensed insurance producers shall not act as agents for the Plan.

20.58(3) Licensed insurance producers shall not do any of the following:

a. Bind coverage for the Plan.

b. Alter or change policies issued by the Plan.

c. Settle losses of the Plan.

d. Act on behalf of the Plan or commit the Plan to any course of action.

20.58(4) Licensed insurance producers shall assist applicants who need to apply for coverage under the Plan, and shall submit applications that meet the requirements under rule 191—20.49(515,515F). Producers shall follow the rules and procedures of the Plan.

191—20.59(515,515F) Review by commissioner. The governing committee shall report to the commissioner the name of any insurer or producer which fails to comply with the provisions of the Plan or with any rules prescribed thereunder by the governing committee or to pay within 30 days any assessment levied.

191—20.60(515,515F) Indemnification. Each person serving on the governing committee or any of its subcommittees, each member of the Plan, and the manager and each officer and employee of the Plan shall be indemnified by the Plan against all cost, settlement, judgment, and expense actually and necessarily incurred by that person in connection with the defense of any action, suit, or proceeding in which that person is made a party by reason of that person's being or having been a member of the governing committee or a member or manager or officer or employee of the Plan, except in relation to matters as to which that person has been judged in an action, suit, or proceeding to be liable by reason of willful misconduct in the performance of that person's duties as a member of the governing committee or as a member, manager, officer or employee of the Plan. This indemnification shall not apply to any loss, cost or expense on insurance policy claims under the Plan. Indemnification under this rule shall not be exclusive of other rights to which the member, manager, officer, or employee may be entitled as a matter of law.

191—20.61 to **20.69** Reserved.

These rules are intended to implement 2003 Iowa Acts, chapter 119.

DIVISION III
CERTIFICATES OF INSURANCE FOR COMMERCIAL LENDING TRANSACTIONS

191—20.70(515) Purpose. The purpose of division III is to clarify what information an insurance company regulated by the division may provide its customer in connection with a commercial real estate transaction between the customer and a lender.
[**ARC 0133C**, IAB 5/30/12, effective 5/9/12]

191—20.71(515) Definitions. For purposes of division III, the following definitions shall apply:

"ACORD" means the Association for Cooperative Operations Research and Development.

"Commercial real estate transaction" means a non-recourse commercial lending transaction in which the underlying property serves as the primary collateral securing the borrower's repayment of the loan and neither the borrower nor any of its members, partners, or shareholders, nor any related person to any of the aforementioned persons, bears the economic risk of loss in the event of a payment default under the terms of the lending transaction.

"Division" means the insurance division.

"ISO" means the insurance services office.
[**ARC 0133C**, IAB 5/30/12, effective 5/9/12]

191—20.72(515) Evidence of insurance.

20.72(1) Prior to the issuance of an insurance policy by an insurer, an insured who has entered into a commercial real estate transaction may request that the relevant insurer or a producer acting on behalf of the insurer provide the following items as evidence of insurance:

a. An ACORD Form 75, a successor ACORD form, an ISO binder form, or a substantially similar binder form approved by the division; and

b. An ACORD Form 28, a successor ACORD form, an ISO certificate form, or a substantially similar certificate of insurance form approved by the division.

The insurer or the producer acting on behalf of an insurer has the sole discretion to determine which division-approved binder form or certificate of insurance form the insurer or producer uses to comply with this rule.

20.72(2) An insurer or a producer acting on behalf of an insurer shall comply with a request made pursuant to this rule within 20 business days of the receipt of the request. The requirements of this rule shall not apply to an insurance producer who:

a. Is unauthorized to provide the documents described in this rule; and

b. Informs the insured of this fact within 20 business days of the receipt of the request.

20.72(3) Delivery of a binder along with a certificate of insurance requested pursuant to this rule may be accomplished by regular mail, overnight delivery, facsimile, physical delivery, electronic means, or other appropriate means.

20.72(4) Notwithstanding any language on a form provided pursuant to subrule 20.72(1) which language states that the form is for "information only," a binder together with a certificate of insurance delivered pursuant to this rule shall be valid and may be relied upon by the borrower or by the borrower's lender as evidence of insurance, including in any private civil action or administrative proceeding, until the delivery of the insurance policy to the borrower or the cancellation of the binder pursuant to Iowa Code sections 515.125 to 515.127.

20.72(5) An insurer or producer acting on behalf of an insurer that produces or delivers a binder and certificate of insurance to its customer pursuant to this rule may charge a reasonable fee for the production and delivery of the documents.

20.72(6) All insurers and all producers subject to this rule shall comply with the terms hereof within 90 days from May 9, 2012.

[**ARC 0133C**, IAB 5/30/12, effective 5/9/12]

These rules are intended to implement 2011 Iowa Code Supplement chapter 515.

191—20.73 to **20.79** Reserved.

DIVISION IV
CANCELLATIONS, NONRENEWALS AND TERMINATIONS

191—20.80(505B,515,515D,518,518A,519) Notice of cancellation, nonrenewal or termination of property and casualty insurance.

20.80(1) *Purpose.* The purpose of this rule is to implement the policyholder protections of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 by clarifying the authorized methods of delivery for notices of cancellation, nonrenewal and termination by an insurer. Presumption of receipt in the context of a postal service mailing is a well-settled principle of Iowa law (see *Montgomery Ward v. Davis,* 398 N.W.2d 869, 870-871 (Iowa 1982)), but Iowa courts have not yet recognized a presumption of receipt for electronic transmissions. Notwithstanding Iowa Code section 554D.110(4)*"b,"* delivery by electronic transmission, for the purposes of this rule, does not provide for satisfactory verification or acknowledgment of receipt, as required by Iowa Code section 505B.1(6).

20.80(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508, 515, 518, and 518A.

20.80(3) *Delivery and receipt.* For any notice of cancellation, nonrenewal or termination by an insurer under Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 to be effective, an insurer must, within the time frame established by law, either deliver the notice to the named insured in person or mail the notice through the U.S. Postal Service to the last-known address of the named insured. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in the Iowa Code sections cited in this subrule for certified mail or certificate of mailing as proof of mailing.

20.80(4) *Electronic transmissions.* Electronic transmissions do not currently satisfy the notice requirements of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8. However, additional communication of notices by electronic means may be provided by an insurer as a service to a policyholder.

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

[Filed July 1, 1975]
[Filed 4/11/79, Notice 2/7/79—published 5/2/79, effective 6/7/79]
[Filed 11/20/80, Notice 9/17/80—published 12/10/80, effective 1/15/81]

[Filed 7/11/86, Notice 6/4/86—published 7/30/86, effective 9/3/86][1]
[Editorially transferred from [510] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]
[Filed emergency 6/24/88—published 7/13/88, effective 7/1/88]
[Filed 12/9/88, Notice 11/2/88—published 12/28/88, effective 2/1/89]
[Filed 7/20/90, Notice 6/13/90—published 8/8/90, effective 9/12/90]
[Filed 2/7/97, Notice 1/1/97—published 2/26/97, effective 4/2/97]
[Filed 3/29/01, Notice 10/18/00—published 4/18/01, effective 7/1/01]
[Filed 11/19/03, Notice 10/1/03—published 12/10/03, effective 1/14/04]
[Filed 11/5/04, Notice 9/29/04—published 11/24/04, effective 12/29/04]
[Filed 10/5/06, Notice 8/30/06—published 10/25/06, effective 11/29/06]
[Filed 11/2/06, Notice 9/27/06—published 11/22/06, effective 12/27/06]
[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]
[Filed emergency 4/18/07—published 5/9/07, effective 5/2/07]
[Filed ARC 8624B (Notice ARC 8492B, IAB 1/27/10), IAB 3/24/10, effective 4/28/10]
[Filed Emergency After Notice ARC 0133C (Notice ARC 0070C, IAB 4/4/12), IAB 5/30/12, effective 5/9/12]
[Filed ARC 1125C (Notice ARC 0892C, IAB 7/24/13), IAB 10/16/13, effective 11/20/13]
[Filed ARC 1334C (Notice ARC 1127C, IAB 10/16/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[1] See IAB Insurance Division

LIFE AND HEALTH INSURANCE

CHAPTER 30
LIFE INSURANCE POLICIES

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

191—30.1(508) Purpose. In the best interest of the citizens of Iowa and to maintain a fair and honest life insurance market, certain types of life policy forms and certain policy provisions shall be either prohibited, altered or clarified as set out herein.

191—30.2(508) Scope. These rules shall apply to all insurance policies issued by insurance companies holding a certificate of authority under the provisions of Iowa Code chapter 508.

191—30.3(508) Definitions. Certain life insurance policy forms and provisions referred to herein shall have the following meaning:

30.3(1) *Founders policy.* The term or name assigned to a policy of insurance offered to the public by a newly organized stock life insurance company, issued on a participating basis with the representations that the purchasers will share preferentially in the future divisible surplus earnings of the company arising from all classes of business, both participating and nonparticipating, and all plans of insurance.

30.3(2) *Profit-sharing policy.* It is any policy form which contains provisions or is represented in such a way that the policyholder will be eligible to preferentially participate in any future distribution of general corporate profits.

30.3(3) *Coupon policy.* It is any policy or contract of life insurance, other than annuity, which contains in addition to basic life insurance benefits a series of annual pure endowment benefits evidenced in the policy contract by a series of coupons each of which matures on the maturation date of an annual pure endowment. For the purposes of these rules, policies containing annual pure endowments evidenced by coupons, passbooks or other devices generally acquainted with savings, banking or investment institutions shall be considered coupon policies.

30.3(4) *Pure endowment benefit.* It is a guaranteed insurance benefit, actuarially determined, the payment of which is contingent upon the survival of the insured to a specific point in time.

191—30.4(508) Prohibitions, regulations and disclosure requirements. In accordance with the purpose expressed in 30.1(508) and in conjunction with the intent of Iowa Code section 508.28, the use of certain types of policy forms and policy provisions shall be subject to the following prohibitions and regulations:

30.4(1) *Policy names.* Any insurance policy labeled or described as a founders, charter or coupon policy or names of similar connotation shall not be approved for use in this state on or after the effective date of these rules, and furthermore no policies so named or labeled heretofore approved shall be issued or delivered in this state on or after March 1, 1964.

30.4(2) *Founders policy.* No founders policy as herein defined shall be approved for use in this state on or after the effective date of these rules, and furthermore no founders policy as herein defined heretofore approved shall be issued or delivered in this state on or after March 1, 1964.

30.4(3) *Profit-sharing policy.* No profit-sharing policy shall be approved for use in this state on or after the effective date of these rules, and furthermore no profit-sharing policy heretofore approved shall be issued or delivered in this state on or after March 1, 1964. This subrule does not intend to restrict or prohibit the sale in this state of any participating life insurance policy where the dividend or abatement of premium is derived solely from the profits of that class of participating business.

30.4(4) *Coupon policy.* No coupon policy shall be approved or issued in this state after the effective date of these rules, and furthermore no coupon policy heretofore approved shall be issued or delivered in this state on or after March 1, 1964.

30.4(5) *Guaranteed pure endowment benefits.* No policy containing a series of guaranteed pure endowment benefits shall be approved for use after the effective date of these rules unless it meets the following requirements:

a. The gross premium charged for this benefit shall be separately stated in a size and style of type equal in prominence to that stating the gross premium for the other benefits contained in the policy.

b. The payment of any guaranteed pure endowment benefit shall not be made contingent upon the payment of premiums falling due on or after the time the pure endowment benefit has matured.

c. The amount of the guaranteed series of pure endowment benefits shall be expressed in dollar amounts and shall not be presented or defined, either in the policy or any sales and advertising material, as a "percentage" of any of the premiums or benefits contained therein.

d. No participating policy shall include as part of its benefits a guaranteed pure endowment benefit.

e. The language and terminology of the policy or any of the sales and advertising materials used in connection with any policy, which has a series of pure endowment benefits therein, shall not purport to represent the pure endowment benefit of the policy to be anything other than a guaranteed insurance benefit for which a premium is being paid by the policyholder.

191—30.5(508) General filing requirements.

30.5(1) Insurance companies required to file rates or forms with the division shall submit required rate and form filings pursuant to rule 191—20.1(505,509,514A,515,515A,515F).

30.5(2) Each filing must be submitted to the division of insurance not less than 60 days prior to the effective date of the filing, unless the 60-day period is waived by the division for good cause. Any deficiencies or discrepancies in the filing will delay final approval. In case of disapproval, the company will be notified by the division.

30.5(3) A filing which has not been previously approved, disapproved or questioned shall be deemed approved on or after 30 days from its receipt by the division.

30.5(4) Any insured or established organization with one or more insureds among its members may object to a form or rate filing pursuant to rule 191—20.2(505).

191—30.6(508) Back dating of life policies. Upon the specific written request of an applicant for life insurance, an insurer may issue a policy with an effective date not more than six months prior to the date of the policy application. This regulation shall not be construed to prohibit the exercise of any exchange or conversion privileges in any policy or contract.

191—30.7(508,515) Expiration date of policy vs. charter expiration date. The mere fact that a corporate contract may extend beyond the term of the life of the corporation does not destroy it. We believe as a matter of public policy, insurance corporations frequently enter into such contracts. This is graphically illustrated in the case of a life insurance contract issued by a company with a limited corporate period. It has been held that the renewal of articles of incorporation is a continuation of the original corporate period which lends support to the proposition that it is within the public interest that contracts of this nature be permitted.

191—30.8(509) Electronic delivery of group life insurance certificates.

30.8(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of group life insurance certificates in an efficient manner by insurers and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 509.2(7), and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

30.8(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508 and 515.

30.8(3) *Electronic delivery—insurance companies.* The insurer will be deemed to comply with the requirements of Iowa Code section 509.2(7) if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The insurer takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which can be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the insurer furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

30.8(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 509.2(7) if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

191—30.9(505,508) Notice of cancellation, forfeiture, lapse, nonrenewal or termination of life insurance and annuities.

30.9(1) *Purpose.* The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, forfeiture, lapse, nonrenewal and termination by an insurer, so as to require reasonable procedures for providing notice to policyholders of the consequences of cancellation, forfeiture, lapse, nonrenewal or termination of life insurance and annuity contracts. In universal life contracts, specific advance notice is required by rule 191—92.6(508). The Uniform Electronic Transactions Act, in Iowa Code section 554D.110(4)*"b,"* provides that a requirement under a law to send, communicate, or transmit a record by first-class mail postage prepaid may be varied by agreement to the extent permitted by the other law. Notification regulation should effectively require reasonable advance notice to life insurance and annuity policyholders that insurance coverage will cease or be placed under a nonforfeiture benefit on a date certain. Presumption of receipt in the context of a postal service mailing is a well-settled principle of Iowa law (see *Montgomery Ward v. Davis,* 398 N.W.2d 869, 870-871 (Iowa 1982)), but Iowa courts have not yet recognized a presumption of receipt for electronic transmissions. Notwithstanding Iowa Code section 554D.110(4)*"b,"* delivery by electronic transmission, for the purposes of this rule, does not provide for satisfactory verification or acknowledgment of receipt, as required by Iowa Code section 505B.1(6).

30.9(2) *Scope.* This rule shall apply to all insurance companies that issue contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25.

30.9(3) *Delivery and receipt.* For any notice of cancellation, forfeiture, lapse, nonrenewal or termination by an insurer in contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25 to be effective, an insurer must, within the time frame established by law, or such

reasonable time in advance and as governed by contract, either deliver the notice to the named insured in person or mail the notice through the U.S. Postal Service to the last-known address of the named insured. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement for the contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25 for certified mail or certificate of mailing as proof of mailing.

30.9(4) *Electronic transmissions.* Electronic transmissions do not currently satisfy the requirements of this rule or of rule 191—92.6(508). However, additional communication of notices by electronic means may be provided by an insurer as a service to a policyholder.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code sections 505.8, 508.25, 508.28 and 508A.4 and Iowa Code chapters 505B and 509.

[Filed November 21, 1963]
[Filed 7/3/80, Notice 5/14/80—published 7/23/80, effective 8/29/80]
[Filed 7/11/86, Notice 6/4/86—published 7/30/86, effective 9/3/86][1]
[Editorially transferred from [510] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]
[Filed 7/18/03, Notice 6/11/03—published 8/6/03, effective 9/10/03]
[Filed 10/5/06, Notice 8/30/06—published 10/25/06, effective 11/29/06]
[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[1] See IAB Insurance Division

CHAPTER 35
ACCIDENT AND HEALTH INSURANCE

BLANKET ACCIDENT AND SICKNESS INSURANCE
[Prior to 10/22/86, Insurance Department[510]]

191—35.1(509) Purpose. The purpose of this regulation is to establish guidelines for insurers to make special risk coverage available to particular groups that will be exposed to specific hazards for a certain period of time.

191—35.2(509) Scope. These rules shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508 and 515.

191—35.3(509) Definitions.

35.3(1) Blanket accident and sickness insurance is hereby declared to be that form of accident, sickness or accident and sickness insurance designed to insure against specified hazards incident to or defined by reference to a particular activity or activities and covering groups of persons as enumerated in the following subparagraphs:

a. Under a policy issued to an employer, who shall be deemed the policyholder covering any group of employees defined by reference to specific hazards incident to an activity or activities of the policyholder.

b. Under a policy issued to a college, high school, junior high school, grade school, school district, school jurisdictional unit or other institution of learning; or to the head, principal, governing board of any such educational unit who or which shall be deemed the policyholder covering students, teachers or employees.

c. Under a policy issued to any religious, charitable or educational organization, or branch thereof, which shall be deemed the policyholder covering any group of members or participants defined by reference to specified hazards incident to an activity or activities sponsored or supervised by such policyholder.

d. Under a policy issued to a sports team, youth camp, recreational organization or sponsor thereof, which shall be deemed the policyholder, covering members, campers, participants, employees, officials or supervisors.

e. Under a policy issued to any volunteer fire department, first aid, civil defense or other such volunteer organizations, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

f. Under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, covering its carriers.

g. Under a policy issued to an association, other than a labor union, trade association or industrial association, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

h. Under a policy issued to cover any other risk or class of risks which, in the discretion of the commissioner, may be properly eligible for blanket accident and sickness insurance. The discretion of the commissioner may be exercised on an individual risk basis or class of risks, or both.

35.3(2) Brochure shall mean an instrument, booklet or pamphlet setting forth a statement as to the insurance protection provided, to whom the insurance benefits are payable, sufficient information on the procedure an insured shall follow in filing a claim and such other provisions as are in the opinion of the commissioner of insurance necessary to inform the holder thereof as to rights under the policy.

35.3(3) For purposes of 2005 Iowa Acts, House File 420, section 1, relating to biologically based mental illness coverage in a group policy, contract or plan providing for third-party payment of health, medical, and surgical coverage benefits issued by a carrier or by an organized delivery system,

"biologically based mental illness" shall mean the following mental disorders as they are defined under the following diagnostic classes within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, edition DSM-IV-TR:

a. Schizophrenia. Diagnostic codes 295.xx and 293.xx, including all specific subtypes of schizophrenia listed under those two diagnostic codes and using an appropriate extension. Schizophrenia also includes diagnostic codes 295.40, 295.70, 297.1, 298.8, 297.3 and 298.9.

b. Bipolar disorders. Diagnostic code 296.xx including all specific subtypes of bipolar disorders listed under that diagnostic code and using an appropriate extension. Bipolar disorders also includes diagnostic codes 286.89, 301.13, 296.80, 293.83 and 296.90.

c. Major depressive disorders. Diagnostic codes 296.2x and 296.3x including all specific subtypes of major depressive disorders listed under those two diagnostic codes and using an appropriate extension.

d. Schizo-affective disorders. Diagnostic code 295.70.

e. Obsessive-compulsive disorders. Diagnostic code 300.3.

f. Pervasive development disorders. Diagnostic codes 299.00, 299.80 and 299.10.

g. Autistic disorders. Diagnostic code 299.00.

191—35.4(509) Required provisions. No blanket policy as herein defined shall be issued or delivered in this state unless a copy of the policy and brochure if required, has been approved by the commissioner of insurance in accordance with the provisions set forth in rule 35.7(509). All policies of blanket accident or sickness insurance or combination thereof issued in this state shall contain in substance the following provisions:

35.4(1) A provision that the policy including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense of a claim under the policy, unless it is contained in a written application. If a copy of such application is not delivered to the person insured the insurer shall be precluded from introducing such application as evidence in any action involving any statements contained therein.

35.4(2) A provision that written notice of sickness or of injury must be given to the insurer within 20 days of the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

35.4(3) A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after giving such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

35.4(4) A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 90 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

35.4(5) A provision that all benefits payable under the policy other than benefits for loss of time will be payable immediately upon receipt of due written proof of such loss, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

35.4(6) A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.

35.4(7) A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

191—35.5(509) Application and certificates not required. An individual application need not be required from a person covered under a blanket accident and sickness policy, nor shall it be necessary for the insurer to furnish each person a certificate; however, a brochure as herein defined shall be issued to the policyholder for delivery to each person insured as defined in 35.3(1)*"b"* and *"g."*

191—35.6(509) Facility of payment. All benefits under any blanket accident and sickness policy shall be payable to the person insured, to a designated beneficiary or beneficiaries, or to their estate, except that if the person insured be a minor or otherwise not competent to give a valid release, such benefits may be made payable to their parent, guardian or other person actually supporting the insured, designated beneficiary, or beneficiaries. The policy may also provide that all or a portion of any indemnities provided by any such policy on account of hospital, nursing, medical or surgical services may with the consent of the insured be paid directly to the hospital or person rendering such services, but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid.

These rules are intended to implement Iowa Code section 509.6.

191—35.7(509) General filing requirements.

35.7(1) Insurance companies required to file rates or forms with the division shall submit required rate and form filings pursuant to rule 191—20.1(505,509,514A,515,515A,515F).

35.7(2) Each filing must be submitted to the division of insurance not less than 60 days prior to the effective date of the filing. Any deficiencies or discrepancies in the filing will delay final approval. In case of disapproval, the company will be notified by the division.

191—35.8(509) Electronic delivery of accident and health group insurance certificates.

35.8(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of accident and health group insurance certificates in an efficient manner by insurers and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 509.3(2), and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

35.8(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508 and 515.

35.8(3) *Electronic delivery—insurance companies.* The insurer will be deemed to comply with the requirements of Iowa Code section 509.3(2) if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The insurer takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the insurer furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

35.8(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 509.3(2) if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

This rule is intended to implement Iowa Code chapter 509.

GENERAL ACCIDENT AND HEALTH INSURANCE REQUIREMENTS

191—35.9(509B,513B,514D) Notice of cancellation, rescission, discontinuance or termination of accident and health insurance.

35.9(1) *Purpose.* The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, rescission, discontinuance and termination by an insurer, so as to implement the various policyholder protections intended by Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A. Presumption of receipt in the context of a postal service mailing is a well-settled principle of Iowa law (see *Montgomery Ward v. Davis,* 398 N.W.2d 869, 870-871 (Iowa 1982)), but Iowa courts have not yet recognized a presumption of receipt for electronic transmissions. Notwithstanding Iowa Code section 554D.110(4)*"b,"* delivery by electronic transmission, for the purposes of this rule, does not provide for satisfactory verification or acknowledgment of receipt, as required by Iowa Code section 505B.1(6).

35.9(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508, 512B, 515, and 520.

35.9(3) *Delivery and receipt.* For any notice of cancellation, rescission, discontinuance or termination by an insurer under Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A to be effective, an insurer must, within the time frame established by law, either deliver the notice to the named insured in person or mail the notice through the U.S. Postal Service to the last-known address of the named insured. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in the Iowa Code sections cited in this subrule for certified mail or certificate of mailing as proof of mailing.

35.9(4) *Electronic transmissions.* Electronic transmissions do not currently satisfy the notice requirements of Iowa Code sections 509B.5, 513B.5 and 514D.3. However, additional communication of notices by electronic means may be provided by an insurer as a service to a policyholder.

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

191—35.10 to **35.19** Reserved.

191—35.20(509A) Life and health self-funded plans.

35.20(1) Scope. This rule shall apply to life and health self-funded plans for political subdivisions of the state, school corporations, and all other public bodies of the state. This rule shall not apply to life and health self-funded plans for the state of Iowa.

35.20(2) Iowa Code chapter 28E agreements—certificate of registration. Public entities seeking to pool risk through a joint exercise of power under Iowa Code chapter 28E shall apply for and obtain a certificate of registration from the commissioner. This subrule shall not apply to single-employer public entities with self-insured plans.

a. An application for a certificate of registration shall contain the following:

(1) A copy of the proposed agreement entered into pursuant to Iowa Code chapter 28E, to be executed by all plan participants;

(2) A copy of the articles of incorporation, bylaws, agreements, or other documents or instruments describing the rights and obligations of employers, employees and beneficiaries;

(3) A copy of all contracts with insurance companies, consultants and third-party administrators;

(4) A business plan, including a copy of all contracts or other instruments which the 28E agreement proposes to make with or sell to its members, a copy of its plan description and the printed matter to be used in the solicitation of members; and

(5) A current list of all participating public entities.

b. Iowa Code chapter 28E agreements shall contain the following provisions:

(1) If the plan is in a deficit position, a participant cannot terminate from the plan without the prior written consent of the commissioner;

(2) If a participant in the plan terminates, the terminating participant shall be assessed its proportionate share of the plan's deficit, if any;

(3) Deficit assessments shall be mandatory for all plan participants within a time frame acceptable to the commissioner;

(4) Plan participants have no individual interest in the accumulated surplus of a plan; and

(5) Upon termination of the plan, surplus remaining after the payment of all liabilities shall be distributed proportionately to plan participants that were active members of the plan on the termination date.

c. Reporting requirements. In addition to the requirements of subrule 35.20(3), all public entities pooling risk shall submit:

(1) Quarterly financial statement. A plan shall file with the commissioner of insurance within 60 days of the end of each quarter a report which has been verified by at least two of its principal officers and which covers the preceding calendar quarter. The report shall be on a form prescribed by the commissioner. The commissioner of insurance may request additional reports and information from a plan as often as is deemed necessary.

(2) Amendments. A plan shall submit copies of any proposed amendment to the documents submitted in accordance with subrule 35.20(2), paragraph *"a,"* 30 days in advance of the amendment's proposed effective date.

(3) Other documents. A plan shall submit any other documents deemed necessary by the commissioner.

35.20(3) Minimum plan standards for both pooled and single-employer public entities. Self-funded life plans subject to this rule shall meet the requirements of Iowa Code sections 509.1, 509.2, 509.4, and 509.15 and rules thereunder. Self-funded health plans subject to this rule shall meet the requirements of Iowa Code sections 509.1 and 509.3 and rules thereunder. In order to ensure that a self-funded life or health plan is able to cover all reasonably anticipated expenses and to avoid liability for the public body, a self-funded life or health plan shall provide that:

a. An annual report showing the starting and ending balance of the fund, deposits of monthly accrual rates and other assets of the fund, and the amount and nature of all disbursements from the fund

shall be prepared and submitted to the governing body of the public body. An annual report shall be made to show a separate accounting to reflect all required reserves.

b. Monthly accrual rates shall be established at a satisfactory level to provide funds to cover all claims, reserves, and expenses to operate the plan. Accrual rates shall be reevaluated annually. Accrual rates shall be funded solely through public body contributions or through a combination of employer and employee contributions.

c. A plan fund shall be established exclusively for the deposit of monthly accrual rates and other assets pertaining to the plan. After a self-funded life or health plan is established and as long as any claims may be made against the plan fund, all contributions shall be deposited as collected in the plan fund. The plan fund shall be disbursed only for plan expenses.

d. The following reserves shall be established in the plan fund:

(1) A reserve for claims that have been incurred by participants under the plan, but have not yet been presented for payment. The appropriate amount of this reserve shall be on an actuarially sound basis as determined by an independent actuary, an insurance company, or a nonprofit health service corporation authorized pursuant to Iowa Code chapter 514.

(2) A claims fluctuation reserve for setting aside funds that become available during a month when claims are less than projected for that month. Funds shall be maintained and available for a month in which claims exceed those projected for that month. For public entities that require a certificate of registration under subrule 35.20(2), the claims fluctuation reserve shall equal or exceed a minimum of two months of paid claims.

e. The public body shall obtain a fidelity bond as a guaranty of faithful operation of the self-funded plan by the public body, its officers, agents, and employees.

f. Disbursements from the plan fund shall be made only for the following specified plan expenses:

(1) Payment of claims.

(2) Cost of aggregate excess loss coverage.

(3) Cost of specific excess loss coverage.

(4) Bonding expenses.

(5) Payment of service fees applicable to plan design, payment of claims, materials explaining plan benefits, actuarial assistance, legal assistance, and accounting assistance.

(6) Other expenses directly related to the operation of the plan.

g. Aggregate excess loss coverage shall be obtained which will limit a public body's total claim liability for each year to not more than 125 percent of the level of claims liability as projected by an independent actuary or insurance company. A public body shall fund this potential additional liability of 25 percent either by allocating necessary funds from the operating fund of the general fund or by setting up an additional reserve in the operating fund. Specific excess loss coverage may also be obtained if a public body wishes to limit its total annual liability on claims for any one claimant.

h. The commissioner may retain an independent actuary, at the commissioner's discretion, to review the adequacy of a plan's reserves. The cost of such review shall be paid by the plan. Examples that illustrate when the commissioner may retain an independent actuary include, but are not limited to, negative trends in the plan's financial statements, an increase in consumer complaints about the plan's failing to timely pay claims and material changes to the plan's operations.

35.20(4) Plan shortfalls. If the resources of any self-funded plan subject to this rule are not adequate to fully cover all claims under that plan, then the public body sponsoring that plan shall make up the shortfall from other resources.

35.20(5) Confidentiality. Information held by the plan administrator of a self-funded plan shall be kept confidential. An employee or agent of the plan administrator shall not use or disclose any information to any person, except to the extent necessary to administer claims or as otherwise authorized by law.

35.20(6) A health self-funded plan subject to this rule shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of a self-funded plan's position on the treatment options, or from advocating on behalf of covered persons

within the utilization review or grievance processes established by the self-funded plan or a person contracting with the self-funded plan.

The self-funded plan shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the self-funded plan that, in the opinion of the provider, jeopardizes patient health or welfare.

35.20(7) Benefits shall be made available by the health self-funded plan for inpatient and outpatient emergency services. Since self-funded plans may not contract with every emergency care provider in an area, self-funded plans shall make every effort to inform members of participating providers.

The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

Reimbursement to a provider of "emergency services" shall not be denied by any health maintenance organization without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial diagnosis as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that a noncontracted provider performed services. If reimbursement for emergency services is denied, the enrollee may file a complaint with the self-funded plan. Upon denial of reimbursement for emergency services, the self-funded plan shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

35.20(8) A health self-funded plan subject to this rule shall allow a female member direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

This rule is intended to implement Iowa Code chapter 509A and 2003 Iowa Acts, chapter 83.

191—35.21(509) Review of certificates issued under group policies.

35.21(1) *Nondiscretionary groups.* A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state.

35.21(2) *Discretionary groups.* A certificate of coverage delivered in this state under a group life or accident and health insurance policy issued to a group not substantially as described in Iowa Code section 509.1, subsections (1) to (7), shall not be reviewed by the commissioner if the policy is issued outside of this state and if the policy is issued or offered in a state which has reviewed and approved the policy under a statute substantially similar to Iowa Code section 509.1(8).

These rules are intended to implement Iowa Code sections 509.1, 509.6, and 509A.14.

LARGE GROUP HEALTH INSURANCE COVERAGE

191—35.22(509) Purpose. This division of Chapter 35 implements the requirements of Pub.L. 104-191, the Health Insurance Portability and Accountability Act of 1996 and Iowa Code section 509.3 for large group health insurance coverage.

191—35.23(509) Definitions.

"Affiliation period" means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

"Beneficiary" has the meaning given the term under Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which states, "a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit" under the plan.

"Bona fide association" means, with respect to group health insurance coverage offered in Iowa, an association that meets the following conditions:

1. Has been actively in existence for at least five years.
2. Has been formed and maintained in good faith for purposes other than obtaining insurance.
3. Does not condition membership in the association on any health status-related factor relating to an individual including an employee of an employer or a dependent of any employee.
4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member.
5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

"Carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Commissioner" means the commissioner of insurance.

"Continuation coverage" means coverage under a COBRA continuation provision or a similar state program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar state program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

"Creditable coverage" means health benefits or coverage provided to an individual under any of the following:

1. A group health plan.
2. Health insurance coverage.
3. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.
4. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under Section 1928 of that Act.
5. 10 U.S.C. ch. 55.
6. A health or medical care program provided through the Indian Health Service or a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C. ch. 89.
9. A public health plan as defined under federal regulations.
10. A health benefit plan under Section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).
11. An organized delivery system licensed by the director of public health.
12. A short-term limited durational policy.

"Director" means the director of public health appointed pursuant to Iowa Code section 135.2.

"Division" means the division of insurance.

"Eligible employee" means an individual who is eligible to enroll in group health insurance coverage offered to a group health plan maintained by an employer, in accordance with the terms of the group health plan.

"Employee" means any individual employed by an employer.

"Enrollment date" means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

"Exhaustion of continuation coverage" means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted continuation coverage if:

1. Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or

2. When the individual no longer resides, lives, or works in a service area of an HMO or similar program, whether or not within the choice of the individual, and there is no other continuation coverage available to the individual.

"Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

1. For purposes of this rule, "medical care" means amounts paid for any of the following:

- The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.
- Transportation primarily for and essential to medical care referred to in this definition.
- Insurance covering medical care referred to in this definition.

2. For purposes of this division, a plan, fund, or program established or maintained by a partnership which, but for this paragraph, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care, for present or former partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.

3. With respect to a group health plan, the term "employer" includes a partnership with respect to a partner.

4. With respect to a group health plan the term "participant" includes the following:

- With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.
- With respect to a group health plan maintained by a self-employed individual, under which one or more of the self-employed individual's employees are participants, the self-employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual's dependents may be eligible to receive benefits under the plan.

"Health insurance coverage" or *"Health insurance plan"* means benefits consisting of health care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

1. "Health insurance coverage" does not include any of the following:

- Coverage for accident only, or disability income insurance.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Workers' compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinic care.

- Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- Flexible spending accounts.

2. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

- Limited scope dental or vision benefits.
- Benefits for long-term care, nursing home care, home health care, or community-based care.
- Short-term limited durational insurance.
- Any other similar, limited benefits as provided by rule of the commissioner.
- Stop loss insurance coverage.

3. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

- Coverage only for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance.

4. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under Section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55, and similar supplemental coverage provided under insurance coverage.

5. "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan.

"Health maintenance organization" or *"HMO"* means a federally qualified health maintenance organization as defined in Section 1301(a) of the Public Health Services Act or an organization licensed under Iowa Code section 514B.5.

"Large employer" means an employer employing two or more employees and which does not meet the definition of small employer under Iowa Code section 513B.2(16).

"Late enrollee" means an individual, other than one who enrolls during a special enrollment period, who enrolls under a health benefit plan or health insurance coverage in connection with which it is issued, other than during the first period in which the individual is eligible to enroll under terms of the health benefit plan or health insurance coverage.

"Network plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier.

"Organized delivery system" or *"ODS"* means an organized delivery system licensed by the director.

"Plan year" means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

1. The deductible/limit year used under the plan.
2. If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year.
3. If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year.

"Preexisting condition exclusion" means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

"Short-term limited duration insurance" means health insurance coverage provided under a contract with a carrier that has an expiration date specified in the contract, taking into account any extensions that

may be elected by the policyholder without the carrier's consent, that is, within 12 months of the date the contract becomes effective.

"Significant break in coverage" means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

"Special enrollment period" means a period other than the first period in which an eligible employee or a dependent is eligible to enroll under the terms of group health insurance coverage in connection with which it is issued, without regard to other enrollment periods defined under the health insurance coverage.

"Waiting period" means, with respect to group health insurance coverage and an eligible employee or a dependent who is potentially eligible for coverage under the plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan.

191—35.24(509) Eligibility to enroll.

35.24(1) A carrier or an organized delivery system offering group health insurance coverage shall not establish rules for eligibility, including continued eligibility, of an individual to enroll under the terms of the coverage based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

a. Health status.

b. Medical condition, including both physical and mental conditions.

c. Claims experience.

d. Receipt of health care.

e. Medical history.

f. Genetic information.

g. Evidence of insurability, including conditions arising out of acts of domestic violence.

h. Disability.

35.24(2) Subrule 35.24(1) does not require group health insurance coverage to provide particular benefits other than those provided under the terms of the coverage, and does not prevent a coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the coverage.

35.24(3) Rules for eligibility to enroll under group health insurance coverage include rules defining any applicable waiting or affiliation periods for such enrollment.

35.24(4) A carrier or organized delivery system offering health insurance coverage shall not require an individual, as a condition of enrollment or continued enrollment under the coverage, to pay a premium or contribution which is greater than a premium or contribution for a similarly situated individual enrolled in the coverage on the basis of a health status-related factor in relation to the individual or to a dependent of an individual enrolled under the coverage. This subrule shall not be construed to do either of the following:

a. Restrict the amount that an employer may be charged for health insurance coverage.

b. Prevent a carrier or organized delivery system offering group health insurance coverage from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

35.24(5) A carrier or organized delivery system shall not modify a health insurance coverage with respect to an employer or any eligible employee or dependent through riders, endorsements or other means, to restrict or exclude coverage or benefits for specific diseases, medical conditions, or services otherwise covered by the health insurance coverage.

191—35.25(509) Special enrollments.

35.25(1) A carrier or organized delivery system shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health insurance coverage, if an eligible employee requests enrollment or, if the group health insurance coverage

makes coverage available to dependents, on behalf of a dependent who is eligible but not enrolled under the group health insurance coverage, during the special enrollment period, which shall be 30 days following an event described in subrules 35.25(2) or 35.25(3) with respect to the individual for whom enrollment is requested. A carrier or organized delivery system may impose enrollment requirements that are otherwise applicable under terms of the group health insurance coverage to individuals requesting immediate enrollment.

35.25(2) An individual, who previously had other coverage for medical care and for whom an eligible employee declined coverage under the group health insurance coverage, may be enrolled during a special enrollment period if the individual has lost the other coverage for medical care and:

a. If required by the group health insurance coverage, the eligible employee stated in writing when declining the coverage, after being given a notice of the requirement form, and the consequences of failure to submit a written statement that coverage was declined because the individual had coverage for medical care under another group health insurance coverage, group health plan, or otherwise; and

b. When enrollment was declined for the individual:

(1) The individual had coverage under a COBRA continuation provision and the coverage has been exhausted; or

(2) The individual had coverage other than under a COBRA continuation provision and the coverage has been terminated due to loss of eligibility for the coverage, including loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing, or termination of employer contributions toward the other coverage.

c. For purposes of subparagraph 35.25(2)*"b"*(2):

(1) Loss of eligibility for the coverages does not include loss of eligibility due to the eligible employee's or dependent's failure to make timely premium payments or termination of coverage for cause such as making a fraudulent claim or intentional misrepresentation of material fact in connection with the group health insurance coverage; and

(2) Employer contributions include contributions by any current or former employer of the individual or another person that was contributing to coverage for the individual.

(3) Exhaustion of COBRA continuation coverage means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted COBRA continuation coverage if the coverage ceases.

35.25(3) If the eligible employee has previously declined enrollment under the group health insurance coverage but acquires a dependent through marriage, birth, adoption or placement for adoption, the eligible employee or dependent may be enrolled during the special enrollment period with respect to the individual.

35.25(4) Enrollment of the eligible employee or dependent is effective not later than the first day of the calendar month or, for a newborn or adopted child, on the date of birth, adoption, or placement for adoption.

191—35.26(509) Group health insurance coverage policy requirements.

35.26(1) Group health insurance coverage subject to the rules in this division is renewable with respect to all eligible employees or their dependents at the option of the employer, except for one or more of the following reasons:

a. The health insurance coverage sponsor fails to pay or to make timely payments of premiums or contributions pursuant to the terms of the health insurance coverage.

b. The health insurance coverage sponsors, performs an act or practice constituting fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.

c. Noncompliance with the carrier's or organized delivery system's minimum participation requirements or employer contribution requirements.

d. For a network plan, no enrollees connected to the plan live, reside, or work in the service area of the issuer.

e. A carrier or ODS may choose to discontinue offering and cease to renew a particular type of health insurance coverage in the large group market if the carrier does all of the following:

(1) Provides advance notice of its decision to discontinue the plan to the commissioner or director a minimum of three days prior to the notice for affected employers, participants, and beneficiaries.

(2) Provides notice of its decision not to renew a plan to all affected employers, participants, and beneficiaries no less than 90 days prior to nonrenewal of a plan.

(3) Offers to each plan sponsor of the discontinued coverage the option to purchase any other coverage currently offered by the carrier or ODS to other employers in this state.

(4) Acts uniformly, in opting to discontinue the coverage and in offering the option under subparagraph 35.26(1)*"e"*(3), without regard to the claims experience of the sponsors under the discontinued coverage or to a health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

f. A decision by the carrier or ODS to discontinue offering and cease to renew all of its health insurance delivered or issued for delivery to employers in this state shall do all of the following:

(1) Provide advance notice of its decision to discontinue such coverage to the commissioner or director. Notice to the commissioner or director, at a minimum, shall be no less than three days prior to the notice provided for in subparagraph 35.26(1)*"f"*(2) to affected employers, participants, and beneficiaries.

(2) Provide notice of its decision not to renew such coverage to all affected employers, participants, and beneficiaries no less than 180 days prior to the nonrenewal of the coverage.

(3) Discontinue all health insurance coverage issued or delivered for issuance to employers in this state and cease renewal of such coverage.

g. The membership of an employer in a bona fide association, which is the basis for the coverage which is provided through such association, ceases, but only if the termination of coverage under this subrule occurs uniformly without regard to any health status-related factor relating to any covered individual.

h. The commissioner or director finds that the continuation of the coverage is not in the best interests of the policyholders or certificate holders, or would impair the carrier's or ODS's ability to meet its contractual obligations.

i. At the time of coverage renewal, a carrier or ODS may modify the health insurance coverage for a product offered under group health insurance coverage in the group market, if such modification is consistent with the laws of this state and is effective on a uniform basis among group health insurance coverage with that product.

35.26(2) A carrier or ODS that elects not to renew health insurance coverage under 35.26(1)*"f"* shall not write any new business in the group market in this state for a period of five years after the date of notice to the commissioner or director.

35.26(3) This rule applies only to a carrier or ODS doing business in one established geographic service area of the state and the carrier's or ODS's operations in that service area.

35.26(4) Preexisting condition exclusions.

a. A carrier or ODS, with respect to a participant or beneficiary, may impose a preexisting condition exclusion only as follows:

(1) The exclusion relates to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date. However, genetic information shall not be treated as a condition under this subparagraph in the absence of a diagnosis of the condition related to such information.

(2) The exclusion extends for a period of not more than 12 months, or 18 months in the case of a late enrollee, after the enrollment date.

(3) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

b. A carrier or ODS offering group health insurance coverage shall not impose any preexisting condition as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. A carrier or ODS shall waive any waiting period applicable to a preexisting condition exclusion or limitation period with respect to particular services under health insurance coverage for the period of time an individual was covered by creditable coverage, provided that the creditable coverage was continuous to a date not more than 63 days prior to the effective date of the new coverage. Any period that an individual is in a waiting period for any coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining the period of continuous coverage. A health maintenance organization that does not use preexisting condition limitations in any of its health insurance coverage may impose an affiliation period. For purposes of this paragraph, "affiliation period" means a period of time not to exceed 60 days for new entrants and not to exceed 90 days for late enrollees during which no premium shall be collected and coverage issued is not effective, so long as the affiliation period is applied uniformly, without regard to any health status-related factors.

d. A group health plan, carrier, or ODS offering group health insurance under the plan may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant under rule 35.29(509).

191—35.27(509) Methods of counting creditable coverage.

35.27(1) For purposes of reducing any preexisting condition exclusion period, a group health plan, carrier, or ODS offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in paragraph 35.27(1)*"a,"* except that the plan, carrier or ODS may use the alternative method under paragraph 35.27(1)*"b"* with respect to any or all of the categories of benefits described under paragraph 35.27(1)*"d."*

a. Under the standard method, a group health plan, health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

(1) For purposes of reducing the preexisting condition exclusion period, a group health plan, health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(2) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(3) Notwithstanding any other provisions of paragraph 35.27(1)*"b,"* for purposes of reducing a preexisting condition exclusion period, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in paragraph 35.27(1)*"b."*

b. Under the alternative method, a group health plan, a health insurance carrier, or an ODS offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in paragraph 35.27(1)*"d"* and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage

for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph 35.27(1)*"a."*

c. A plan, carrier, or ODS using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

d. The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

(1) Mental health.

(2) Substance abuse treatment.

(3) Prescription drugs.

(4) Dental care.

(5) Vision care.

e. If the alternative method is used, the plan is required to:

(1) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan;

(2) Include in these statements a description of the effect of using the alternative method, including an identification of the category's uses; and

(3) Count creditable coverage within a category if any level of benefits is provided within the category.

191—35.28(509) Certificates of creditable coverage.

35.28(1) Group health plans, carriers, or ODSs shall issue certificates of creditable coverage to persons losing coverage. A group health plan, carrier, or ODS required to provide a certificate under this rule for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

a. Automatically upon the termination of an individual's group coverage;

b. Automatically upon the termination of COBRA coverage;

c. Upon request within 24 months after coverage ends.

35.28(2) Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

a. The individual requesting the certificate is not entitled to receive a certificate;

b. The individual requests that the certificate be sent to another plan, carrier, or ODS;

c. The plan, carrier, or ODS receiving the certificate agrees to accept the information through means other than a written certificate;

d. The plan or carrier receiving the certificate receives the certificate within a reasonable amount of time.

35.28(3) Required information. The certificate shall include the following information:

a. The date the certificate is issued;

b. The name of the group plan providing coverage;

c. The name of the employee or dependent to whom the certificate applies, other relevant identifying information, and the name of the employee if the certificate is for a dependent;

d. The plan administrator's name, address and telephone number;

e. A telephone number to call for further information if different from above;

f. Either a statement that the person has at least 18 months' creditable coverage without a significant break of coverage or the date any waiting period and creditable coverage began;

g. The date creditable coverage ended or an indication that the coverage is in force.

35.28(4) Family information. Information for families may be combined on one certificate. Any differences in creditable coverages shall be clearly delineated.

35.28(5) Dependent coverage transition rule. A group health plan, carrier, or ODS that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

35.28(6) Delivering certificates. The certificate shall be given to the individual, plan, carrier, or ODS requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

35.28(7) A group health plan, carrier, or ODS shall establish a procedure for individuals to request and receive certificates.

35.28(8) A certificate is not required to be furnished until the group health plan, carrier, or ODS knows or should have known that dependent's coverage terminated.

35.28(9) Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health plan, carrier, or ODS shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

191—35.29(509) Notification requirements.

35.29(1) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents that includes the following:

a. The existence of any preexisting condition exclusions.

b. A determination that the group health plan, carrier, or ODS intends to impose a preexisting condition exclusion and:

(1) The basis for the decision to do so;

(2) The length of time to which the exclusion will apply;

(3) The right of the employee or dependent to appeal a decision to impose a preexisting condition exclusion;

(4) The right of the person to demonstrate creditable coverage including the right of the person to request a certificate from a prior group health plan, carrier, or ODS and a statement that the current group health plan, carrier, or ODS will assist in obtaining the certificate.

c. That the group health plan, carrier, or ODS will use the alternative method of counting creditable coverage.

d. Special enrollment rights when an employee declines coverage for the employee or dependents.

35.29(2) A group health plan, carrier, or ODS shall provide written notice to the employee and dependents of a modification of a prior creditable coverage decision when the group health plan, carrier, or ODS subsequently determines either no or less creditable coverage existed provided that the group health plan, carrier, or ODS acts according to its initial determination until the final determination is made.

191—35.30(509) Mental health benefits. Rescinded IAB 12/7/05, effective 1/11/06.

191—35.31(509) Disclosure requirements. All carriers and ODSs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all carriers and ODSs offering health insurance coverage that includes a prescription drug formulary shall inform enrollees of the coverage, and prospective enrollees of the coverage during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All carriers and ODSs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other

family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—35.32(514C) Treatment options.

35.32(1) A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

35.32(2) A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

191—35.33(514C) Emergency services. Benefits shall be available by the carrier for inpatient and outpatient emergency services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

35.33(1) The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

35.33(2) The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

35.33(3) Reimbursement to a provider of "emergency services" shall not be denied by any carrier without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the carrier. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—35.34(514C) Provider access. A carrier subject to this chapter shall allow a female enrollee direct access to obstetrical and gynecological services from network or participating providers. The carrier shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

These rules are intended to implement Iowa Code chapters 509 and 514C and 1999 Iowa Acts, Senate File 276.

191—35.35(509) Reconstructive surgery.

35.35(1) A carrier or organized delivery system that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

a. Reconstruction of the breast on which the mastectomy has been performed;

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

35.35(2) The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

35.35(3) Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

35.35(4) A carrier or organized delivery system shall not deny an enrollee eligibility or continued eligibility to enroll or renew coverage under the terms of the health insurance solely for the purpose of avoiding the requirements of this rule. A carrier or organized delivery system shall not penalize, reduce or limit the reimbursement of an attending provider or induce the provider to provide care in a manner inconsistent with this rule.

This rule is intended to implement Public Law 105-277.

CONSUMER GUIDE

191—35.36(514K) Purpose. These rules implement Iowa Code Supplement section 514K.1(2) which requires the commissioner and the director of public health to annually publish a consumer guide. These rules apply to all carriers providing health insurance coverage in the individual, small employer group and large group markets that utilize a preferred provider arrangement and to all health maintenance organizations.

191—35.37(514K) Information filing requirements.

35.37(1) Each health maintenance organization shall annually file with the division no later than July 1 the following information by plan as requested by the division:

a. Health plan employer data information set (HEDIS).

b. Network composition.

c. Other information determined to be beneficial to consumers including but not limited to consumer survey information.

35.37(2) Each preferred provider organization health network shall annually file with the division no later than July 1 the following information by plan as requested by the division:

a. Reportable information as defined by a nationally recognized accreditation organization for preferred provider organization health networks.

b. Network composition.

c. Other information determined to be beneficial to consumers including but not limited to consumer survey information.

35.37(3) Each health maintenance organization and insurer using a preferred provider organization health network shall transmit the requested information by electronic mail or diskette in a format prescribed by the division.

191—35.38(514K) Limitation of information published. The division may establish limits on the data to be collected and published in the event the division believes the information is not statistically relevant and would not be beneficial to consumers.

These rules are intended to implement Iowa Code Supplement section 514K.1(2).

191—35.39(514C) Contraceptive coverage.

35.39(1) A carrier or organized delivery system that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

35.39(2) A carrier or organized delivery system is not required to provide benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

35.39(3) A contraceptive drug or contraceptive device does not include surgical services intended for sterilization, including, but not limited to, tubal ligation or vasectomy.

35.39(4) A carrier or organized delivery system shall be required to provide benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

35.39(5) If a carrier or organized delivery system does not provide benefits for a routine physical examination, the carrier or organized delivery system is not required to provide benefits for a routine physical examination provided in the course of prescribing a contraceptive drug or contraceptive device.

This rule is intended to implement 2000 Iowa Acts, Senate File 2126.

191—35.40(514C) Autism spectrum disorders coverage.

35.40(1) *Purpose.* This rule implements Iowa Code section 514C.28, relating to autism spectrum disorders coverage in a group plan established pursuant to Iowa Code chapter 509A for employees of the state that provides for third-party payment or prepayment of health, medical, and surgical coverage benefits.

35.40(2) *Definitions.* For purposes of this rule, the definitions found in Iowa Code section 514C.28(2) shall apply. In addition, the following definitions shall apply:

"Autism spectrum disorders" means the following neurological disorders as defined under the following diagnostic classes within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, edition DSM-IV-TR:

1. Autistic disorders. Diagnostic code 299.00.
2. Rett's Disorder. Diagnostic code 299.80.
3. Childhood Disintegrative Disorder. Diagnostic code 299.10.
4. Asperger's Disorder. Diagnostic code 299.80.
5. Pervasive Developmental Disorder NOS. Diagnostic code 299.80.

"Commissioner" means the commissioner of insurance.

"Group plan" or *"group health plan"* means a group health plan established for the employees of the state of Iowa under Iowa Code chapter 509A.

35.40(3) *Services.* A group plan is not required to provide coverage for any of the following:

a. Acupuncture.
b. Animal-based therapy including hippotherapy.
c. Auditory integration training.
d. Chelation therapy.
e. Child care.
f. Cranial sacral therapy.
g. Custodial or respite care.
h. Hyperbaric oxygen therapy.
i. Special diets or supplements.

35.40(4) *Parents or legal guardians of children diagnosed with autism spectrum disorders.* A group plan shall not be required to pay for treatment rendered by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for treatment rendered to their own children.

35.40(5) *Locations for services.*

a. A group plan shall provide coverage for treatments, therapies and services to an insured diagnosed with autism spectrum disorders by an autism service provider in locations including the provider's office or clinic or in a setting conducive to the acquisition of the target skill. Treatments may be provided in schools when the treatments, therapies, and services are related to the goals of the treatment plan and do not duplicate services provided by a school.

b. A group health plan is not required to provide coverage for therapy, treatment or services when the therapy, treatment or services are provided to an insured who is residing in a residential treatment center or inpatient treatment or day treatment facility.

35.40(6) *Verification of qualified provider.* A group health plan is required to verify the licensure, certification and all training or other credentials of a qualified provider or health professional. A group health plan shall not deny payment or reimbursement for the necessary diagnosis or treatment provided by a certified behavior analyst or a health professional licensed under Iowa Code chapter 147.

35.40(7) *Annual publication CPI adjustment.* The commissioner shall publish on or before April 1 of each year beginning April 1, 2014, an adjustment to the required maximum benefit equal to

the percentage change in the United States Department of Labor Consumer Price Index for all urban consumers in the preceding year. The adjusted maximum benefit published each April shall be used by group health plans in order to comply with this rule and shall be effective January 1 for group plans issued or renewed on or after January 1 of the following calendar year.

35.40(8) *Notice to insureds.* A group plan shall provide written notice to the insured regarding claims submitted and processed for the treatment of autism spectrum disorders and shall include the total amount expended to date for the current policy year. The notice may be included with the explanation of benefits form or in a separate communication provided on a periodic basis during the course of treatment.

This rule is intended to implement Iowa Code section 514C.28.

[**ARC 9500B**, IAB 5/4/11, effective 6/8/11]

[Filed 11/16/65]
[Filed 11/18/85, Notice 10/9/85—published 12/4/85, effective 1/8/86]
[Filed 7/11/86, Notice 6/4/86—published 7/30/86, effective 9/3/86][1]
[Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]
[Filed 9/18/87, Notice 8/12/87—published 10/7/87, effective 11/11/87]
[Filed 12/9/88, Notice 9/21/88—published 12/28/88, effective 2/1/89]
[Filed emergency 6/26/97—published 7/16/97, effective 7/1/97]
[Filed 10/10/97, Notice 7/16/97—published 11/5/97, effective 12/10/97]
[Filed 4/1/98, Notice 2/11/98—published 4/22/98, effective 5/27/98]
[Filed emergency 10/16/98—published 11/4/98, effective 10/16/98]
[Filed 12/28/98, Notice 12/2/98—published 1/13/99, effective 3/3/99]
[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]
[Filed 9/3/99, Notice 7/14/99—published 9/22/99, effective 10/27/99]
[Filed 4/10/00, Notice 1/12/00—published 5/3/00, effective 6/7/00]
[Filed 5/10/00, Notice 4/5/00—published 5/31/00, effective 7/5/00]
[Filed 8/17/00, Notice 7/12/00—published 9/6/00, effective 10/11/00]
[Filed emergency 10/26/01—published 11/14/01, effective 10/26/01]
[Filed 3/29/02, Notice 2/6/02—published 4/17/02, effective 5/22/02]
[Filed 7/18/03, Notice 6/11/03—published 8/6/03, effective 9/10/03]
[Filed 12/15/04, Notice 11/10/04—published 1/5/05, effective 2/9/05]
[Filed 11/16/05, Notice 10/12/05—published 12/7/05, effective 1/11/06]
[Filed 10/5/06, Notice 8/30/06—published 10/25/06, effective 11/29/06]
[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]
[Filed ARC 9500B (Notice ARC 9340B, IAB 1/26/11), IAB 5/4/11, effective 6/8/11]
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[1] See IAB Insurance Division

CHAPTER 39
LONG-TERM CARE INSURANCE

DIVISION I
GENERAL PROVISIONS

191—39.1(514G) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514G, to promote the availability of long-term care insurance coverage, to protect applicants for long-term care insurance, as defined, from unfair or deceptive sales or enrollment practices, to facilitate public understanding and comparison of long-term care insurance coverages, and to facilitate flexibility and innovation in the development of long-term care insurance.

191—39.2(514G) Authority. This chapter is issued pursuant to the authority vested in the commissioner under Iowa Code section 514G.7 in accordance with the procedures set forth in Iowa Code chapter 17A.

191—39.3(514G) Applicability and scope. Except as otherwise specifically provided, this chapter applies to all long-term care insurance policies and long-term care coverage arrangements delivered or issued for delivery in this state on or after the effective date hereof, by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations and all similar organizations.

191—39.4(514G) Definitions. For the purpose of these rules, the terms *"Group long-term care insurance," "Commissioner," "Applicant," "Policy," "Preexisting condition"* and *"Certificate"* shall have the meanings set forth in Iowa Code chapter 514G, "Long-Term Care Insurance Act."

"Long-term care insurance" means an insurance policy, insurance contract, insurance certificate, or rider, which is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care service provided in a setting other than an acute care unit of a hospital. This definition also encompasses group and individual annuities and life insurance policies or riders that provide directly for or supplement long-term care insurance as well as a policy or rider providing for payment of benefits based upon cognitive impairment or the loss of functional capacity.

Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organizations to the extent they are otherwise authorized to issue life or health insurance.

Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare Supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset-protection coverage, or accident-only coverage, specific disease or specified accident coverage, or limited benefit health coverage. The definition does not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor eligibility for those benefits is conditional upon the receipt of long-term care. Notwithstanding any other provision contained herein, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of 191—Chapter 39.

"Long-term care coverage arrangement" is a promise that long-term care will be delivered to a person upon need and the meeting of certain contractual requirements. The arrangement is offered to the general public or a sector of the general public at a cost determined by the use of sound actuarial principles based upon the probability of use. This definition does not include self-insurance.

"Qualified long-term care insurance contract" or *"federally tax-qualified long-term care insurance contract"* means an individual or group insurance contract that meets the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as follows:

1. The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

2. The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount. The requirements of this paragraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payor. A contract shall not fail to satisfy the requirements of this paragraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate;

3. The contract is guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986;

4. The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed;

5. All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract; and

6. The contract meets the consumer protection provisions set forth in Section 7702B(g) of the Internal Revenue Code of 1986.

"Qualified long-term care insurance contract" or "federally tax-qualified long-term care insurance contract" also means the portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of Sections 7702B(b) and (e) of the Internal Revenue Code of 1986.

191—39.5(514G) Policy definitions. No long-term care insurance policy delivered or issued for delivery in this state shall use the terms set forth below, unless the terms are defined in the policy and the definitions satisfy the following requirements:

39.5(1) *"Medicare"* shall be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

39.5(2) *"Mental or nervous disorder"* shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

39.5(3) *Nursing care.*

a. *"Skilled nursing care"* shall not be defined more restrictively than one or more professional services performed for the benefit of the insured on a daily basis, by or under the supervision of a registered nurse, prescribed by a physician, appropriate and consistent with the diagnosis and conditions requiring care.

b. *"Intermediate nursing care"* shall not be defined more restrictively than care which meets all of the above when professional nursing services are delivered on a regular basis but less often than daily.

c. *"Custodial nursing care"* shall not be defined more restrictively than that level of care required to assist an individual in activities of daily living when, due to age complicated by sickness or injury, such care is required. This level of care can be performed by persons without professional skills or training.

39.5(4) *"Nursing facility"* shall be defined in relation to its status, facilities, and available services.

a. A definition of such home or facility shall not be more restrictive than one requiring that it:

(1) Be operated pursuant to law; be appropriately licensed or certified;

(2) Be primarily engaged in providing, in addition to room and board accommodations, skilled or intermediate nursing care under the supervision of a duly licensed physician;

(3) Provide nursing service by or under the supervision of a registered nurse (R.N.); and

(4) Maintain a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not include:

(1) Any home, facility or part thereof used primarily for rest;

(2) A home or facility for the aged or for the care of drug addicts or alcoholics; or

(3) A home or facility primarily used for the care and treatment of mental diseases, or disorders, or custodial or educational care.

39.5(5) *"Acute condition"* means that the individual is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain the individual's health status.

39.5(6) *"Home health care services"* means medical and nonmedical services, provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living and respite care services.

39.5(7) *"Activities of daily living"* means at least bathing, continence, dressing, eating, toileting and transferring.

39.5(8) *"Adult day care"* means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

39.5(9) *"Bathing"* means washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

39.5(10) *"Cognitive impairment"* means a deficiency in a person's short- or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.

39.5(11) *"Continence"* means the ability to maintain control of bowel and bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

39.5(12) *"Dressing"* means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

39.5(13) *"Eating"* means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

39.5(14) *"Exceptional increase"* means only those increases filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state or due to increased and unexpected utilization that affects the majority of insurers of similar products. Except as provided in rule 191—39.28(514G), exceptional increases are subject to the same requirements as other premium rate schedule increases.

The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase. The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

39.5(15) *"Hands-on assistance"* means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activities of daily living.

39.5(16) *"Incidental,"* as used in subrule 39.28(10), means that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured as of the date of issue.

39.5(17) *"Personal care"* means the provision of hands-on services to assist an individual with activities of daily living.

39.5(18) *"Qualified actuary"* means a member in good standing of the American Academy of Actuaries.

39.5(19) *"Similar policy forms"* means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in Iowa Code section 514G.4(4) are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable

certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, noninstitutional long-term care benefits only, or comprehensive long-term care benefits.

39.5(20) *"Toileting"* means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

39.5(21) *"Transferring"* means moving into or out of a bed, chair or wheelchair.

191—39.6(514G) Policy practices and provisions.

39.6(1) *Renewability.* The terms *"guaranteed renewable"* and *"noncancellable"* shall not be used in any individual long-term care insurance policy without further explanatory language in accordance with the disclosure requirements of this chapter. No such policy issued to an individual shall contain renewal provisions other than "guaranteed renewable" or "noncancellable."

a. The term *"guaranteed renewable"* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force and cannot decline to renew. Rates may be revised by the insurer on a class basis.

b. The term *"noncancellable"* may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums during which period the insurer has no right to unilaterally make any change in any provision of the insurance or in the premium rate.

c. Notwithstanding the provisions in 191—subrule 36.5(4), long-term care insurance policies may contain a return of premium or cash value benefit so long as:

(1) The return of premium or cash value benefit is not reduced by an amount greater than the aggregate of any claims paid under the policy; and

(2) The insurer demonstrates in its filings that the reserve basis for the policies is adequate.

Any advertisement or sales presentation of a long-term care insurance policy with a return of premium or cash value benefit provision shall include a side-by-side comparison of premiums for the same policy with and without the return of premium or cash value benefit provision.

d. The term "level premium" may be used only when the insurer does not have the right to change the premium.

e. In addition to the other requirements of this subrule, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of the Internal Revenue Code of 1986.

39.6(2) *Limitations and exclusions.*

a. No policy may be delivered or issued for delivery in this state as long-term care insurance if such policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:

(1) Preexisting conditions or disease;

(2) Mental or nervous disorders (however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's disease or similar forms of irreversible dementia nor limit coverage for Alzheimer's disease to the skilled or intermediate level of care);

(3) Alcoholism and drug addiction;

(4) Illness, treatment or medical condition arising out of:

1. War or act of war (whether declared or undeclared);
2. Participation in a felony, riot or insurrection;
3. Service in the armed forces or units auxiliary thereto;
4. Attempted suicide (sane or insane) or intentional self-inflicted injury;
5. Aviation (this exclusion applies only to non-fare-paying passengers).

(5) Treatment provided in a government facility (unless otherwise required by law), services for which benefits are available under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law, services provided by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(6) Expenses for services or items available or paid under another long-term care insurance or health insurance policy;

(7) In the case of a qualified long-term care insurance contract, expenses for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance amount.

Paragraph *"a"* is not intended to prohibit exclusions and limitations by type of provider or territorial limitations.

b. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Iowa Code section 514G.7(3)*"b"* expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in Iowa Code section 514G.7(3)*"b."*

c. No long-term care insurance policy may be delivered or issued for delivery in this state if the policy conditions eligibility for any benefits other than waiver of premium, postconfinement, postacute care or recuperative benefits on a prior institutionalization requirement.

39.6(3) *Extension of benefits.* Termination of long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the long-term care insurance was in force may be limited to the duration of the benefit period, if any, or to payment of the maximum benefits and may be subject to any policy waiting period, and all other applicable provisions of the policy.

39.6(4) *Continuation or conversion.*

a. Group long-term care insurance issued in this state on or after January 1, 1992, shall provide covered individuals with a basis for continuation or conversion of coverage.

b. For the purposes of this rule, *"a basis for continuation of coverage"* means a policy provision which maintains coverage under the existing group policy when such coverage would otherwise terminate and which is subject only to the continued timely payment of premium when due. Group policies which restrict provision of benefits and services to, or contain incentives to use, certain providers or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The commissioner shall make a determination as to the substantial equivalency of benefits, and in doing so, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

c. For the purposes of this rule, *"a basis for conversion of coverage"* means a policy provision that an individual whose coverage under the group policy would otherwise terminate or has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy (and any group policy which it replaced), for at least six months immediately prior to termination, shall be entitled to the issuance of a converted policy by the insurer under whose group policy the individual is covered, without evidence of insurability.

d. For the purposes of this rule, *"converted policy"* means an individual policy of long-term care insurance providing benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided under the group policy from which conversion is made. Where the group policy from which conversion is made restricts provision of benefits and services to, or contains incentives to use, certain providers or facilities, the commissioner, in making a determination as to the substantial equivalency of benefits, shall take into consideration the differences between managed care and nonmanaged care plans including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.

e. Written application for the converted policy shall be made and the first premium due, if any, shall be paid as directed by the insurer not later than 31 days after termination of coverage under the

group policy. The converted policy shall be issued effective on the day following the termination of coverage under the group policy, and shall be renewable annually.

f. Unless the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy from which conversion is made. Where the group policy from which conversion is made replaced previous group coverage, the premium for the converted policy shall be calculated on the basis of the insured's age at inception of coverage under the group policy replaced.

g. Continuation of coverage or issuance of a converted policy shall be mandatory, except where:

(1) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or

(2) The terminating coverage is replaced not later than 31 days after termination, by group coverage, effective on the day following termination of coverage, that provides benefits identical to or benefits determined by the commissioner to be substantially equivalent to or in excess of those provided by the terminating coverage, and for which the premium is calculated in a manner consistent with the requirements of paragraph *"f"* of this subrule.

h. Notwithstanding any other provision of this rule, a converted policy issued to an individual who at the time of conversion is covered by another long-term care insurance policy which provides benefits on the basis of incurred expenses, may contain a provision which results in a reduction of benefits payable if the benefits provided under the additional coverage, together with the full benefits provided by the converted policy, would result in payment of more than 100 percent of incurred expenses. Such provision shall only be included in the converted policy if the converted policy also provides for a premium decrease or refund which reflects the reduction in benefits payable.

i. The converted policy may provide that the benefits payable under the converted policy, together with the benefits payable under the group policy from which conversion is made, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in force and effect.

j. Notwithstanding any other provision of this rule, any insured individual whose eligibility for long-term care coverage is based upon the individual's relationship to another person shall be entitled to continuation of coverage under the group policy upon termination of the qualifying relationship by death or dissolution of marriage.

k. For the purpose of this rule: a *"Managed-Care Plan"* is a health care or assisted living arrangement designed to coordinate patient care or control costs through utilization review, case management or use of specific provider networks.

39.6(5) *Discontinuance and replacement.* If a group long-term care policy is replaced by another group long-term care policy issued to the same policyholder, the succeeding insurer shall offer coverage to all persons covered under the previous group policy on its date of termination. Coverage provided or offered to individuals by the insurer and premiums charged to persons under the new group policy:

a. Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

b. Shall not vary or otherwise depend on the individual's health or disability status, claim experience, or use of long-term care services.

39.6(6) *Premiums.*

a. The premiums charged to an insured for long-term care insurance shall not increase due to either:

(1) The increasing age of the insured at ages beyond 65; or

(2) The duration the insured has been covered under the policy.

b. The purchase of additional coverage shall not be considered a premium rate increase, but for purposes of the calculation required under subrule 39.29(6), the portion of the premium attributable to the additional coverage shall be added to and considered part of the initial annual premium.

c. A reduction in benefits shall not be considered a premium change, but for purposes of the calculation required under subrule 39.29(6), the initial annual premium shall be based on the reduced benefits.

39.6(7) *Electronic enrollment for group policies.* In the case of a group defined in Iowa Code section 514G.4(4), any requirement that a signature of an insured be obtained by a producer or insurer shall be deemed satisfied if:

a. The consent is obtained by telephonic or electronic enrollment by the group policyholder or insurer. A verification of enrollment information shall be provided to the enrollee;

b. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure the accuracy, retention and prompt retrieval of records; and

c. The telephonic or electronic enrollment provides necessary and reasonable safeguards to ensure that the confidentiality of individually identifiable information and privileged information is maintained.

The insurer shall make available, upon request of the commissioner, records that will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.7(514G) Required disclosure provisions.

39.7(1) *Renewability.*

a. Individual long-term care insurance policies shall contain a renewability provision. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration of the term of coverage for which the policy is issued and for which it may be renewed. This provision shall not apply to policies which do not contain a renewability provision, and under which the right to nonrenew is reserved solely to the policyholder.

b. A long-term care insurance policy or certificate, other than one in which the insurer does not have the right to change the premium, shall include a statement that premium rates may change.

39.7(2) *Riders and endorsements.* Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under an individual long-term care insurance policy, no riders or endorsements may be added to an individual long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy, rider or endorsement.

39.7(3) *Payment of benefits.* A long-term care insurance policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

39.7(4) *Limitations.* If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

39.7(5) *Other limitations or conditions on eligibility for benefits.* A long-term care insurance policy or certificate containing any limitations or conditions for eligibility, other than those prohibited in Iowa Code section 514G.7(4)*"b,"* shall set forth a description of the limitations or conditions, including any required number of days of confinement, in a separate paragraph of the policy or certificate and shall label such paragraph "Limitations or Conditions on Eligibility for Benefits."

39.7(6) *Disclosure of tax consequences.* With regard to life insurance policies which provide an accelerated benefit for long-term care, a disclosure statement is required at the time of application for the policy or rider and at the time the accelerated benefit payment request is submitted that receipt of these accelerated benefits may be taxable, and that assistance should be sought from a personal tax advisor. The disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subrule shall not apply to qualified long-term care insurance contracts.

39.7(7) *Benefit triggers.* Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and shall be described in the policy or certificate in a separate paragraph and shall be labeled "Eligibility for the Payment of Benefits." Any additional benefit triggers

shall also be explained in this paragraph. If these triggers differ for different benefits, explanation of the trigger shall accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too shall be specified.

39.7(8) *Qualified long-term care contracts.* A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

39.7(9) *Nonqualified long-term care contracts.* A nonqualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage that the policy is not intended to be a qualified long-term care insurance contract.

191—39.8(514G) Prohibition against postclaims underwriting.

39.8(1) All applications for long-term care insurance policies or certificates except those which are guaranteed issue shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

39.8(2) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

39.8(3) Except for policies or certificates which are guaranteed issue:

a. The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] has the right to deny benefits or rescind your policy.

b. The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

39.8(4) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate.

39.8(5) Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this information to the insurance commissioner in the format prescribed by the National Association of Insurance Commissioners.

191—39.9(514D,514G) Minimum standards for home health care benefits in long-term care insurance policies.

39.9(1) A long-term care insurance policy or certificate may not, if it provides benefits for home health care services, limit or exclude benefits:

a. By requiring that the insured/claimant would need skilled care in a nursing facility if home health care services were not provided;

b. By requiring that the insured/claimant first or simultaneously receive nursing or therapeutic services in a home or community setting before home health care services are covered;

c. By limiting eligible services to services provided by registered nurses or licensed practical nurses;

d. By requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the provider's licensure or certification;

e. By requiring that the insured/claimant have an acute condition before home health care services are covered;

f. By limiting benefits to services provided by Medicare-certified agencies or providers;

g. By excluding coverage for personal care services provided by a home health aide;

h. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

i. By excluding coverage for adult day care services.

39.9(2) Home health care coverage may be applied to the nonhome health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.10(514D,514G) Requirement to offer inflation protection.

39.10(1) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection offers, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers must offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

a. Increases benefit levels annually in a manner so that the increases are compounded annually at a rate not less than 5 percent;

b. Guarantees the insured individual the right to periodically increase benefit levels without providing evidence of insurability or health status so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least 5 percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

c. Covers a specified percentage of actual or reasonable charges and does not include a maximum specified indemnity amount or limit.

39.10(2) Where the policy is issued to a group, the required offer in subrule 39.10(1) shall be made to the group policyholder; except, if the policy is issued to a group defined in Iowa Code section 514G.4(5)*"d,"* other than to a continuing care retirement community, the offering shall be made to each proposed certificate holder.

39.10(3) The offer in subrule 39.10(1) shall not be required of life insurance policies or riders containing accelerated long-term care benefits.

39.10(4) Insurers shall include the following information in or with the outline of coverage:

a. A graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20-year period.

b. Any expected premium increases or additional premiums to pay for automatic or optional benefit increases. If premium increases or additional premiums will be based on the attained age of the applicant at the time of the increase, the insurer shall also disclose the magnitude of the potential premiums the applicant would need to pay at ages 75 and 85 for benefit increases.

An insurer may use a reasonable hypothetical, or a graphic demonstration, for the purposes of this disclosure.

39.10(5) Inflation protection benefit increases under a policy which contains these benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

39.10(6) An offer of inflation protection that provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. The offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

39.10(7) Inflation protection as provided in this subrule shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subrule. The rejection may be either in the application or on a separate form. The rejection shall be considered a part of the application and shall state:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with and without inflation protection. Specifically, I have reviewed Plans _____, and I reject inflation protection.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

191—39.11(514D,514G) Requirements for application forms and replacement coverage.

39.11(1) Application forms shall include the following questions designed to elicit information whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer, except where the coverage is sold without a producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by Iowa Code section 514G.4(5)*"a,"* the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced; provided, however, that the certificate holder has been notified of the replacement.

a. Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

b. Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(1) If so, with which company?

(2) If that policy lapsed, when did it lapse?

c. Are you covered by Medicaid?

d. Do you intend to replace any of your medical or health insurance coverage with this policy [certificate]?

39.11(2) Producers shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

39.11(3) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer, other than an insurer using direct response solicitation methods, or its producer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by [company name]. Your new policy provides ten days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY PRODUCER
[BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____
(Signature of Producer, Broker or Other Representative)
[Typed Name and Address of Producer or Broker]
The above "Notice to Applicant" was delivered to me on:

_____
(Date)

_____
(Applicant's Signature)

39.11(4) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following manner:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE
[Insurance company's name and address]
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to [your application] [information you have furnished], you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by [company name]. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to [company name and address] within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

39.11(5) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

39.11(6) Life insurance policies that accelerate benefits for long-term care shall comply with this subrule if the policy being replaced is a long-term care insurance policy. If the policy being replaced is a life insurance policy, the insurer shall comply with the replacement requirements of 191—Chapter 16. If a life insurance policy that accelerates benefits for long-term care is replaced by another such policy, the replacing insurer shall comply with both the long-term care and the life insurance replacement requirements.

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.12(514G) Reserve standards.

39.12(1) When long-term care benefits are provided through the acceleration of benefits under group or individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Iowa Code section 508.36(3)*"a"*(7). Claim reserves must also be established when such policy or rider is in claim status.

Reserves for policies and riders subject to this subrule should be based on the multiple decrement model utilizing all relevant decrements except for voluntary termination rates. Single decrement approximations are acceptable if the calculation produces essentially similar reserves, if the reserve is clearly more conservative, or if the reserve is immaterial. The calculations may take into account the reduction in life insurance benefits due to the payment of long-term care benefits. However, in no event shall the reserves for the long-term care benefit and the life insurance benefit be less than the reserves for the life insurance benefit assuming no long-term care benefit.

In the development and calculation of reserves for policies and riders subject to the subrule, due regard shall be given to the applicable policy provisions, marketing methods, administrative procedures and all other considerations which have an impact on projected claim costs, including, but not limited to, the following:

a. Definition of insured events;

b. Covered long-term care facilities;

c. Existence of home convalescence care coverage;
d. Definition of facilities;
e. Existence or absence of barriers to eligibility;
f. Premium waiver provision;
g. Renewability;
h. Ability to raise premiums;
i. Marketing method;
j. Underwriting procedures;
k. Claims adjustment procedures;
l. Waiting period;
m. Maximum benefit;
n. Availability of eligible facilities;
o. Margins in claim costs;
p. Optional nature of benefit;
q. Delay in eligibility for benefit;
r. Inflation protection provisions; and
s. Guaranteed insurability option.

Any applicable valuation morbidity table shall be certified as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.

39.12(2) When long-term care benefits are provided other than as in subrule 39.12(1), reserves shall be determined in accordance with sound actuarial standards, applied consistently and accepted by the commissioner of insurance.

191—39.13(514D) Loss ratio.

39.13(1) *Applicability.* This rule shall apply to all long-term care insurance policies or certificates except those covered under rules 191—39.26(514G) and 191—39.28(514G).

39.13(2) *Minimum loss ratio.* Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least 60 percent, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors including:

a. Statistical credibility of incurred claims experience and earned premiums.
b. The period for which rates are computed to provide coverage.
c. Experienced and projected trends.
d. Concentration of experience within early policy duration.
e. Expected claim fluctuation.
f. Experience refunds, adjustments or dividends.
g. Renewability features.
h. All appropriate expense factors.
i. Interest.
j. Experimental nature of the coverage.
k. Policy reserves.
l. Mix of business by risk classification.
m. Product features such as long elimination periods, high deductibles and high maximum limits.

39.13(3) *Accelerated benefits.* Subrule 39.13(2) shall not apply to life insurance policies that accelerate benefits for long-term care. A life insurance policy that funds long-term care benefits entirely by accelerating the death benefit is considered to provide reasonable benefits in relation to premiums paid, if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Iowa Code section 508.37;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The policy illustration meets the applicable requirements of 191—Chapter 14 regarding illustrations; and

e. An actuarial memorandum is filed with the insurance division that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying life insurance policy, both for active lives and those in long-term care claim status.

191—39.14(514G) Filing requirement. Prior to an insurer or similar organization's offering group long-term care insurance to a resident of this state pursuant to Iowa Code section 514G.4(5)*"d,"* it shall file with the commissioner evidence that the group policy or certificate thereunder has been approved by a state having statutory or regulatory long-term care insurance requirements substantially similar to those adopted in this state.

191—39.15(514D,514G) Standards for marketing.

39.15(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

a. Establish marketing procedures to ensure that any comparison of policies by its producers or by other producers will be fair and accurate.

b. Establish marketing procedures to ensure that excessive insurance is not sold or issued.

c. Display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy, the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance.

e. Every insurer or entity marketing long-term care insurance shall establish auditable procedures for verifying compliance with this subrule.

f. If the state in which the policy or certificate is to be delivered or issued for delivery has a senior insurance counseling program approved by the commissioner, the insurer shall, at solicitation, provide written notice to the prospective policyholder and certificate holder that such a program is available and the name, address and telephone number of the program.

g. For long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to paragraph 39.6(1)*"b."*

h. Provide an explanation of contingent benefit upon lapse provided for in 39.29(6)*"c."*

39.15(2) In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

a. *Twisting.* Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

b. *High-pressure tactics.* Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. *Cold-lead advertising.* Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance producer or insurance company.

d. *Misrepresentation.* Misrepresenting a material fact in selling or offering to sell a long-term care insurance policy.

39.15(3) Association marketing.

a. When a group long-term care insurance policy is issued to an association or a trust or the trustees of a fund established, created or maintained for the benefit of members of one or more associations, the association or associations, or the insurer of the association or associations, shall, prior to advertising, marketing or offering the policy within this state, file evidence with the commissioner that the association or associations have at the outset a minimum of 100 persons and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(1) The association or associations hold regular meetings not less than annually to further purposes of the members;

(2) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(3) The members have voting privileges and representation on the governing board and committees.

Thirty days after the filing, the association or associations will be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements.

b. When a professional, trade, or occupational association is issued a group long-term care policy for its members or retired members or combination thereof, the association shall have as its primary responsibility, when endorsing or selling long-term care insurance, to educate its members concerning long-term care issues in general so that its members can make informed decisions. Associations shall provide objective information regarding long-term care insurance policies or certificates endorsed or sold by such associations to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being endorsed or sold.

(1) The insurer shall file with the insurance division the following material:

1. The policy and certificate;
2. A corresponding outline of coverage; and
3. All advertisements requested by the insurance division.

(2) The association shall disclose in any long-term care insurance solicitation the specific nature and amount of the compensation arrangements (including all fees, commissions, administrative fees and other forms of financial support) that the association receives from endorsement or sale of the policy or certificate to its members; and a brief description of the process under which the policies and the insurer issuing the policies were selected.

(3) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose that fact to its members.

(4) The board of directors of associations selling or endorsing long-term care insurance policies or certificates shall review and approve the insurance policies as well as the compensation arrangements made with the insurer.

(5) The association shall also:

1. At the time of the association's decision to endorse, engage the services of a person with expertise in long-term care insurance who is not affiliated with the insurer to conduct an examination of the policies, including its benefits, features, and rates and update the examination thereafter in the event of material change;

2. Actively monitor the marketing efforts of the insurer and its producers; and

3. Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.

Numbered paragraphs "1" through "3" shall not apply to qualified long-term care insurance contracts.

(6) No group long-term care insurance policy or certificate may be issued to an association unless the insurer files with the insurance division the information required in this subrule.

(7) The insurer shall not issue a long-term care policy or certificate to an association or continue to market such a policy or certificate unless the insurer certifies annually that the association has complied with the requirements set forth in this subrule.

(8) Failure to comply with the filing and certification requirements of this subrule constitutes an unfair trade practice in violation of Iowa Code chapter 507B.

39.15(4) *Producer training requirements.*

a. Purpose. The purpose of this subrule is to require certain specific minimum training for insurance producers who wish to sell long-term care insurance or long-term care partnership insurance in Iowa. This additional training is necessary due to the complex nature of long-term care insurance and long-term care partnership insurance products. This additional training is also necessary to ensure that insurance producers are able to determine whether long-term care insurance or long-term care partnership insurance products are suitable for consumers and that producers are able to adequately explain to consumers how the long-term care insurance and long-term care partnership insurance products work. The ultimate goal of this subrule is to ensure that purchasers of long-term care insurance and long-term care partnership insurance products understand basic features of the products.

(1) This subrule applies to all long-term care insurance and long-term care partnership insurance products sold on or after January 1, 2010.

(2) For purposes of this subrule, "CE," "CE provider," "CE term" and "credit" shall mean the same as defined in rule 191—11.2(505,522B).

b. Required training.

(1) An individual may not sell, solicit or negotiate long-term care insurance or long-term care partnership insurance products unless the individual is licensed as an insurance producer with an accident and health or sickness line of authority and has completed a one-time training course and ongoing training every CE term thereafter. The training shall meet the requirements set forth in paragraph 39.15(4)*"c."*

(2) The training content of paragraph 39.15(4)*"c"* must be approved as continuing education courses under 191—Chapter 11, except that the one-time training required under subparagraph 39.15(4)*"b"*(1) must be classroom training. However, a CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

c. Training content.

(1) The one-time training required by this subrule shall be no less than eight credits and the ongoing training required by this subrule shall be no less than four credits, except that producers who have completed four credits of long-term care insurance training prior to January 1, 2010, shall complete only four credits of one-time training specifically related to the long-term care partnership program and Iowa-specific Medicaid requirements.

(2) The training required under subparagraph (1) shall consist of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership programs, including, but not limited to:

1. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid requirements;

2. Available long-term care services and providers;

3. Changes or improvements in long-term care services or providers;

4. Alternatives to the purchase of private long-term care insurance or long-term care partnership insurance;

5. The effect of inflation on benefits and the importance of inflation protection;

6. Consumer suitability standards and guidelines;

7. The Deficit Reduction Act;

8. Iowa's laws regarding the long-term care partnership program;

9. The Iowa Medicaid program;

10. Miller trusts;

11. Spousal protection;

12. Transfer of assets;

13. Estate recovery; and

14. Eligibility.

(3) Unless otherwise required by state or federal law, the training required by this subrule shall not include training that is specific to a single insurer or company product and shall not include any sales or marketing information, materials, or training, other than those required by state or federal law.

d. Requirements for insurers.

(1) Insurers subject to this chapter shall obtain verification that a producer has received training required by subparagraph 39.15(4)*"b"*(1) before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance or long-term care partnership insurance products; shall make verifications available to the division upon request; and shall maintain records subject to the state's record retention requirements.

(2) Each insurer subject to this chapter shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the division to provide assurance to the Iowa department of human services that producers have received the training set forth in subparagraph 39.15(4)*"c"*(2), numbered paragraph "1," as required by subparagraph 39.15(4)*"b"*(1) and that producers have demonstrated an understanding of the partnership policies and the policies' relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the division upon request.

e. Training obtained in other states. The satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements in this state.

f. Requirements for continuing education providers to provide long-term care partnership insurance training. In addition to having been approved as a CE provider under rule 191—11.9(505,522B), a CE provider intending to provide either the initial training or the ongoing continuing education required under subrule 39.15(4) shall:

(1) Provide only classroom training for the initial one-time training for providers. However, the CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

(2) If approved, comply with rules 191—11.10(505,522B) and 191—11.11(505,522B).

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.16(514D,514G) Suitability.

39.16(1) This rule shall not apply to life insurance policies that accelerate benefits for long-term care.

39.16(2) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

a. Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

b. Train its producers in the use of its suitability standards; and

c. Maintain a copy of its suitability standards and make it available for inspection upon request by the commissioner.

39.16(3) To determine whether the applicant meets the standards developed by the issuer, the producer and issuer shall develop procedures that take into consideration the following:

a. The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

b. The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

c. The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

39.16(4) The issuer, and, when a producer is involved, the producer, shall make reasonable efforts to obtain the information set out in subrule 39.16(3). The efforts shall include presentation of the "Long-Term Care Insurance Personal Worksheet" to the applicant, at the time of or prior to application. The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Appendix B, in not less than 12-point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the commissioner.

A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

The sale or dissemination outside the company or agency by the issuer or producer of information obtained through the personal worksheet in Appendix B is prohibited.

39.16(5) The issuer shall use the suitability standards it has developed pursuant to this rule in determining whether issuing long-term care insurance coverage to an applicant is appropriate.

39.16(6) Producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

39.16(7) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format contained in Appendix C, in not less than 12-point type.

39.16(8) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a letter similar to Appendix D. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

39.16(9) The issuer shall report annually to the commissioner the total number of applications received from residents of this state, the number of applicants who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of applicants who chose to confirm after receiving a suitability letter.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.17(514G) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates. If a long-term care insurance policy or certificate replaces another long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

191—39.18(514G) Standard format outline of coverage. This rule, which is not applicable to life policies with long-term care riders attached, implements, interprets and makes specific the provisions of Iowa Code section 514G.7(1) in prescribing a standard format and the content of an outline of coverage.

39.18(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

39.18(2) In the case of producer solicitations, a producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

39.18(3) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

39.18(4) The commissioner shall prescribe the standard format, including style, arrangement, and overall appearance and content of an outline of coverage.

39.18(5) The outline of coverage shall be a freestanding document, using no smaller than 10-point type.

39.18(6) The outline of coverage shall contain no material of an advertising nature.

39.18(7) Text which is capitalized or underscored in the standard format outline of coverage may be emphasized by other means which provide prominence equivalent to such capitalization or underscoring.

39.18(8) Use of the text and sequence of text of the standard format outline of coverage is mandatory, unless otherwise specifically indicated.

39.18(9) Format for outline of coverage:

[COMPANY NAME]
[ADDRESS — CITY & STATE]
[TELEPHONE NUMBER]
LONG-TERM CARE INSURANCE
OUTLINE OF COVERAGE
[Policy Number or Group Master Policy and Certificate Number]

[Except for policies or certificates which are guaranteed issue, the following caution statement, or substantially similar language, must appear as follows in the outline of coverage.]

Caution: The issuance of this long-term care insurance [policy] [certificate] is based upon your responses to the questions on your application. A copy of your [application] [enrollment form] [is enclosed] [was retained by you when you applied]. If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: [insert address]

1. This policy is [an individual policy of insurance] [[a group policy] which was issued in the [indicate jurisdiction in which group policy was issued]].

2. PURPOSE OF OUTLINE OF COVERAGE. This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!

3. FEDERAL TAX CONSEQUENCES.

This [POLICY] [CERTIFICATE] is intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986.

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986. Benefits received under the [POLICY] [CERTIFICATE] may be taxable as income.

4. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE CONTINUED IN FORCE OR DISCONTINUED.

(a) [For long-term care health insurance policies or certificates, describe one of the following permissible policy renewability provisions:

(1) [Policies and certificates that are guaranteed renewable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your [policy] [certificate], to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

(2) [Policies and certificates that are noncancellable shall contain the following statement:] RENEWABILITY: THIS [POLICY] [CERTIFICATE] IS NONCANCELLABLE. This means that you have the right, subject to the terms of your policy, to continue this policy as long as you pay your premiums on time. [Company Name] cannot change any of the terms of your policy on its own and cannot change the premium you currently pay. However, if your policy contains an inflation protection feature where you choose to increase your benefits, [Company Name] may increase your premium at that time for those additional benefits.

(b) [For group coverage, specifically describe continuation/conversion provisions applicable to the certificate and group policy;]

(c) [Describe waiver of premium provisions or state that there are not such provisions.]

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS.

[In bold type larger than the maximum type required to be used for the other provisions of the outline of coverage, state whether or not the company has a right to change the premium and, if a right exists, describe clearly and concisely each circumstance under which the premium may change.]

6. TERMS UNDER WHICH THE POLICY OR CERTIFICATE MAY BE RETURNED AND PREMIUM REFUNDED.

(a) [Provide a brief description of the right to return—"free look" provision of the policy.]

(b) [Include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or surrender of the policy or certificate. If the policy contains such provisions, include a description of them.]

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the insurance company.

(a) [For producers] Neither [insert company name] nor its producers represent Medicare, the federal government or any state government.

(b) [For direct response] [insert company name] is not representing Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE. Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a nursing home, in the community or in the home.

This policy provides coverage in the form of a fixed dollar indemnity benefit for covered long-term care expenses, subject to policy [limitations] [waiting periods] and [coinsurance] requirements. [Modify this paragraph if the policy is not an indemnity policy.]

9. BENEFITS PROVIDED BY THIS POLICY.

(a) [Covered services, related deductibles, waiting periods, elimination periods and benefit maximums.]

(b) [Institutional benefits, by skill level.]

(c) [Noninstitutional benefits, by skill level.]

(d) Eligibility for Payment of Benefits

[Activities of daily living and cognitive impairment shall be used to measure an insured's need for long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained. If these triggers differ for different benefits, explanation of the triggers should accompany each benefit description. If an attending physician or other specified person must certify a certain level of the insured's functional dependency in order for the insured to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

(a) Preexisting conditions;

(b) Noneligible facilities and provider;

(c) Noneligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);

(d) Exclusions and exceptions;

(e) Limitations.]

[This section should provide a brief, specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of the benefits described in "6" above.]

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS. Because the costs of long-term care services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. [As applicable, indicate the following:

(a) That the benefit level will not increase over time;

(b) Any automatic benefit adjustment provisions;

(c) Whether the insured will be guaranteed the option to buy additional benefits and the basis upon which benefits will be increased over time if not by a specified amount or percentage;

(d) If there is such a guarantee, include whether additional underwriting or health screening will be required, the frequency and amounts of the upgrade options, and any significant restrictions or limitations;

(e) And finally, describe whether there will be any additional premium charge imposed, and how that is to be calculated.]

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.

[State that the policy provides coverage for insureds clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses. Specifically describe each benefit screen or other policy provision which provides preconditions to the availability of policy benefits for such an insured.]

13. PREMIUM.

[(a) State the total annual premium for the policy;

(b) If the premium varies with an applicant's choice among benefit options, indicate the portion of annual premium which corresponds to each benefit option.]

14. ADDITIONAL FEATURES.

[(a) Indicate if medical underwriting is used;

(b) Describe other important features.]

15. CONTACT THE STATE SENIOR HEALTH INSURANCE INFORMATION PROGRAM (800-351-4664) IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.19(514G) Requirement to deliver shopper's guide.

39.19(1) A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, the Blue Cross and Blue Shield Association, the Health Insurance Association of America or the senior health insurance information program of the insurance division shall be provided to all prospective applicants of a long-term care insurance policy or certificate or life insurance policy or certificate that includes a long-term care rider.

a. In the case of producer solicitations, a producer must deliver the shopper's guide to the applicant at the time of application.

b. In the case of direct response solicitations, the shopper's guide must be presented to the applicant at the time the policy is delivered.

39.19(2) Insurers offering life insurance policies or riders containing accelerated long-term care benefits are not required to comply with 39.19(1), but shall furnish the policy summary required under rule 191—39.20(514G).
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.20(514G) Policy summary and delivery of life insurance policies with long-term care riders.

39.20(1) If an application for a long-term care insurance contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.

39.20(2) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

a. An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

b. An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, if any, for each covered person;

c. Any exclusions, reductions, and limitations on benefits of long-term care;

d. If applicable to the policy type, the summary shall also include a disclosure of the effects of exercising other rights under the policy, a disclosure of guarantees related to long-term care costs of insurance charges, and current and projected maximum lifetime benefits; and

e. A statement that any long-term care inflation protection option required by rule 191—39.10(514D,514G) is not available under this policy.

The provisions of the policy summary listed above may be incorporated into a basic illustration required to be delivered in accordance with 191—Chapter 14 or into the life insurance policy summary which is required to be delivered in accordance with rule 191—15.4(507B).

191—39.21(514G) Reporting requirement for long-term care benefits funded through life insurance by acceleration of the death benefit. Any time a long-term care benefit, funded through life insurance which by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

1. Any long-term care benefits paid out during the month;
2. An explanation of any changes in the policy, e.g., death benefits or cash values, due to long-term care benefits being paid out; and
3. The amount of long-term care benefits existing or remaining.

191—39.22(514G) Unintentional lapse.

39.22(1) Notice before lapse or termination. No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either: a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium; or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation shall not constitute acceptance of any liability on the third party for services provided to the insured. The form used for the written designation must provide space clearly designated for listing at least one person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand

that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice."

The insurer shall notify the insured of the right to change this written designation no less often than once every two years.

39.22(2) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subrule 39.22(1) need not be met until 60 days after the policyholder or certificate holder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

39.22(3) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to subrule 39.22(1) at the address provided by the insured for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five days after the date of mailing.

39.22(4) Reinstatement. In addition to the requirement in subrule 39.22(1), a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy and certificate.

191—39.23(514G) Denial of claims. If a claim under a long-term care insurance contract is denied, the issuer shall, within 60 days of the date of a written request by the policyholder or certificate holder, or a representative thereof, provide a written explanation of the reasons for the denial; and make available all information directly related to the denial.

191—39.24(514G) Incontestability period.

39.24(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

39.24(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

39.24(3) After a policy or certificate has been in force for two years, it is not contestable upon the grounds of misrepresentation alone; such policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

39.24(4) No long-term care insurance policy or certificate may be field-issued based on medical or health status. For purposes of this subrule, "field-issued" means a policy or certificate issued by a producer or a third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer.

39.24(5) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

39.24(6) In the event of the death of the insured, this rule shall not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care. In this situation, the

remaining death benefits under these policies shall be governed by Iowa Code section 508.28. In all other situations, this rule shall apply to life insurance policies that accelerate benefits for long-term care.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.25(514G) Required disclosure of rating practices to consumers.

39.25(1) *Applicability.* This rule applies to any new long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force prior to February 1, 2003, the provisions of this rule shall apply on the policy anniversary following February 1, 2003.

39.25(2) *Contents of disclosure.* Other than policies for which no applicable premium rate or rate schedule increases can be made, insurers shall provide all of the information listed in this subrule to the applicant at the time of application or enrollment, unless the method of application does not allow for delivery at that time. In such a case, an insurer shall provide all of the information listed in this subrule to the applicant no later than at the time of delivery of the policy or certificate.

a. A statement that the policy may be subject to rate increases in the future;

b. An explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

c. The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

d. A general explanation for applying premium rate or rate schedule adjustments that shall include:

(1) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and

(2) The right to a revised premium rate or rate schedule as provided in paragraph 39.25(2)*"c"* if the premium rate or rate schedule is changed;

e. Information regarding each premium rate increase on this policy form or similar policy forms over the past ten years for this state or any other state.

(1) The following, at a minimum, shall be included:

1. The policy forms for which premium rates have been increased;

2. The calendar years when the form was available for purchase; and

3. The amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(2) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.

(3) An insurer shall have the right to exclude from the disclosure premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(4) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or on a block of policy forms acquired from nonaffiliated insurers on or before the later of February 1, 2003, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the non-affiliated selling company shall include the disclosure of that rate increase in accordance with paragraph *"e."*

(5) If the acquiring insurer in subparagraph (4) above files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in subparagraph (4), the acquiring insurer shall make all disclosures required by paragraph *"e,"* including disclosure of the earlier rate increase referenced in subparagraph (4).

39.25(3) *Acknowledgment.* An applicant shall sign an acknowledgment at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosure required under 39.25(2)*"a"* and 39.25(2)*"e."* If due to the method of application the applicant

cannot sign an acknowledgment at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

39.25(4) *Required format.* An insurer shall use the forms in Appendices B and F to comply with the requirements of this rule.

39.25(5) *Notice of rate increase.* An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by subrule 39.25(2) when the rate increase is implemented.

191—39.26(514G) Initial filing requirements.

39.26(1) *Effective date.* This rule applies to any long-term care policy issued in this state on or after February 1, 2003.

39.26(2) *Required filing.* An insurer shall provide the information listed in this subrule to the commissioner pursuant to rule 191—20.1(505,509,514A,515,515A,515F) 30 days prior to making a long-term care insurance form available for sale.

a. A copy of the disclosure documents required in rule 191—39.25(514G); and

b. An actuarial certification consisting of at least the following:

(1) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(2) A statement that the policy design and coverage provided have been reviewed and taken into consideration;

(3) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(4) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

1. Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

2. A statement that the assumptions used for reserves contain reasonable margins for adverse experience;

3. A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

4. A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur;

- An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;
- If the gross premiums for certain age groups appear to be inconsistent with this requirement, the commissioner may request a demonstration under subrule 39.26(3) based on a standard age distribution; and

(5) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

39.26(3) *Demonstration on request.*

a. The commissioner may request an actuarial demonstration that benefits are reasonable in relation to premiums. The actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both.

b. In the event the commissioner asks for additional information under this provision, the period in subrule 39.26(2) does not include the period during which the insurer is preparing the requested information.

191—39.27(514G) Reporting requirements.

39.27(1) Every insurer shall maintain for each producer records of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales.

39.27(2) Every insurer shall report annually by June 30 the 10 percent of its producers with the greatest percentages of lapses and replacements as measured by subrule 39.27(1) in the format prescribed in Appendix G.

39.27(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or necessarily imply wrongdoing. The reports are for the purpose of reviewing more closely producer activities regarding the sale of long-term care insurance.

39.27(4) Every insurer shall report annually by June 30 the number of lapsed policies as a percent of its total annual sales and as a percent of its total number of policies in force as of the end of the preceding calendar year in the format prescribed in Appendix G.

39.27(5) Every insurer shall report annually by June 30 the number of replacement policies sold as a percent of its total annual sales and as a percent of its total number of policies in force as of the preceding calendar year in the format prescribed in Appendix G.

39.27(6) Every insurer shall report annually by June 30, for qualified long-term care insurance contracts, the number of claims denied for each class of business, expressed as a percentage of claims denied in the format prescribed in Appendix E.

39.27(7) For purposes of rule 191—39.27(514G):

a. "Policy" means only long-term care insurance;

b. Subject to paragraph *"c"* below, "claim" means a request for payment of benefits under an in-force policy regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

c. "Denied" means the insurer refuses to pay a claim for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition; and

d. "Report" means on a statewide basis.

39.27(8) Reports required under this rule shall be filed with the commissioner. The first reports under this rule are due June 30, 2004.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.28(514G) Premium rate schedule increases.

39.28(1) This rule applies to any long-term care policy or certificate issued in this state on or after February 1, 2003. For certificates issued under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall apply on the policy anniversary following July 1, 2003.

39.28(2) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days prior to the notice to the policyholders and shall include:

a. Information required by rule 191—39.25(514G);

b. Certification by a qualified actuary that:

(1) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;

(2) The premium rate filing is in compliance with the provisions of this rule;

c. An actuarial memorandum justifying the rate schedule change request that includes:

(1) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;

1. Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

2. The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

3. The projections shall demonstrate compliance with subrule 39.28(3); and

4. For exceptional increases,

- The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
- In the event the commissioner determines that offsets may exist, the insurer shall use appropriate net projected experience;

(2) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(3) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(4) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and

(5) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates;

d. A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

e. Sufficient information for review of the premium rate schedule increase by the commissioner.

39.28(3) All premium rate schedule increases shall be determined in accordance with the following requirements:

a. Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;

b. Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(1) The accumulated value of the initial earned premium multiplied by 58 percent;

(2) Eighty-five percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(3) The present value of future projected initial earned premiums multiplied by 58 percent; and

(4) Eighty-five percent of the present value of future projected premiums not in subparagraph (3) above on an earned basis;

c. In the event that a policy form has both exceptional and other increases, the values in subparagraphs 39.28(3)*"b"*(2) and (4) will also include 70 percent for exceptional rate increase amounts; and

d. All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as recommended by the NAIC Financial Examiners Handbook. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

39.28(4) For each rate increase that is implemented, the insurer shall file for review by the commissioner updated projections, as defined in subparagraph 39.28(2)*"c"*(1), annually for the next three years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this subrule shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(5) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in subparagraph

39.28(2)*"c"*(1), shall be filed for review by the commissioner every five years following the end of the required period in subrule 39.28(4). For group insurance policies that meet the conditions in subrule 39.28(11), the projections required by this paragraph shall be provided to the policyholder in lieu of filing with the commissioner.

39.28(6) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subrule 39.28(3), the commissioner may require the insurer to implement any of the following:

a. Premium rate schedule adjustments; or

b. Other measures to reduce the difference between the projected and actual experience.

In determining whether the actual experience adequately matches the projected experience, consideration should be given to subparagraph 39.28(2)*"c"*(5), if applicable.

39.28(7) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

a. A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise, the commissioner may impose the condition in subrule 39.28(8); and

b. The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subrule 39.28(3) had the greater of the original anticipated lifetime loss ratio or 58 percent been used in the calculations described in subparagraphs 39.28(3)*"b"*(1) and (3).

39.28(8) Review of lapse rates.

a. For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

(1) The rate increase is not the first rate increase requested for the specific policy form or forms;

(2) The rate increase is not an exceptional increase; and

(3) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

b. In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in-force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(1) The offer shall:

1. Be subject to the approval of the commissioner;

2. Be based on actuarially sound principles, but not be based on attained age; and

3. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(2) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

1. The maximum rate increase determined based on the combined experience; and

2. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

39.28(9) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of subrule 39.28(8), prohibit the insurer from either of the following:

a. Filing and marketing comparable coverage for a period of up to five years; or

b. Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

39.28(10) Subrules 39.28(1) through 39.28(9) shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in subrule 39.5(16), if the policy complies with all of the following provisions:

a. The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

b. The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(1) Iowa Code section 508.37, regarding nonforfeiture standards for life insurance;

(2) Iowa Code section 508.38, regarding nonforfeiture standards for individual deferred annuities; and

(3) Iowa Code section 508A.5 and 191—subrule 31.3(8), regarding variable annuities;

c. The policy meets the disclosure requirements of rules 191—39.20(514G) and 191—39.21(514G);

d. The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(1) Policy illustrations as required by 191—Chapter 14;

(2) Disclosure requirements for annuities as required by the commissioner; and

(3) Disclosure requirements for variable annuities as required by 191—Chapter 31;

e. An actuarial memorandum is filed with the insurance division that includes:

(1) A description of the basis on which the long-term care rates were determined;

(2) A description of the basis for the reserves;

(3) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(4) A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

(5) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(6) The estimated average annual premium per policy and the average issue age;

(7) A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if underwriting is used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and

(8) A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

39.28(11) Subrules 39.28(6) and 39.28(8) shall not apply to group insurance policies where:

a. The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or

b. The policyholder, and not the certificate holders, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year prior to the year a rate increase is filed.

191—39.29(514G) Nonforfeiture.

39.29(1) Except as provided in subrule 39.29(2), a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy. In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a

contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

39.29(2) When a group long-term care insurance policy is issued, the offer required in subrule 39.29(1) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance to a group as defined in Iowa Code section 514G.4(4)*"d,"* other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder.

39.29(3) This rule does not apply to life insurance policies or riders containing accelerated long-term care benefits.

39.29(4) To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of subrule 39.29(1):

a. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subrule 39.29(7); and

b. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

39.29(5) If the offer required to be made under subrule 39.29(1) is rejected, the insurer shall provide the contingent benefit upon lapse described in this rule.

39.29(6) Benefit triggers.

a. After rejection of the offer required under subrule 39.29(1), for individual and group policies without nonforfeiture benefits issued after February 1, 2003, the insurer shall provide a contingent benefit upon lapse.

b. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

c. The contingent benefit upon lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

d. On or before the effective date of a substantial premium increase as defined in paragraph 39.29(6)*"c,"* the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subrule 39.29(7). This option may be elected at any time during the 120-day period referenced in paragraph 39.29(6)*"c"*; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph 39.29(6)*"c"* shall be deemed to be the election of the offer to convert in subparagraph (2) above.

39.29(7) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subrule.

a. For purposes of this subrule, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

b. For purposes of this subrule, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph *"c."*

c. The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subrule 39.29(8).

d. Benefit dates.

(1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) Notwithstanding subparagraph (1), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

1. The end of the tenth year following the policy or certificate issue date; or

2. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

e. Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

39.29(8) All benefits paid by the insurer while the policy or certificate is in premium-paying status and in paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

39.29(9) There shall be no difference in the minimum nonforfeiture benefits as required under this rule for group and individual policies.

39.29(10) The requirements set forth in this rule shall become effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph *"b,"* the provisions of this rule apply to any long-term care policy issued on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall not apply.

39.29(11) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 39.13(2) or 191—39.28(514G), whichever applies, treating the policy as a whole.

39.29(12) To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph 39.29(6)*"c,"* a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

39.29(13) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

a. The nonforfeiture provision shall be appropriately captioned;

b. The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium-paying contracts approved by the commissioner for the same contract form; and

c. The nonforfeiture provision shall provide at least one of the following:

(1) Reduced paid-up insurance;

(2) Extended term insurance;

(3) Shortened benefit period; or

(4) Other similar offerings approved by the commissioner.

39.29(14) Notwithstanding subrule 39.29(10), if an insurer requests a premium rate increase on any long-term care policy issued prior to February 1, 2003, the commissioner shall require as a condition of approval of such premium rate increase that the insurer provide notice to all affected policyholders and

certificate holders that, in lieu of the requested premium rate increase, the insured may opt for one of the following:

a. A reduced benefit. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. The age used to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. The reduced benefit offered may include one or more of the following:

(1) A reduced daily, weekly, or monthly benefit;

(2) A longer waiting period;

(3) A reduced benefit period or a reduced maximum lifetime benefit; or

(4) Any other benefit or coverage reduction option consistent with the policy or certificate design or the carrier's administrative processes.

b. A contingent benefit upon lapse as described in subrules 39.29(7), 39.29(8), 39.29(9), and 39.29(12) if the requested premium rate increase results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in paragraph 39.29(6)*"c."*

c. Any other alternative mechanism filed by the insurer and approved by the commissioner.

191—39.30(514G) Standards for benefit triggers.

39.30(1) A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

39.30(2) Activities of daily living.

a. Activities of daily living shall include at least the following as defined in rule 191—39.5(514G) and in the policy:

(1) Bathing;

(2) Continence;

(3) Dressing;

(4) Eating;

(5) Toileting; and

(6) Transferring.

b. Insurers may use other activities of daily living to trigger covered benefits as long as the activities are defined in the policy.

39.30(3) An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subrules 39.30(1) and 39.30(2).

39.30(4) For purposes of this rule, the determination of a deficiency shall not be more restrictive than:

a. Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

b. If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

39.30(5) Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

39.30(6) Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

39.30(7) The requirements set forth in this rule shall be effective July 1, 2003, and shall apply as follows:

a. Except as provided in paragraph *"b,"* the provisions of this rule apply to a long-term care policy issued in this state on or after February 1, 2003.

b. For certificates issued on or after July 1, 2003, under a group long-term care insurance policy as defined in Iowa Code section 514G.4(4)*"a"* that was in force on February 1, 2003, the provisions of this rule shall not apply.

191—39.31(514G) Additional standards for benefit triggers for qualified long-term care insurance contracts.

39.31(1) For purposes of this rule, the following definitions apply:

"Chronically ill individual" has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

1. Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

2. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term "chronically ill individual" shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

"Licensed health care practitioner" means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

"Maintenance or personal care services" means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

"Qualified long-term care services" means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(2) A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

39.31(3) A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

39.31(4) Certifications regarding activities of daily living and cognitive impairment required pursuant to subrule 39.31(3) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

39.31(5) Certifications required pursuant to subrule 39.31(3) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

39.31(6) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

191—39.32(514G) Penalties. Violations of this chapter shall be subject to the penalties imposed under Iowa Code chapter 507B.

191—39.33(514G) Notice of cancellation, forfeiture, lapse or termination of long-term care insurance.

39.33(1) *Purpose.* The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, forfeiture, lapse and termination by an insurer, so as to implement the various policyholder protections intended by Iowa Code section 514G.111 and rule 191—39.22(514G). Presumption of receipt in the context of a postal service mailing is a well-settled principle of Iowa law (see *Montgomery Ward v. Davis,* 398 N.W.2d 869, 870-871 (Iowa 1982)), but Iowa courts have not yet recognized a presumption of receipt for electronic transmissions. Notwithstanding Iowa Code section 554D.110(4)*"b,"* delivery by electronic transmission, for the purposes of this rule, does not provide for satisfactory verification or acknowledgment of receipt, as required by Iowa Code section 505B.1(6).

39.33(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapter 508 or 515.

39.33(3) *Delivery and receipt.* For any notice of cancellation, forfeiture, lapse or termination by an insurer under Iowa Code section 514G.111 and rule 191—39.22(514G) to be effective, an insurer must, within the time frame established by law, either deliver the notice to the named insured in person or mail the notice through the U.S. Postal Service to the last-known address of the named insured. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code section 514G.111 and rule 191—39.22(514G) for certified mail or certificate of mailing as proof of mailing.

39.33(4) *Electronic transmissions.* Electronic transmissions currently fail to satisfy the notice requirements of Iowa Code section 514G.111 and rule 191—39.22(514G). However, additional communication of notices by electronic means may be provided by an insurer as a service to a policyholder.

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

191—39.34 to **39.40** Reserved.

DIVISION II
INDEPENDENT REVIEW OF BENEFIT TRIGGER DETERMINATIONS

191—39.41(514G) Purpose. This division is intended to implement Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, to provide a uniform process for insureds covered under long-term care insurance to request an independent review of a denial of coverage based on a benefit trigger determination.

191—39.42(514G) Effective date. The rules contained in this division shall apply to all requests for benefit trigger determinations made on or after January 1, 2009.

191—39.43(514G) Definitions. For purposes of this division, the definitions found in 2008 Iowa Acts, House File 2694, section 4, shall apply.

191—39.44(514G) Notice of benefit trigger determination and content. The notice required by 2008 Iowa Acts, House File 2694, section 10, shall contain the following information:

1. The reason that the insurer determined that the policy benefit trigger has not been met by the insured.
2. A description of the internal appeal mechanism provided under the long-term care policy.
3. A description of how the insured, after exhausting the insurer's internal appeal process, has the right to have the benefit trigger determination reviewed under the independent review process required by 2008 Iowa Acts, House File 2694, section 11.

191—39.45(514G) Notice of internal appeal decision and right to independent review. Upon the conclusion of the internal appeal mechanism specified in 2008 Iowa Acts, House File 2694, section

10, the notice required in 2008 Iowa Acts, House File 2694, section 10, shall contain the following information:

39.45(1) A description of additional internal appeal rights, if any, offered by the insurer.

39.45(2) A description of how the insured can request independent review of the benefit trigger determination. Such description must specify the following:

a. The insured must submit a written request within 60 days of the insured's receiving written notice of the insurer's internal appeal decision;

b. The request must be made to the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319;

c. A copy of the insurer's benefit trigger determination letter must accompany the written request for an independent review;

d. A $25 filing fee is required unless the insured is requesting that the fee be waived. The check should be made payable to the Iowa Insurance Division. If a waiver is requested, the request shall include an explanation for the insured's request that the fee be waived.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.46(514G) Independent review request.

39.46(1) The insured shall send a copy of the insurer's notice explaining why the benefit trigger has not been met, with the insured's request for an independent review, to the insurance commissioner within 60 days of receipt of the benefit trigger determination. The notice shall be sent to the commissioner at the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319.

39.46(2) A $25 filing fee shall be enclosed with the independent review request. The commissioner may waive the fee for good cause.

191—39.47(514G) Certification process.

39.47(1) The commissioner shall provide written notice of the certification decision to the insurer and the insured within the two-business-day period specified in 2008 Iowa Acts, House File 2694, section 11.

39.47(2) The insurer may appeal the commissioner's certification decision within three business days after receiving notice of the decision. The commissioner shall review any such appeal and promptly notify the insured and the insurer of the commissioner's decision.

191—39.48(514G) Selection of independent review entity.

39.48(1) Within three business days of receiving the commissioner's certification decision, the insurer shall:

a. Select an independent review entity from the list certified by the commissioner;

b. Notify the insured in writing of the name, address, and telephone number of the independent review entity;

c. Notify the independent review entity of its selection and provide the independent review entity with sufficient information to allow selection of qualified licensed health care professionals to conduct the independent review;

d. Provide the commissioner with copies of the notices required by this subrule.

39.48(2) Within three business days of receiving the notice specified in subrule 39.48(1), the independent review entity shall do one of the following:

a. Accept its selection, designate a qualified licensed health care professional to perform the independent review, and notify the insured and insurer, with a copy to the commissioner, of the designation, the qualifications of the qualified licensed health care professional, and the reasons why the licensed health care professional is qualified to conduct the independent review;

b. Decline its selection and provide notice to the commissioner, the insured, and the insurer of the declination. The insurer shall have three business days after receipt of the declination notice to designate a different independent review entity pursuant to subrule 39.48(1); or

c. Request that the commissioner grant the independent review entity additional time to have a qualified licensed health care professional certified and provide notice of such request to the insured, the insurer, and the commissioner. Within three business days of such a request, the commissioner shall notify the insured, the insurer, and the independent review entity how to proceed.

39.48(3) Within ten days of receiving the notice specified in paragraph 39.48(1)*"b,"* an insured may object to the independent review entity selected by the insurer or the licensed health care professional selected by the independent review entity. Such an objection shall state the reasons for the objection with particularity. The objection shall be sent to the commissioner, and a copy shall be sent to the insurer. The commissioner shall notify the insured, the insurer, and the independent review entity of the commissioner's decision within two business days of receipt of the objection.

191—39.49(514G) Independent review process.

39.49(1) Within five business days of receiving either the notice provided in paragraph 39.48(1)*"b,"* or the denial of an objection made pursuant to subrule 39.48(3), whichever is later, the insured may submit any additional information or documentation in support of the insured's claim to both the independent review entity and the insurer.

39.49(2) Within 15 days of receiving the notice provided in paragraph 39.48(1)*"b,"* or within three business days of receiving notice of the denial of an objection made pursuant to subrule 39.48(3), whichever is later, an insurer shall:

a. Provide the independent review entity with any information submitted to the insurer by the insured during the insurer's internal appeal process relating to the benefit trigger determination that is the subject of the independent review proceeding;

b. Provide the independent review entity with any other relevant documents used by the insurer in making its benefit trigger determination; and

c. Provide the commissioner and the insured with confirmation that the information required by this subrule was submitted to the independent review entity, including the date such information was submitted.

39.49(3) The independent review entity shall not commence its review of the insurer's benefit trigger determination until 15 business days after either the independent review entity receives the notice of its selection specified in paragraph 39.48(1)*"c"* or the resolution of any objection made pursuant to subrule 39.48(3), whichever is later.

39.49(4) During the time period specified in subrule 39.48(3), the insurer may consider any information provided by the insured pursuant to subrule 39.49(1) and affirm or overturn the insurer's benefit trigger determination. If the insurer overturns its benefit trigger determination:

a. The insurer shall provide notice to the independent review entity, the commissioner, and the insured of the insurer's decision; and

b. The independent review process shall immediately cease.

191—39.50(514G) Decision notification.

39.50(1) The independent review entity shall immediately notify the insurer, the insured, and the commissioner of the independent review decision either affirming or overturning the insurer's benefit trigger determination. The initial notification shall be delivered by telephone or fax transmission, and a written copy of the decision notification delivered by regular mail. The written copy of the decision shall include a description of the basis for the independent review entity's decision.

39.50(2) If the independent review entity overturns the insurer's decision, the independent review entity shall include all of the following in the decision:

a. The precise date that the benefit trigger was deemed to have been met;

b. The specific period of time under review for which the insurer declined eligibility but during which the independent review entity determined that the benefit trigger was met;

c. For qualified long-term care insurance contracts, a certification made only by a licensed health care practitioner that the insured is a chronically ill individual.

191—39.51(514G) Insurer information.

39.51(1) No later than January 1, 2009, each insurer delivering or issuing for delivery long-term care insurance policies in this state on or after July 1, 2008, and each insurer that has active long-term care policies or riders under which claims for benefits may be made on or after July 1, 2008, shall provide the commissioner the name or title, telephone and fax numbers and E-mail address of an individual who shall be the insurer's contact person for independent review procedures and matters. Any changes in personnel or communication numbers shall be immediately communicated to the commissioner.

39.51(2) Each insurer shall provide the commissioner a detailed description of the process that the insurer has in place to ensure compliance with the requirements of this division and of 2008 Iowa Acts, House File 2694, sections 10 and 11. The description required by this subrule shall be filed in a format as directed by the commissioner on or before March 1, 2009, and thereafter as requested by the commissioner. The description shall include:

a. An explanation of how the insurer determines when an insured has qualified for independent review of the benefit trigger decision and should receive a notice from the insurer,

b. A copy of the notice sent to insureds who fall within the scope of the law, and

c. An explanation of the internal appeal process.

191—39.52(514G) Certification of independent review entity. The following minimum standards are required for certification as an independent review entity:

39.52(1) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding holds a current unrestricted license or certification to practice a health care profession in the United States.

39.52(2) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is a physician holds a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(3) The entity shall ensure that any licensed health care professional on its staff who participates in an independent review proceeding and who is not a physician holds a current certification in the specialty in which that person is licensed by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

39.52(4) The entity shall ensure that any licensed health care professionals on its staff who participate in an independent review proceeding have no history of disciplinary actions or sanctions including, but not limited to, the loss of staff privileges or any participation restriction taken or pending by any hospital or state or federal government regulatory agency for wrongdoing by the health care professional.

39.52(5) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, receive compensation of any type that is dependent on the outcome of the review.

39.52(6) The entity shall ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are in any manner related to, employed by, or affiliated with the insured or with a person who previously provided medical care to the insured.

39.52(7) The entity shall provide a description of the qualifications of the reviewers retained to conduct independent review of long-term care insurance benefit trigger decisions, including the reviewers' employment histories and practice affiliations for at least the prior ten years, and a description of past experience with decisions relating to long-term care, functional capacity, and dependency in activities of daily living, or in assessing cognitive impairment.

39.52(8) The entity shall provide a description of the procedures employed to ensure that reviewers conducting independent reviews are appropriately: licensed, registered or certified; trained in the principles, procedures and standards of the independent review entity; knowledgeable about the functional or cognitive impairments associated with the diagnosis and disease staging processes, including expected duration of such impairment; and knowledgeable and experienced in diagnosing a person as a "chronically ill individual" as defined in Section 7702B(c)(2) of the Internal Revenue Code.

39.52(9) The entity shall provide a description of the evaluation tools the entity would use to conduct a review of a long-term care insurance benefit trigger decision.

39.52(10) The entity shall provide a description of the methods of recruiting and selecting impartial reviewers and matching such reviewers to specific cases.

39.52(11) The entity shall provide the number of reviewers retained by the independent review entity and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity).

39.52(12) The entity shall provide a description of the policies and procedures employed to protect confidentiality of individual personally identifiable health information in accordance with applicable state and federal laws.

39.52(13) The entity shall provide a description of the quality assurance program established by the independent review entity.

39.52(14) The entity shall provide the names of all corporations and organizations owned or controlled by the independent review entity or which own or control the entity, and the nature and extent of any such ownership or control. The entity must ensure that neither the entity, nor any of its employees, agents, or licensed health care professionals utilized, are a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insurer is a member.

39.52(15) The entity shall provide the names and résumés of all directors, officers and executives of the entity.

39.52(16) The entity shall provide a description of the fees to be charged by the entity for independent reviews of a long-term care insurance benefit trigger decision.

39.52(17) The entity shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

39.52(18) The entity must have on staff or contract with a licensed health care practitioner who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

191—39.53(514G) Additional requirements. The independent review entity shall develop and maintain written policies and procedures governing all aspects of the independent review process. The written policies and procedures include, but are not limited to, the following:

39.53(1) Procedures to ensure that independent reviews are conducted within the time frames specified in this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, and that any required notices are provided in a timely manner.

39.53(2) Procedures to ensure the selection of qualified and impartial reviewers. The reviewers shall be qualified to render impartial determinations relating to the benefit trigger which is the subject of the benefit trigger decision under review (e.g., assessment of cognitive impairment or inability to perform activities of daily living due to a loss of functional capacity) and be deemed experts in the assessment of such benefit trigger.

39.53(3) Procedures to ensure that the insured is notified in writing of the insured's right to object to the independent review entity selected by the insurer or to the licensed health care professional designated by the independent review entity to conduct the review by filing a notice of objection, along with the reasons for the objection, with the commissioner at the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319, within ten days of the receipt of a notice from the independent review entity.

39.53(4) Procedures to ensure the confidentiality of protected health information records and review materials, in accordance with federal and state law.

39.53(5) Procedures to ensure adherence to the requirements of this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694, by any contractor, subcontractor, subvendor, agent or employee affiliated with the independent review entity.

39.53(6) Policies and procedures establishing a quality assurance program. The program shall include a written description to be provided to all individuals involved in the program, the organizational arrangements, and the ongoing procedures for the identification, evaluation, resolution and follow-up of

potential and actual problems in independent reviews performed by the independent review entity and procedures to ensure the maintenance of program standards pursuant to this requirement.

191—39.54(514G) Toll-free telephone number. The independent review entity shall establish a toll-free telephone service to receive information relating to independent reviews pursuant to this division and Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694. The system shall include a procedure to ensure the capability of accepting, recording, or providing instruction to respond to incoming telephone calls during other than normal business hours. The independent review entity shall also establish a facsimile and electronic mail service.

191—39.55(514G) Insurance division application and reports. The independent review entity shall provide the commissioner such data, information, and reports as the commissioner determines necessary to evaluate the independent review process established under Iowa Code chapter 514G as amended by 2008 Iowa Acts, House File 2694. An application for certification as an independent review entity must be submitted in duplicate to the Iowa Insurance Division, 330 Maple Street, Des Moines, Iowa 50319. An application must be submitted in full to be considered. Every applicant will be notified of the certification decision. A list of certified independent review entities shall be maintained at the insurance division and shall be available through the division's Web site, www.iid.state.ia.us.

191—39.56 to **39.74** Reserved.

DIVISION III
LONG-TERM CARE PARTNERSHIP PROGRAM

191—39.75(514H,83GA,HF723) Purpose.

39.75(1) This division is intended to implement Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, and Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171, to establish, in conjunction with the department of human services, a long-term care partnership program in Iowa to provide for financing of long-term care through a combination of private insurance and Iowa Medicaid.

39.75(2) The Iowa long-term care partnership program shall:

a. Provide incentive for individuals to insure against the costs of providing for long-term care needs;

b. Provide a mechanism for individuals to qualify for coverage under Iowa Medicaid while having certain assets disregarded for eligibility determinations and recovery; and

c. Reduce the financial burden on the state's Medicaid program by encouraging the pursuit of private initiatives using qualified long-term care partnership policies or certificates.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.76(514H,83GA,HF723) Effective date. The rules in this division shall apply to all long-term care partnership policies or certificates sold or issued for delivery on or after January 1, 2010.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.77(514H,83GA,HF723) Definitions. For purposes of this division, the definitions in Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, and the definitions in rule 191—39.4(514G) shall apply. In addition, the following definitions shall apply:

"Asset disregard" means, with regard to the state's Medicaid program, disregarding assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care partnership policy.

"Division" means the Iowa insurance division.

"Iowa long-term care partnership policy" or *"partnership policy"* means an insurance policy that meets the following requirements:

1. The policy covers an insured who, when coverage first became effective under the policy, was a resident of Iowa or was an individual eligible under subrule 39.78(2).

2. The policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than January 1, 2010.

3. The policy meets all of the applicable requirements of this chapter and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

4. The division has certified the policy as meeting the requirements of the following: Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and any applicable federal regulations or guidelines.

5. The policy provides the following inflation protections:

- For a person who is less than 61 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either annual compounded inflation protection of not less than 3 percent or annual compounded inflation protection of not less than a rate based on changes in the consumer price index. "Consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.
- For a person who is at least 61 years of age but less than 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either an inflation feature that meets the requirements of this definition, paragraph "5," first bulleted paragraph, or an automatic inflation feature that provides annual simple inflation increases at a rate of not less than 3 percent.
- For a person who is at least 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, an inflation protection feature may be included in the policy but is not required.

"Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

"Medicaid" means the program of medical assistance operated by the Iowa department of human services under Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and amendments thereto.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.78(514H,83GA,HF723) Eligibility.

39.78(1) An individual who is a beneficiary of an Iowa long-term care partnership policy or certificate may be eligible for assistance under the state's Medicaid program using the asset disregard as provided under Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

39.78(2) An individual who is a beneficiary of a long-term care partnership policy or certificate issued in another state which grants reciprocity to an Iowan who moves to that state is eligible for benefits under Iowa's Medicaid program using the asset disregard as provided in Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723. For purposes of this subrule, "reciprocity" means the granting of all the benefits by one state to an individual who becomes a resident of that state but who purchased a long-term care partnership policy while residing in another state.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.79(514H,83GA,HF723) Discontinuance of partnership program. If the Iowa long-term care partnership program established by this division and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, is discontinued, any individual who purchased an Iowa long-term care partnership policy or certificate before the date the program was discontinued shall be eligible to receive asset disregard if allowed as provided by Title VI, Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.80(514H,83GA,HF723) Required disclosures.

39.80(1) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a Partnership Program Notice. The notice must be substantially similar to

Appendix H of this chapter. The Partnership Program Notice shall be provided with the required outline of coverage.

39.80(2) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a copy of the Iowa Long-Term Care Partnership Program Consumer Guide. The Iowa Long-Term Care Partnership Program Consumer Guide form may be found on the division's Web site, www.iid.state.ia.us.

39.80(3) A partnership policy or certificate issued or issued for delivery in Iowa shall be accompanied by a Partnership Status Disclosure Notice (Appendix I). A similar notice may be used if filed with and approved by the division.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.81(514H,83GA,HF723) Form filings.

39.81(1) A partnership policy shall not be issued or issued for delivery in Iowa unless filed with and approved by the division. Any policy submitted for certification as a partnership policy shall be accompanied by a Partnership Issuer Certification. The Partnership Issuer Certification form may be found on the division's Web site, www.iid.state.ia.us. Insurance companies required to file rates or forms with the division shall submit required rate and form filings and any fees required for the filings electronically using the System for Electronic Rate and Form Filing (SERFF). Insurance companies must comply with the division's requirements, including both the Iowa general instructions and the specific submission requirements for the type of insurance for which the companies are submitting forms or rates, as set forth on the SERFF Web site at www.serff.org.

39.81(2) Insurers may request to make use of a previously approved policy form as a qualified state long-term care partnership policy. Requests shall be filed electronically via SERFF and according to instructions on the SERFF Web site.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.82(514H,83GA,HF723) Exchanges.

39.82(1) An insurer must offer, on a one-time basis, in writing, to all existing policyholders that were issued long-term care policies between February 1, 2003, and January 1, 2010, the option to exchange their existing long-term care policies for an Iowa long-term care partnership policy. The insurer must make this offer within 18 months of the date the insurer begins the first marketing efforts for any long-term care partnership insurance product.

39.82(2) Under an exchange program, an insurer must comply with all of the following:

a. The mandatory offer of an exchange shall apply only to products issued by the insurer that are comparable to the type of policy, such as group policies and individual policies, and to the policy series that the company has certified as partnership-qualified.

b. An insurer must provide the insured a minimum of 90 days from the date of mailing of the offer by the insurer to accept or reject the offer.

c. An insurer must make the offer on a nondiscriminatory basis without regard to the age or health status of the insured. However, the insurer may underwrite if the policy is amended to provide additional benefits or if the exchange would require the issuance of a new policy, except as described in paragraph 39.82(2)*"d"* below. Any portion of the policy that was issued prior to the exchange date shall be priced based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

d. If there is no change in coverage that is material to the risk, policies exchanged under this rule shall not be subject to any medical underwriting.

e. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the policy or certificate being replaced.

f. Any portion of the policy that was issued prior to the exchange date shall maintain the policy's original price based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

g. When the policy is issued to a group, the offer required in subrule 39.82(1) shall be made to the group policyholder.

h. Notwithstanding paragraphs 39.82(2)*"a"* and *"c,"* an insurer is not required to offer an exchange to an individual who is eligible for benefits within an elimination period, who is or who has been in claim status, or who would not be eligible to apply for coverage due to issue age or plan design limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including plan design, underwriting, if applicable, and payment of the required premium.

39.82(3) Policies issued pursuant to this rule shall be considered exchanges and not replacements and are not subject to rule 191—39.11(514D,514G).

39.82(4) A policy received in an exchange after January 1, 2010, is treated as newly issued and is eligible for long-term care partnership policy status. For purposes of applying the Medicaid rules relating to Iowa's long-term care partnership program, the addition of a rider, endorsement or change in schedule page for a policy may be treated as giving rise to an exchange.

39.82(5) An insurer or a producer offering an exchange shall provide to each prospective applicant a Partnership Program Notice, as required by subrule 39.80(1), and a copy of the Iowa Long-Term Care Partnership Program Consumer Guide, as required by subrule 39.80(2). An insurer issuing or issuing for delivery in Iowa an exchange shall provide the policyholder or certificate holder a Partnership Status Disclosure Notice, as required by subrule 39.80(3).

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.83(514H,83GA,HF723) Required policy terms and disclosures.

39.83(1) A policy or certificate designed or marketed as a long-term care insurance policy or certificate must prominently disclose on the schedule page the following statements:

"Some long-term care insurance [policies or certificates] may qualify under the state's Long-Term Care Partnership Program. Under this Program the [policyholder or certificate holder] may be able to protect some of the [policyholder's or certificate holder's] assets from Medicaid spend-down requirements through a feature known as 'Asset Disregard.' Nothing in this [policy or certificate] is a guarantee of Medicaid eligibility nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility. If you have questions about whether or not your policy currently qualifies under the Long-Term Care Partnership Program, please contact [the insurer at ###-###-####] and request a long-term care partnership program policy summary."

39.83(2) If a policyholder or certificate holder or that person's representative requests a long-term care partnership program policy summary, as provided in subrule 39.83(1), the information the insurer shall provide and the format of the long-term care partnership program policy summary shall be as set forth in Appendix J. An insurer may submit a form substantially similar to Appendix J to the commissioner for approval to use as a substitute for Appendix J.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.84(514H,83GA,HF723) Standards for marketing and suitability. The standards for marketing found in rule 191—39.15(514D,514G) and the suitability requirements of rule 191—39.16(514D,514G) shall apply to the marketing and sale of long-term care partnership policies.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.85(514H,83GA,HF723) Required reports.

39.85(1) Each issuer of partnership-qualified long-term care insurance in this state shall provide regular reports to the Secretary of the United States Department of Health and Human Services in accordance with federal law and regulations and to the Iowa department of human services and the division as provided in Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171. The report shall include information as required by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Submission of the report to the Iowa department of human services or the division is not required if the issuer files the report through the Centers for Medicare and Medicaid Services filing system.

39.85(2) When a policyholder or certificate holder begins receiving any benefits under a policy, the issuer shall begin providing to the policyholder or certificate holder statements of benefits either monthly or within a reasonable time after benefits have been paid. The statements of benefits shall include, at a minimum, detailed information regarding benefits paid and dates of service.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

These rules are intended to implement Iowa Code section 514D.9, Iowa Code chapter 514G and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

[Filed 4/28/88, Notice 1/13/88—published 5/18/88, effective 7/1/88]
[Filed 1/19/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]
[Filed 10/25/91, Notice 9/18/91—published 11/13/91, effective 1/1/92]
[Filed 12/3/93, Notice 8/18/93—published 12/22/93, effective 1/26/94]
[Filed 6/5/02, Notice 5/1/02—published 6/26/02, effective 7/31/02]
[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]
[Filed 8/10/07, Notice 7/4/07—published 8/29/07, effective 10/3/07][1]
[Filed emergency 12/12/07—published 1/2/08, effective 12/12/07]
[Filed 10/30/08, Notice 9/24/08—published 11/19/08, effective 1/1/09][◊]
[Filed emergency 12/24/08—published 1/14/09, effective 1/1/09]
[Filed ARC 8271B (Notice ARC 8132B, IAB 9/9/09), IAB 11/4/09, effective 12/9/09]
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

◊ Two or more ARCs

[1] Effective date of subrule 39.15(4) delayed 70 days by the Administrative Rules Review Committee at its meeting held September 11, 2007.

APPENDIX A

RESCISSION REPORTING FORM FOR
LONG-TERM CARE POLICIES
FOR THE STATE OF IOWA
FOR THE REPORTING YEAR 20[ ]

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

Policy Form #	Policy and Certificate #	Name of Insured	Date of Policy Issuance	Date/s Claim/s Submitted	Date of Rescission

Detailed reason for rescission: _____

_____

_____

_____

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX B

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be [$_____ per month, or $_____ per year] [a one-time single premium of $_____].

Type of Policy (noncancellable/guaranteed renewable):_____

The Company's Right to Increase Premiums:_____

[The company cannot raise your rates on this policy.] [The company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.] [Insurers shall use appropriate bracketed statement. Rate guarantees shall not be shown on this form.]

Rate Increase History

The company has sold long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any long-term care policy it has sold in this state or any other state.] [The company has not raised its rates for this policy form or similar policy forms in this state or any other state in the last 10 years.] [The company has raised its premium rates on this policy form or similar policy forms in the last 10 years. Following is a summary of the rate increases.]

Drafting Note: A company may use the first bracketed sentence above only if it has never increased rates under any prior policy forms in this state or any other state. The issuer shall list each premium increase it has instituted on this or similar policy forms in this state or any other state during the last 10 years. The list shall provide the policy form, the calendar years the form was available for sale, and the calendar year and the amount (percentage) of each increase. The insurer shall provide minimum and maximum percentages if the rate increase is variable by rating characteristics. The insurer may provide, in a fair manner, additional explanatory information as appropriate.

Questions Related to Your Income

How will you pay each year's premium?
□ From my Income □ From my Savings/Investments □ My Family will Pay
[□ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?]

Drafting Note: The issuer is not required to use the bracketed sentence if the policy is fully paid up or is a noncancellable policy.

What is your annual income? (check one) □ Under $10,000 □ $[10-20,000] □ $[20-30,000] □ $[30-50,000] □ Over $50,000

Drafting Note: The issuer may choose the numbers to put in the brackets to fit its suitability standards.

How do you expect your income to change over the next 10 years? (check one)
□ No change □ Increase □ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) □ Yes □ No
If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?
□ From my Income □ From my Savings/Investments □ My Family will Pay

The national average annual cost of care in [insert year] was [insert $ amount], but this figure varies across the country. In ten years the national average annual cost would be about [insert $ amount] if costs increase 5% annually.

Drafting Note: The projected cost can be based on federal estimates in a current year. In the above statement, the second figure equals 163% of the first figure.

What elimination period are you considering? Number of days _____ Approximate cost $_____for that period of care.

How are you planning to pay for your care during the elimination period? (check one)
□ From my Income □ From my Savings/Investments □ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)
□ Under $20,000 □ $20,000-$30,000 □ $30,000-$50,000 □ Over $50,000

How do you expect your assets to change over the next ten years? (check one)
□ Stay about the same □ Increase □ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

☐	The answers to the questions above describe my financial situation. **Or** I choose not to complete this information. (Check one.)
☐	I acknowledge that the carrier and/or its producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including the premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked.)

Signed: _____ _____

(Applicant) (Date)

[□ I explained to the applicant the importance of completing this information.]

Signed: _____ _____

(Producer) (Date)

Producer's Printed Name: _____]

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____

(Applicant) (Date)

Drafting Note: Choose the appropriate sentences depending on whether this is a direct mail or producer sale.

The company may contact you to verify your answers.

Drafting Note: When the Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.

APPENDIX C

Things You Should Know Before You Buy

Long-Term Care Insurance

Long-Term Care Insurance

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.

- [You should **not** buy this insurance policy unless you can afford to pay the premiums every year.] [Remember that the company can increase premiums in the future.]

Drafting Note: For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.

- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long-term care.

Medicaid

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.

- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.

- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.

- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or producer gives you a copy of a booklet called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

APPENDIX D

Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for long-term care insurance included a "personal worksheet," which asked questions about your finances and your reasons for buying long-term care insurance. For your protection, state law requires us to consider this information when we review your application, to avoid selling a policy to those who may not need coverage.

[Your answers indicate that long-term care insurance may not meet your financial needs. We suggest that you review the information provided along with your application, including the booklet "Shopper's Guide to Long-Term Care Insurance" and the page titled "Things You Should Know Before Buying Long-Term Care Insurance." Your state insurance department also has information about long-term care insurance and may be able to refer you to a counselor free of charge who can help you decide whether to buy this policy.]

[You chose not to provide any financial information for us to review.]

Drafting Note: Choose the paragraph that applies.

We have suspended our final review of your application. If, after careful consideration, you still believe this policy is what you want, check the appropriate box below and return this letter to us within the next 60 days. We will then continue reviewing your application and issue a policy if you meet our medical standards.

If we do not hear from you within the next 60 days, we will close your file and not issue you a policy. You should understand that you will not have any coverage until we hear back from you, approve your application and issue you a policy.

Please check one box and return in the enclosed envelope.

□ **Yes,** [although my worksheet indicates that long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

Drafting Note: Delete the phrase in brackets if the applicant did not answer the questions about income.

□ **No.** I have decided not to buy a policy at this time.

_____ _____

APPLICANT'S SIGNATURE DATE

Please return to [issuer] at [address] by [date].

APPENDIX E

Claims Denial Reporting Form
Long-Term Care Insurance

For the State of Iowa
For the Reporting Year of_____

Company Name: _____ Due: June 30 annually
Company Address: _____
_____
Company NAIC Number: _____
Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this form is to report all long-term care claim denials under in-force long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

		State Data	**Nationwide Data**[1]
1	Total Number of Long-Term Care Claims Reported		
2	Total Number of Long-Term Care Claims Denied/Not Paid		
3	Number of Claims Not Paid due to Preexisting Condition Exclusion		
4	Number of Claims Not Paid due to Waiting (Elimination) Period Not Met		
5	Net Number of Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4)		
6	Percentage of Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1)		
7	Number of Long-Term Care Claims Denied due to:		
8	• Long-Term Care Services Not Covered under the Policy[2]		
9	• Provider/Facility Not Qualified under the Policy[3]		
10	• Benefit Eligibility Criteria Not Met[4]		
11	• Other		

[1]The nationwide data may be viewed as a more representative and credible indicator where the data for claims reported and denied for your state are small in number.

[2] Example—home health care claim filed under a nursing home only policy.

[3]Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

[4] Examples—a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

APPENDIX F

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

Long-Term Care Insurance
Potential Rate Increase Disclosure Form

1. **[Premium Rate] [Premium Rate Schedules]:** [Premium rate] [Premium rate schedules] that [is][are] applicable to you and that will be in effect until a request is made and [filed][approved] for an increase [is][are] [on the application][$_____].

Drafting Note: Use "approved" in states requiring prior approval of rates.

2. **The [premium] [premium rate schedule] for this policy [will be shown on the schedule page of] [will be attached to] your policy.**

3. **Rate Schedule Adjustments:**

   The company will provide a description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.) (fill in the blank): _____.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

Turn the Page

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premiums.
- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy).

Turn the Page

Contingent Nonforfeiture
Cumulative Premium Increase Over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

APPENDIX G

Long-Term Care Insurance

Replacement and Lapse Reporting Form

For the State of_____ For the Reporting Year of_____

Company Name:_____ Due: June 30 annually

Company Address:_____ Company NAIC Number:_____

Contact Person:_____ Phone Number: (_____)_____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each producer on that producer's amount of long-term care insurance replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Producers with the Greatest Percentage of Replacements

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Replaced By This Producer	Number of Replacements As % of Number Sold By This Producer

Listing of the 10% of Producers with the Greatest Percentage of Lapses

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Lapsed By This Producer	Number of Lapses As % of Number Sold By This Producer

Company Totals

Percentage of Replacement Policies Sold to Total Annual Sales ____%

Percentage of Replacement Policies Sold to Policies In Force (as of the end of the preceding calendar year) ____%

Percentage of Lapsed Policies to Total Annual Sales _____%

Percentage of Lapsed Policies to Policies In Force (as of the end of the preceding calendar year) _____%

APPENDIX H

Partnership Program Notice
Important Consumer Information Regarding the
Iowa Long-Term Care Partnership Program

Some long-term care insurance policies or certificates sold in Iowa may qualify for the Iowa Long-Term Care Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain state and federal requirements. Long-term care insurance policies or certificates that qualify as partnership policies or certificates may protect the policyholder's or certificate holder's assets through a feature known as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership policy or certificate without affecting the person's eligibility for Medicaid.

All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. Therefore, you should consider if Asset Disregard is important to you and whether a partnership policy or certificate meets your needs. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

What Are the Requirements for a Partnership Policy or Certificate?

In order for a policy or certificate to qualify as a partnership policy or certificate, it must, among other requirements:

- Be issued to an individual on or after January 1, 2010;
- Be issued to an individual who is an Iowa resident when coverage first becomes effective under the policy;
- Be a tax-qualified policy under Section 7702B(b) of the Internal Revenue Code of 1986;
- Meet the following inflation protection requirements:
  → For a person less than 61 years of age – provides compound annual inflation protection
  → For a person at least 61 but less than 76 years of age – provides 3 percent inflation protection
  → For a person at least 76 years of age – inflation protection may be offered but is not required

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy or certificate qualifies as a partnership policy or certificate.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or insurance company to determine the effect of a proposed change. If you move to a state that does not have a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Sally Oudekerk, Medicaid Policy Specialist, Bureau of Medical Support, telephone number (515)281-3709, E-mail address soudeke@dhs.state.ia.us).

APPENDIX I

Partnership Status Disclosure Notice
Important Information Regarding Your Policy's or Certificate's
Long-Term Care Partnership Status
This disclosure notice is issued in conjunction with your long-term care policy.

Some long-term care insurance policies or certificates sold in Iowa qualify for the Iowa Long-Term Care Partnership Program. Long-term care insurance policies or certificates that qualify as partnership policies or certificates may be entitled to special treatment, in particular as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership policy or certificate without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

Partnership Policy or Certificate Status

Your long-term care insurance policy or certificate is intended to qualify as a partnership policy or certificate under the Iowa Long-Term Care Partnership Program as of your policy's or certificate's effective date.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or your insurance company to determine the effect of a proposed change. If you move to a state that does not maintain a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws may be subject to change. Any change on law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Sally Oudekerk, Medicaid Policy Specialist, Bureau of Medical Support, telephone number (515)281-3709, E-mail address soudeke@dhs.state.ia.us).

APPENDIX J

Long-Time Care Partnership Program Policy Summary

1. Name of insured _____
2. Policy/certificate number _____
3. Effective date of coverage _____
4. The policy/certificate was issued in the state of _____
5. Issue age of the insured at the time the coverage was issued _____
6. The policy/certificate was issued □ With inflation protection coverage
   □ Without inflation protection coverage
7. The inflation protection coverage is □ Simple Inflation □ Compound Inflation □ None
8. The inflation protection coverage is currently in effect on the coverage □ Yes □ No
   If no, the date inflation protection coverage ceased _____
9. The policy is intended to meet the standards of a tax-qualified long-term care policy□ Yes □ No
10. The cumulative dollar amount of insurance benefits paid $_____
    (NOTE: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only.)
11. The total dollar amount of insurance benefits remaining available under the policy $_____
12. This information is correct as of the date this form was completed, which date was _____
13. The name, telephone number and E-mail address of the person completing this form

_____
Name

_____
Telephone Number

_____
E-mail Address

CHAPTER 40
HEALTH MAINTENANCE ORGANIZATIONS

(Health and Insurance—Joint Rules)
Appeared as Ch 12, July 1974 Supplement
[Prior to 10/22/86, Insurance Department [510]]

PREAMBLE

The following rules developed by the division of insurance govern the organization and regulation of health maintenance organizations pursuant to the authority set forth in Iowa Code chapter 514B.

191—40.1(514B) Definitions.

"Act" when used in these rules shall mean Iowa Code chapter 514B.

"Complaint" means a written communication expressing a grievance concerning a health maintenance organization.

"Dental care" means care by licensed dentists or by appropriate auxiliary dental personnel working under the supervision of a dentist. It includes the necessary diagnostic, treatment, and preventive services required to maintain proper oral health.

"Governing body" means the persons in which the ultimate responsibility and authority for the conduct of the HMO is vested.

"HMO" means health maintenance organization and shall be abbreviated as HMO in these rules.

"Inpatient hospital care" means inpatient hospital care provided through a licensed hospital on a 24-hour basis.

"Outpatient medical services" means outpatient medical services provided within or outside of a hospital. This shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

"Physician care" means care by a licensed physician or by paramedical or other ancillary health personnel under the direction of the licensed physician. It shall be of sufficient type and amount to adequately provide for the contracted services including emergency care, inpatient hospital care, and outpatient medical services.

191—40.2(514B) Application. An application on forms provided by the insurance division accompanied by a filing fee of $100 payable to State Treasurer, State of Iowa, shall be completed by an officer or authorized representative of the health maintenance organization. The application with copies in duplicate shall be verified and shall be accompanied by the information found in Iowa Code section 514B.3(1 to 14). An application shall not be deemed to be filed until all information necessary to properly process said application has been received by the commissioner. See 40.11(514B).

An amendment to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

191—40.3(514B) Inspection of evidence of coverage. An enrollee may, if evidence of coverage is not satisfactory for any reason, return evidence of coverage within ten days of receipt of same and receive full refund of the deposit paid, if any. This right shall not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the enrollee utilizes the services of the HMO within the ten-day period.

191—40.4(514B) Governing body and enrollee representation. An HMO shall have a basic written organizational document setting forth its scheme of organization and establishing a governing body appropriate to its form of organization. The governing body shall be responsible for matters of policy and operation.

The HMO shall develop bylaws or guidelines which describe the scope of the health care services the HMO renders to enrollees either directly by its medical staff or dental staff, if dental care is provided, or

through arrangements with others outside of the organization. Initial bylaws, guidelines, and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The bylaws, guidelines, or similar document shall provide for "reasonable representation" on the governing body by enrollees. "Reasonable representation" as used in Iowa Code section 514B.7 shall require not less than 30 percent of the governing board members be enrollees who are not providers or are not associated with a provider. Enrollees shall have the opportunity to nominate said enrollee representatives.

The HMO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the HMO. Such members shall serve until the first annual meeting or election. If there are no enrollee representatives on the initial governing board, they shall be elected at the first annual meeting or election.

The nomination procedures for enrollee representatives should provide for the following to assure an adequate opportunity for participation by enrollees:

40.4(1) An opportunity for adult enrollees to nominate candidates for the governing body.

40.4(2) Notice to all adult enrollees of the nomination and election procedures.

The HMO shall be deemed to have complied with these requirements if it provides notice in its regular newsletter to enrollees of the opportunity to and the procedures for nomination of enrollee representatives.

Nomination procedures may be waived by the commissioner for a period of up to three years from the HMO's commencement of delivery of services to enrollees.

For purposes of this rule, an HMO operated directly by a corporation or corporations subject to Iowa Code chapter 514 and rule 191—34.7(514) shall be deemed to be in compliance with this rule if it is or they are in compliance with Iowa Code section 514.4 and rule 191—34.7(514).

This rule is intended to implement Iowa Code section 514B.7.

191—40.5(514B) Quality of care. Each HMO shall:

40.5(1) Provide primary care physicians' services commensurate with the need of the enrollees, but at a level of not less than that established in the community.

40.5(2) Advise the insurance division annually pursuant to Iowa Code section 514B.12 of the ratio of full-time equivalent physicians, paramedical and ancillary health personnel to enrollees and fee-for-service patients. Changes in the physician ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

40.5(3) Provide assurance that all physicians, paramedical and ancillary health personnel engaged in the provisions of health services to enrollees and fee-for-service patients are currently licensed or certified by the appropriate state agency where they are located to practice their respective profession. These personnel shall be no less qualified in their respective profession than the current level of qualification, which is maintained in their community.

40.5(4) When health care facilities are utilized by the health maintenance organization, these facilities shall be licensed by the appropriate state agency where they are located. These facilities shall be either accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid.

40.5(5) Have a qualified administrator designated by the governing body who shall be responsible for the management of the HMO.

40.5(6) Have a formally organized medical staff.

40.5(7) Have a chief of the medical staff designated by the governing body who shall be responsible for the development of medical staff bylaws, rules which shall include assurance to enrollees that a continuum of health care services will be provided without unreasonable periods of delay.

40.5(8) Provide for an ongoing internal peer review program.

40.5(9) Each HMO shall provide a continuous program of general health education for disease prevention and identification without additional cost to the enrollee. Such a program may include publications, media presentations, and classroom instruction. Programs of wellness education including stress management, smoking cessation, nutritional education, physical fitness programs, and other such

programs as approved by the division of insurance shall be open to all enrollees on a voluntary basis and may be subject to a copayment requirement. These programs shall be conducted by qualified personnel.

The HMO must periodically remind and encourage the enrollees of an HMO to utilize benefits including physical examinations which are available and designed to prevent illness. The HMO must also offer periodic screening programs which in the opinion of the medical staff would effectively identify conditions indicative of a health problem. These periodic screening programs shall not carry a copayment. Each HMO shall keep a record of all activities it has conducted to satisfy this requirement and the cost thereof.

40.5(10) Maintain a medical records system which includes at a minimum the following information:

a. Documentation of utilization rates for every enrollee.

b. Patient's name, identification number, age, sex, and place of residence and employment.

c. Services provided, when provided, where provided, and by whom.

d. Medical diagnosis, treatment prescribed, therapy prescribed and drugs administered.

e. Statement in regard to the status of the patient's health.

40.5(11) Provide by contract or other arrangement for peer reviews. The plans for internal and external peer review shall be submitted to the commissioner of insurance for approval.

a. Internal peer review shall be conducted by the HMO staff on a continuing basis using Joint Commission on Accreditation of Hospitals, American Osteopathic Association, or American Dental Association, if appropriate, standards as a general guide and shall be structured to review the total episode of illness that the HMO is responsible for. The HMO staff may use parts of the total episode of illness peer review done by other internal review committees to avoid duplication of work. This review shall include but not be limited to the following:

(1) Utilization review and evaluation of the quality of care provided enrollees.

(2) The process or method by which care is given.

(3) The outcome of care including the morbidity and mortality rates that result.

b. External review—criteria and methodology for the selection of an external review group (ERG):

(1) Application to be the ERG may be made in the form of a letter to the commissioner of insurance, describing the qualifications of the ERG and how the ERG meets the criteria set forth in this rule.

(2) Deleted per agency memo, 9/29/93 IAC.

(3) The commissioner shall invite an application from any ERG upon the request of any HMO.

(4) The commissioner may also invite applications from any group which might have the capability of carrying out a review.

(5) The commissioner will consider all applications and appoint one, based on the following criteria:

1. The group's experience in evaluating the quality of medical care.

2. The degree to which the group is representative of the licensed physician community in Iowa.

3. The degree to which the group is knowledgeable about the health delivery system in Iowa.

4. The degree to which selection of the group will avoid duplication with other review activities in Iowa.

5. The group's ability to coordinate its activities with other review groups, and with practitioners and providers of health care in Iowa.

6. The group's knowledge of current and accepted medical opinion, and its ability to make qualitative evaluations of clinical practice.

7. The degree to which at least 50 percent of the physician members of the group (or that part of the group responsible for HMO inspections) are members of an HMO medical staff.

(6) No physician shall review an HMO of which the physician is a member.

(7) Appointment of an ERG will be for a four-year period, and only one ERG will be appointed at a time. Applications for appointment or reappointment will be accepted between 180 days and 90 days before the expiration of the acting ERG's four-year term.

c. External review—criteria and methodology by which an ERG will evaluate the effectiveness of an HMO's peer review program:

(1) The ERG will conduct an on-site inspection of each Iowa-certified HMO every two years, or on a schedule requested by the health department.

(2) The inspection will consist of interviewing HMO staff and physicians, and a review of such records (including clinical records of HMO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the HMO or any of its physician members which pertain to HMO quality assurance operations or HMO patients, excluding financial records.

(3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an HMO's internal peer review program, and to report its findings to the health department.

(4) The following items will be considered by the ERG in making its determination:

1. The extent and acuity of the HMO's peer review program in evaluating the clinical management of enrollees provided by HMO physicians.

2. The ability of the HMO's program to identify aberrant practices in clinical management, and to take appropriate disciplinary action.

3. The method within the HMO by which the peer review program reports its findings to the medical staff and the governing body.

4. The authority with the HMO to correct practices which the peer review program has found to be detrimental.

5. The system developed within the HMO to facilitate the work of the peer review program.

6. The commitment on the part of the HMO governing body and medical staff toward an active peer review program with a goal of quality assurance.

d. External review—procedures to be followed upon completion of an ERG's inspection:

(1) Within 30 days of the completion of its inspection, the ERG will submit a written report of its findings to the HMO.

(2) The HMO will have 45 days to respond to the ERG.

(3) The ERG must file its final report with the insurance division within 90 days of the completion of its inspection. The final report must include any comments received from the HMO.

(4) The insurance division may extend the time periods referred to in this paragraph *"d,"* subparagraphs (1) to (3).

(5) After considering the report of the ERG, the insurance commissioner shall determine if the HMO's certificate of authority is to be either continued, suspended or revoked.

This rule is intended to implement Iowa Code section 514B.4.

191—40.6(514B) Change of name. No name other than that certified by the division may be used. The name of the HMO may not be changed without prior approval of the division.

191—40.7(514B) Change of ownership. Each HMO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the HMO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

191—40.8(514B) Termination of services. When an HMO desires to cease offering a service, such service may not be terminated without prior approval of the division. Arrangements equitable to the enrollees providing for a rate adjustment or substitution of an equivalent service satisfactory to the division must be made.

191—40.9(514B) Complaints.

40.9(1) Each health maintenance organization shall provide in its bylaws for a system to resolve and record complaints.

40.9(2) The complaint system shall provide for the resolution of the following kinds of complaints and the recording of the information required to be reported to the commissioner:

a. Complaints about the quality of health care services provided by the health maintenance organization.

b. Complaints about the availability of such services.

c. Complaints relating to enrollee participation in the operation of the health maintenance organization.

40.9(3) The complaint system shall provide for the recording of the information required to be reported to the commissioner relative to the following kinds of complaints:

a. Complaints to the health maintenance organization concerning benefits provided by other than the health maintenance organization under the provisions of any indemnity policy or contract provided by the health maintenance organization. Such complaints shall be referred to the person providing the benefits and a copy shall be forwarded to the commissioner.

b. Malpractice claims settled during the year by the health maintenance organization and any of its providers.

40.9(4) The information required to be reported to the commissioner shall be included in the annual report to the commissioner on the form provided therewith.

40.9(5) All complaint files shall be retained by the health maintenance organization until the examination for the period during which the complaint was received has been completed.

191—40.10(514B) Cancellation of enrollees.

40.10(1) Membership of an enrollee in a health maintenance organization may be terminated by the health maintenance organization for the following reasons and no other:

a. Nonpayment of charges when due.

b. Termination of the conditions, other than a change in the health of the enrollee, under which the enrollee became eligible to be enrolled under a group contract.

c. Termination of the group contract under which the enrollee was enrolled.

d. Change of place of residence of the enrollee from the geographic area served by the health maintenance organization.

e. Failure of the enrollee to pay deductible or coinsurance charges permitted under Iowa Code section 514B.5(3).

f. Unreasonable refusal of the enrollee to follow a prescribed course of treatment.

g. A materially false statement or misrepresentation by the enrollee in an application for membership or benefits.

40.10(2) When membership of an enrollee is terminated by the HMO for a reason other than nonpayment of charges, nonpayment of deductible or coinsurance charges, unreasonable refusal of the enrollee to accept services, or a materially false statement or misrepresentation by the enrollee in the application for membership, the HMO shall arrange to have offered to the enrollee an opportunity to have issued to the enrollee, at the expense of the enrollee, without evidence of insurability, individual or family policy or policies of hospital and medical expense insurance, or individual or family contracts with hospital and medical service corporations. The form of such policies or contracts shall be that shown in the Application for Certificate of Authority of the HMO or the latest approved amendment thereto. The conversion policy or contract shall provide coverage substantially similar to that provided by the HMO. The conversion policy or contract shall also provide at least $250,000 lifetime benefits. If the HMO enrolls persons on other than a group basis, it shall also offer to the enrollee, if the enrollment was canceled for the reason stated in 40.10(1)*"b"* or 40.10(1)*"c,"* an option to be enrolled as an individual enrollee. In the event of insolvency of an HMO and revocation of its certificate of authority, all other HMOs shall offer enrollees of the insolvent HMO an open enrollment period of 30 days after the date of revocation of the certificate.

40.10(3) Membership of an enrollee in a health maintenance organization may be terminated only upon giving a notice of cancellation not less than 30 days before the date of termination. Such notice shall:

a. Be given by delivery of the notice in duplicate to the enrollee in person or by certified mail addressed to the enrollee at the last address known to the health maintenance organization.

b. State the date and hour upon which the enrollment shall terminate.

c. State the reason for cancellation.

d. If cancellation is for nonpayment of charges, state the amount of charges due, the cost of preparing and serving the notice, and the total cost of charges and preparing the notice, and that if the enrollee pays the amount of charges due plus the cost of preparing and serving the notice at any time before the cancellation date the coverage will remain in force.

e. State that the enrollee has the right to a hearing before the commissioner if requested by the enrollee within 20 days after receipt of notice of cancellation.

f. Provide for the enrollee to indicate on the notice that the enrollee requests such hearing.

g. If the enrollee is entitled to have policies or contracts issued as provided in 40.10(2), it shall be stated how the enrollee may apply for such policies or contracts.

h. State that the enrollee may request such hearing by forwarding one copy of the notice of cancellation, marked to request a hearing, to the Commissioner of Insurance, Two Ruan Center, 601 Locust Street, Fourth Floor, Des Moines, Iowa 50309.

40.10(4) When a hearing is requested, the commissioner may require the HMO to continue to provide coverage during the pendency of the hearing and a period of not more than ten days after the decision is made known. The commissioner may require the enrollee, as a condition of granting continued coverage, to pay the HMO the charges for such period of coverage.

40.10(5) The hearing shall be held before the commissioner or the delegated hearing officer in the following manner:

a. Upon receipt of a request for hearing, the commissioner shall notify the health maintenance organization and the enrollee of the time and place of hearing.

b. Formal rules of evidence need not be observed, but no evidence shall be received which does not relate to the issue.

c. The burden of proof shall be upon the health maintenance organization to show by a preponderance of the evidence that it had good cause for cancellation for one or more of the reasons stated in the notice and provided herein, except that when the cancellation is for nonpayment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.

d. At the close of the hearing, or as soon thereafter as possible, the commissioner shall advise the parties of the commissioner's decision.

This rule is intended to implement Iowa Code section 514B.17.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

191—40.11(514B) Application for certificate of authority. The application for certificate of authority shall be in the following form:

HEALTH MAINTENANCE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY

_____

(Name of Health Maintenance Organization)

Organized as _____
under the laws of the state of _____, hereby makes application to the commissioner of insurance for a certificate of authority to establish and operate a health maintenance organization in compliance with Iowa Code chapter 514B.

Attached hereto and hereby made a part of this application are exhibits bearing numbers corresponding to the following:

1. A copy of the basic organizational document, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all of its amendments.

2. A copy of the bylaws, rules or similar document, regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

3.1 A list of the names and addresses of each owner of 5 percent or more of the health maintenance organization.

4. A copy of any contract made or to be made between any providers and the applicant

4.1 A copy of any contract made or to be made between the applicant and any person listed in item (3).

4.2 A copy of any contract made or to be made between the applicant and any person for management services.

5. A statement generally describing the health maintenance organization including, but not limited to, a description of its facilities and personnel.

6. A copy of the form of evidence of coverage.

7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement is attached.

8.1 A copy of any contract made or to be made between the applicant and its reinsurer.

8.2 A copy of any contract made or to be made between the applicant and any person for cash or asset management services.

9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.

10. A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner, his successors in office and deputies as the true and lawful attorney of the applicant for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served and assessing in detail the economic feasibility of the HMO's projected operation.

12. A description of the complaint procedures to be utilized as required under Iowa Code section 514B.14.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the commissioner of insurance in consideration, when deemed appropriate, with the director of public health, under Iowa Code section 514B.4.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by Iowa Code section 514B.7.

14.1 A copy of the notice to be given to enrollees of the procedure for nomination and election of members of the governing body.

15. A schedule of the liability and workmen's compensation insurance to be maintained in force by the health maintenance organization.

15.1 Copies of the forms of policies or contracts to be offered to terminated enrollees as provided in 40.10(2).

VERIFICATION

The undersigned deposes and says that deponent has duly executed the attached application dated _____, 20 _____, for and on behalf of _____;
(Name of Applicant)

that deponent is the _____ of such company,
(Title of Officer)

and that deponent is authorized to execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Subscribed and sworn to before me by _____on this _____ day of _____, 20 _____.

_____
(Notary Public)

191—40.12(514B) Net worth.

40.12(1) An HMO shall not be authorized to transact business with a net worth less than $1 million.

40.12(2) No HMO incorporated by or organized under the laws of any other state or government shall transact business in this state unless it possesses the net worth required of an HMO organized by the laws of this state and is authorized to do business in this state.

40.12(3) As deemed necessary by the division, each health maintenance organization that is a subsidiary of another person shall file with the division, in a form satisfactory to it, a guarantee of the HMO's obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

40.12(4) Each health maintenance organization shall, at the time of application, pay to the division a one-time, nonrefundable fee of $10,000 to be used by the division to create a special fund solely for the payment of administrative expenses in connection with the solvency of an HMO.

191—40.13(514B) Fidelity bond. A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of cancellation or termination has been filed with the commissioner unless an earlier date of cancellation or termination is approved by the commissioner.

This rule is intended to implement Iowa Code section 514B.5(1).

191—40.14(514B) Annual report. A health maintenance organization shall annually, on or before the first day of March, file with the commissioner of insurance a report verified by at least two of its principal officers and covering the preceding calendar year.

The report shall be on the form designated by the National Association of Insurance Commissioners (NAIC) as the report form for health maintenance organizations. The report shall be completed using "statutory accounting practices" (SAP), and shall include any other information required under law or rule.

The commissioner of insurance may request additional reports and information from a health maintenance organization as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

This rule is intended to implement Iowa Code section 514B.12.

191—40.15(514B) Cash or asset management agreements. If an HMO utilizes a cash or asset management arrangement with its parent, affiliate, or any other person, the arrangement shall be written and subject to prior approval by the commissioner. Cash or asset management agreements shall meet the following minimum requirements:

40.15(1) Cash receipts shall be under the direct control of the HMO that generated the receipts. If the system is under the control of the HMO's parent or affiliate, then receipts shall be transferred to the HMO within five working days.

40.15(2) Securities purchased shall be in the name of the HMO generating the funds for the security purchase.

40.15(3) An HMO's investments shall not be pooled with other entities' investments unless there is an agreement which vests an undivided interest in the pooled arrangement to the HMO. Such an agreement shall be subject to prior approval by the commissioner.

40.15(4) An HMO's cash or investments shall not be commingled with the cash or investments of any other person.

40.15(5) Investments made on behalf of an HMO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.15.

40.15(6) The agreement shall provide for prompt notice and verification of investments, establish responsibility for brokerage and other fees and provide for periodic reports on earnings and expenses.

40.15(7) A parent, affiliate, person, and employees thereof providing cash or asset management services shall be bonded and responsible for any physical loss of investments.

191—40.16(514B) Deductibles and coinsurance charges. Rescinded IAB 10/15/03, effective 11/19/03.

191—40.17(514B) Reinsurance. Reinsurance contracts and stop-loss agreements entered into by an HMO shall be subject to prior approval and shall meet the following minimum requirements:

40.17(1) Reinsurance contracts and stop-loss agreements shall provide that the commissioner of insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.

40.17(2) Retention levels shall be reasonable in light of the HMO's financial condition and potential liabilities.

191—40.18(514B) Provider contracts. An HMO's arrangements for health care services shall be by written contract. Initial provider contracts shall be subject to prior approval. Thereafter, any provider contract deviating from previously submitted or approved contracts shall be submitted to the division within 30 days of execution for informational purposes. In all instances, all provider contracts shall include the following provision:

(Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the HMO acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on HMO's behalf made in accordance with terms of (applicable Agreement) between HMO and subscriber/enrollee.

(Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

191—40.19(514B) Producers' duties. In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in a health maintenance organization, a producer must comply with the licensing rules set forth in 191—Chapter 10 of the Iowa Administrative Code and in particular

submit to an examination to determine the applicant's competence to sell accident and health insurance as described in rule 191—10.7(522), classification 6.

191—40.20(514B) Emergency services. Benefits shall be available by the HMO for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since HMOs may not contract with every emergency care provider in an area, HMOs shall make every effort to inform members of participating providers.

40.20(1) The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

40.20(2) The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following:

a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

b. Serious impairment to bodily function; or

c. Serious dysfunction of any bodily organ or part.

191—40.21(514B) Reimbursement. Reimbursement to a provider of "emergency services," as defined in 191—40.1(514B), shall not be denied by any health maintenance organization without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the HMO as outlined in rule 40.9(514B). Upon denial of reimbursement for emergency services, the HMO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—40.22(514B) Health maintenance organization requirements.

40.22(1) A health maintenance organization shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the health maintenance organization's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health maintenance organization or a person contracting with the health maintenance organization.

40.22(2) A health maintenance organization shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health maintenance organization that, in the opinion of the provider, jeopardizes patient health or welfare.

191—40.23(514B) Disclosure requirements. All HMOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, an HMO offering a plan that includes a prescription drug formulary shall inform enrollees of the plan, and prospective enrollees of the plan during any open enrollment period, whether a prescription drug specified in the request is included in such formulary.

All HMOs shall also disclose the existence of any contractual arrangements providing rebates received by them for prescription drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated use and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by sickness or injury.

191—40.24(514B) Provider access. A health maintenance organization shall allow a female enrollee direct access to obstetrical and gynecological services from network or participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

191—40.25(514B) Electronic delivery of accident and health group insurance certificates.

40.25(1) *Purpose.* The purpose of this rule is to authorize the electronic delivery of accident and health group insurance certificates in an efficient manner by health maintenance organizations and group policyholders, while guaranteeing that individual plan members still receive the important information contained in such group insurance certificates, as required by Iowa Code section 514B.9 and as allowed by the uniform electronic transactions Act, Iowa Code chapter 554D.

40.25(2) *Scope.* This rule shall apply to all health maintenance organizations holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapter 514B.

40.25(3) *Electronic delivery—health maintenance organizations.* The health maintenance organization will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the group policyholder electronically and if:

a. The health maintenance organization takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by group policyholders, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each group policyholder is provided notice, through electronic means or in writing, apprising the group policyholder of the fact that the certificate will be furnished electronically, of the significance of the certificate and the group policyholder's obligations under this rule, and of the group policyholder's right to request and receive a paper copy of the document for each participant.

d. Upon request of any group policyholder, the health maintenance organization furnishes paper copies of the group insurance certificate that was delivered to the group policyholder electronically, so that the group policyholder may provide them to participants that have requested paper copies.

40.25(4) *Electronic delivery—group policyholders.* The group policyholder will be deemed to comply with the requirements of Iowa Code section 514B.9 if the group insurance certificate is delivered to the individual plan member electronically and if:

a. The group policyholder takes appropriate and necessary measures to ensure that the system for furnishing group insurance certificates results in actual receipt of transmitted information by participants, which may be done by:

(1) Using return-receipt electronic mail features;

(2) Periodic reviews or surveys to confirm receipt of the transmitted information; or

(3) Any other method approved by the insurance commissioner.

b. The electronic documents contain the same content and appear in reasonably the same format as the certificates previously approved by the insurance commissioner.

c. Each participant is provided notice, through electronic means or in writing, apprising the participant of the fact that the certificate will be furnished electronically, of the significance of the certificate, and of the participant's right to request and receive, free of charge, a paper copy of the document.

d. Upon request of any participant, the group policyholder furnishes, free of charge, a paper copy of the group insurance certificate that was delivered to the participant electronically.

This rule is intended to implement Iowa Code chapter 514B.

191—40.26(514B) Notice of cancellation, rescission, discontinuance or termination of enrollment.

40.26(1) *Purpose.* The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, rescission, discontinuance or termination by a health maintenance organization, so as to

implement the various consumer protections intended by Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B). Presumption of receipt in the context of a postal service mailing is a well-settled principle of Iowa law (see *Montgomery Ward v. Davis,* 398 N.W.2d 869, 870-871 (Iowa 1982)), but Iowa courts have not yet recognized a presumption of receipt for electronic transmissions. Notwithstanding Iowa Code section 554D.110(4)*"b,"* delivery by electronic transmission, for the purposes of this rule, does not provide for satisfactory verification or acknowledgment of receipt, as required by Iowa Code section 505B.1(6).

40.26(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to operate an HMO under the provisions of Iowa Code chapter 514B.

40.26(3) *Delivery and receipt.* For any notice of cancellation, rescission, discontinuance or termination by a health maintenance organization under Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) to be effective, a health maintenance organization must, within the time frame established by law, either deliver the notice to the named insured in person or mail the notice through the U.S. Postal Service to the last-known address of the named insured. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) for certified mail or certificate of mailing as proof of mailing.

40.26(4) *Electronic transmissions.* Electronic transmissions do not currently satisfy the notice requirements of Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B). However, additional communication of notices by electronic means may be provided by an insurer as a service to the named insured.

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code chapter 514B and 1999 Iowa Acts, Senate File 276.

[Filed March 18, 1974]
[Filed 5/7/82, Notice 3/31/82—published 5/26/82, effective 6/30/82]
[Filed 7/30/82, Notice 6/23/82—published 8/18/82, effective 9/30/82]
[Filed 5/18/84, Notice 12/21/83—published 6/6/84, effective 7/11/84]
[Filed 9/18/84, Notice 8/1/84—published 10/10/84, effective 11/14/84]
[Filed 1/23/85, Notice 11/21/84—published 2/13/85, effective 4/24/85]
[Filed emergency after Notice 5/17/85, Notice 2/13/85—published 6/5/85, effective 5/17/85]
[Filed emergency 6/3/85—published 6/19/85, effective 7/1/85]
[Filed 9/18/85, Notice 6/19/85—published 10/9/85, effective 11/13/85]
[Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]
[Filed 1/8/87, Notice 10/22/86—published 1/28/87, effective 3/4/87]
[Filed 3/6/87, Notice 1/28/87—published 3/25/87, effective 7/1/87]
[Filed 10/21/88, Notice 4/20/88—published 11/16/88, effective 12/21/88]
[Filed 12/9/88, Notice 9/21/88—published 12/28/88, effective 2/1/89]
[Filed 4/16/92, Notice 1/8/92—published 5/13/92, effective 6/17/92]
[Filed emergency 9/10/93—published 9/29/93, effective 9/10/93]
[Filed 2/21/97, Notice 1/1/97—published 3/12/97, effective 4/16/97]
[Filed 4/1/98, Notice 2/11/98—published 4/22/98, effective 5/27/98]
[Filed emergency 10/16/98—published 11/4/98, effective 10/16/98]
[Filed 3/5/99, Notice 11/4/98—published 3/24/99, effective 4/28/99]
[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]
[Filed 9/3/99, Notice 7/14/99—published 9/22/99, effective 10/27/99]
[Filed 9/24/03, Notice 7/23/03—published 10/15/03, effective 11/19/03]
[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

IOWA FINANCE AUTHORITY[265]

[Prior to 7/26/85, Housing Finance Authority[495]]
[Prior to 4/3/91, Iowa Finance Authority[524]]

CHAPTER 1
GENERAL

CHAPTER 2
LOAN PROGRAMS

GENERAL PROVISIONS

TERMS AND CONDITIONS

CHAPTER 3
MULTIFAMILY HOUSING

MULTIFAMILY LOAN PROGRAM

CHAPTER 4
GENERAL REVENUE BOND PROCEDURES

CHAPTERS 5 and 6
Reserved

CHAPTER 7
CONTESTED CASES

CHAPTER 8
PRIVATE ACTIVITY BOND ALLOCATION

CHAPTER 9
TITLE GUARANTY DIVISION

CHAPTER 10
MORTGAGE CREDIT CERTIFICATES

CHAPTER 11
IOWA MAIN STREET LOAN PROGRAM

CHAPTER 12
LOW-INCOME HOUSING TAX CREDITS

CHAPTER 13
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

CHAPTER 14
Reserved

CHAPTER 15
PURCHASING

CHAPTER 16
DECLARATORY ORDERS

CHAPTER 17
PROCEDURE FOR RULE MAKING

CHAPTER 18
WAIVERS AND VARIANCES FROM ADMINISTRATIVE RULES

CHAPTER 19
STATE HOUSING TRUST FUND

CHAPTER 20
SENIOR LIVING REVOLVING LOAN PROGRAM

CHAPTER 21
HOME AND COMMUNITY-BASED SERVICES REVOLVING LOAN PROGRAM

CHAPTER 22
IOWA AFTERCARE SERVICES RENT SUBSIDY PROGRAM

CHAPTER 27
MILITARY SERVICE MEMBER HOME OWNERSHIP ASSISTANCE PROGRAM

CHAPTER 28
WASTEWATER TREATMENT FINANCIAL ASSISTANCE PROGRAM

CHAPTER 29
JUMP-START HOUSING ASSISTANCE PROGRAM

CHAPTER 30
QUALIFIED MIDWESTERN DISASTER AREA BOND ALLOCATION

CHAPTER 31
COUNCIL ON HOMELESSNESS

CHAPTER 32
IOWA JOBS PROGRAM

CHAPTER 40
IOWANS HELPING IOWANS HOUSING ASSISTANCE PROGRAM

CHAPTER 41
SHELTER ASSISTANCE FUND

CHAPTER 42
EMERGENCY SOLUTIONS GRANT PROGRAM

CHAPTER 43
COMMUNITY HOUSING AND SERVICES FOR PERSONS WITH DISABILITIES
REVOLVING LOAN PROGRAM

CHAPTER 44
IOWA AGRICULTURAL DEVELOPMENT DIVISION

CHAPTER 15
PURCHASING

265—15.1(16) Applicability of competitive bidding. Items, including goods or services, that are expected to cost in the aggregate in excess of $50,000 will be obtained as a result of a formal or informal competitive bidding process conducted by the authority, or through the department of administrative services whenever such procurement is in the best interests of the authority, as determined by the authority. Items, including goods or services, expected to cost $50,000 or less in the aggregate may be obtained in any manner deemed appropriate by the authority.

Notwithstanding the foregoing, the authority may exempt any item from competitive bidding if the item is noncompetitive or is purchased in quantities too small to be effectively purchased through competitive bidding; if there is an immediate or emergency need for the item; if the purchase of the item facilitates compliance with set-aside procurement provisions; or if the executive director of the authority determines, in the executive director's sole discretion, that the authority's best interests will be served by exemption from the bidding process.

265—15.2(16) Methods of obtaining bids or proposals used by the authority. Formal or informal bids or proposals are to be obtained by one of the following methods. If more than one method is applicable to the purchase of a particular item, the authority shall choose the method of bidding to be utilized.

15.2(1) *Formal bids.*

a. To solicit formal bids, the authority shall prepare a written invitation-to-bid document and shall send it via the United States Postal Service or electronic mail to selected vendors in the business of providing the goods or services sought by the authority. Goods or services may also be obtained by the authority using reverse auction methods via the authority's Internet Web site.

b. The invitation to bid shall contain the due date and time of the bid opening, a complete description of the item needed, and any other necessary or proper items.

c. Formal bids received prior to the submission deadline set in the bidding document shall be made available to any interested party on the date and hour designated on the bid form. As the bids are opened, they shall be tabulated, and the results of the tabulation shall be made available to any interested party. The original bids and the tabulations shall be maintained at the authority for one year following the date on which the bids were opened.

d. An award shall be made within 60 calendar days from the date of the bid opening, unless a different time frame is stated by the authority in the invitation to bid or subsequently agreed to by the vendors. The price quoted by the vendors shall remain binding throughout the applicable time period. If an award is not made within the applicable time frame, all bids shall be deemed rejected.

15.2(2) *Informal bids.*

a. Informal bids may be obtained by the authority through use of a written bid form, over the telephone, via facsimile transmission, or in electronic format, including over the Internet or through electronic mail. When requesting informal bids, the authority shall contact selected vendors supplying the goods or services sought by the authority and shall communicate to each vendor the date on which bids must be received, a complete description of the item to be purchased, and the time period during which the bid must remain valid. Goods or services may also be obtained by the authority using reverse auction methods via the authority's Internet Web site.

b. Written informal bids shall be opened as received, and informal telephone, facsimile, or electronic bids shall be recorded as received. If a bid is received over the telephone, a telephone bid form shall be used to record the bid received. If an electronic bid is received, a printout shall be used to record the bid received. Following the submission deadline, the authority shall tabulate the bids received and make the award. The bids and the tabulations shall be available to interested parties after the submission deadline and shall be maintained by the authority for one year following the submission deadline.

c. If an award is not made within the time frame indicated by the authority when requesting bids, all bids shall be deemed rejected.

15.2(3) *Request for proposals.* Whenever a requirement exists for an item and cost may not be the sole criterion for selection, the authority may issue a request for proposals. The purpose of a request for proposals is to provide the vendor with sufficient information about the authority's requirements and goals to allow the vendor to propose a solution to the authority's requirements.

a. The authority shall prepare a written request for proposals and shall send it via the United States Postal Service or electronic mail to selected vendors in the business of supplying the goods or services sought by the authority.

b. An award shall be made within 60 calendar days from the date of the proposal opening unless a different time frame is stated by the authority in the request for proposals or subsequently agreed to by the vendors. The terms quoted by the vendor shall remain binding throughout the applicable time frame. If an award is not made within the applicable time frame, all proposals shall be deemed rejected and not binding.

c. At a minimum, a request for proposals shall address the following criteria: the need for a proposal conference; the purpose and background of the request; important dates in the proposal and the award process, including the submission deadline; administrative requirements for submitting the proposal and the format required by the authority; the scope of the work to be performed and any specific requirements which the vendor must meet; and any contractual terms and conditions which the authority anticipates may affect the terms of the vendor's proposal.

265—15.3(16) Items purchased through the department of administrative services. Goods and services may be obtained by the authority through the department of administrative services (DAS) whenever procurement through DAS is in the best interests of the authority. Items procured through DAS may be obtained by DAS in any manner it deems appropriate.

265—15.4(16) Posting solicitations. Formal bids and requests for proposals issued by the authority shall be posted to the authority's Internet Web site. The posting shall indicate that it is a notice to prospective bidders, contain the due date and time of opening of the bid or proposal, describe the items to be purchased, and provide the name, address and telephone number of the person to be contacted to obtain official bidding documents.

[**ARC 0430C**, IAB 10/31/12, effective 12/5/12]

265—15.5(16) Contract purchases. The authority may enter into contract purchase agreements for items, groups of items, or services. Contract purchase agreements are subject to the competitive bidding requirements previously outlined, where applicable.

265—15.6(16) Blanket purchase agreements. If the authority foresees a requirement for frequent purchases of off-the-shelf items, the authority may establish blanket purchase agreements. A blanket purchase agreement is a formally approved charge account that is designed to reduce paperwork and the number of checks issued. Blanket purchase agreements are subject to the competitive bidding requirements previously outlined, where applicable.

265—15.7(16) Bids and proposals to conform to specifications. All bids and proposals must conform to the specifications indicated by the authority. Bids and proposals that do not conform to the specifications stated may be rejected. The authority reserves the right to waive deficiencies in the bids or proposals if in the judgment of the authority its best interests would be served by the waiver.

265—15.8(16) Time of delivery. When evaluating bids or proposals, the authority may consider the time of delivery when determining the successful vendor.

265—15.9(16) Cash discounts. When evaluating bids or proposals, the authority may consider cash discounts.

265—15.10(16) Ties. The authority shall resolve ties among bids or proposals which are equal in all respects by drawing lots unless only one of the tied bidders is an Iowa business. If only one of the bidders tied for an award is an Iowa business, the Iowa business shall be given preference over all tied out-of-state businesses. If it is necessary to draw lots, the drawing shall be held in the presence of the vendors who submitted the tied bids or proposals whenever practical. If the tied vendors are not present, the drawing shall be held in front of at least two persons, and the authority shall document the drawing.

265—15.11(16) Time of submission. All formal bids and proposals shall be submitted by the vendor in sufficient time to actually reach the authority prior to the submission deadline specified in the bid document. All informal bids shall be submitted by the vendor in time to reach the authority prior to the submission deadline indicated by the authority. Formal bids and proposals shall be marked by the authority with the date and time received by the authority. Formal bids and proposals received after the submission deadline shall be returned to the vendor unopened. All vendors to whom invitations to bid or requests for proposals are sent shall be notified of any changes in submission deadline.

If a formal bid or request for proposals is canceled prior to the submission deadline, any responses already received shall be returned unopened. If an informal bid is canceled prior to the submission deadline, any bids already received shall be destroyed.

265—15.12(16) Modification or withdrawal of bids. Bids or proposals may be modified or withdrawn prior to the time and date set for the bid or proposal opening. Modifications or withdrawals shall be in writing and delivered in a sealed envelope that properly identifies the correct bid or proposal to be modified or withdrawn. A bid or proposal may be withdrawn after opening only with the approval of the authority if the authority finds that an honest error was made by the vendor that will cause undue financial hardship to the vendor and that will not cause undue financial hardship or inconvenience to the authority.

265—15.13(16) Financial security. The authority may require bid security, litigation security, and performance security on formal bids or proposals. When required, security may be by certified check, certificate of deposit, letter of credit made payable to the authority, or any other form specified by the authority.

265—15.14(16) Rejection of bids and proposals. The authority reserves the right to reject any or all bids or proposals. Bids and proposals may be rejected because of faulty specifications, abandonment of the project, insufficient funds, evidence of unfair or flawed bidding procedures, failure of a vendor to meet the authority's requirements, or for any other reason if the authority determines that its best interests will be served by rejecting any or all bids. Following the rejection of bids, new bids may be requested by the authority at any time deemed convenient by the authority.

265—15.15(16) Vendor appeals. Any vendor whose bid or proposal has been timely filed and who is aggrieved by the award of the authority may appeal the decision by filing a written notice of appeal before the Iowa Finance Authority Board, 2015 Grand Avenue, Des Moines, Iowa 50312, within three days of the date of the award, exclusive of Saturdays, Sundays, and state legal holidays. The notice of appeal must actually be received at this address within the time frame specified to be considered timely. The notice of appeal shall state the grounds upon which the vendor challenges the authority's award. Following receipt of a notice of appeal which has been timely filed, the board shall notify the aggrieved vendor and the vendor who received the contract award of the procedures to be followed in the appeal. The board may appoint a designee to proceed with the appeal on its behalf.

These rules are intended to implement Iowa Code section 16.5(1)*"f."*

[Filed 10/4/07, Notice 8/29/07—published 10/24/07, effective 11/28/07]
[Filed ARC 0430C (Notice ARC 0287C, IAB 8/22/12), IAB 10/31/12, effective 12/5/12]
[Filed ARC 2001C (Notice ARC 1855C, IAB 2/4/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 23
TRANSITIONAL HOUSING REVOLVING LOAN PROGRAM

265—23.1(16) Purpose. Through its transitional housing revolving loan program (program), the authority seeks to assist in the development of affordable housing for parents who are reuniting with their children while completing or participating in substance abuse treatment. This chapter implements Iowa Code section 16.48.
[**ARC 2002C**, IAB 5/27/15, effective 7/1/15]

265—23.2(16) Priority of loan awards. It is the authority's intent to award loans under the program to those applicants that meet all of the requirements of this chapter and satisfy all threshold and underwriting requirements of the applicable qualified allocation plan adopted by the authority pursuant to 265—12.1(16). The authority intends to award the available funds under this program each year if applicants meet all applicable requirements, provided, however, that the authority shall give preference in the manner it deems most appropriate to projects that reunite mothers with their children. The authority will announce its expected amount of funds available prior to each tax credit application deadline. To the extent that sufficient funds are not available to fully fund all applications, awards under this program will be funded in the following order of priority:

1. Applicants awarded tax credits under the service-enriched set-aside;
2. Applicants awarded tax credits under any other set-aside; and
3. Applicants awarded tax credits outside of a set-aside.

Applicants within set-asides will compete based on points awarded under the qualified allocation plan.

265—23.3(16) Application process. Applications will be reviewed as part of an annual competition. Applications must be submitted in conjunction with the applicant's application for low-income housing tax credits, as set forth in the applicable qualified allocation plan. Once funds have been allocated, the authority will not accept for review any applications seeking funding until the next low-income housing tax credit application deadline. Applications for assistance under this program must be made on forms and in the manner provided by the authority. Inquiries with respect to this program should be made to those persons identified on the authority's Web site at www.iowafinanceauthority.gov as contacts for this program.

265—23.4(16) Program guidelines. For-profit and nonprofit sponsors are eligible to apply for assistance under this program based on the following program guidelines:

23.4(1) A project eligible for assistance must meet the following criteria:

a. A project must be geographically located in close proximity to a substance abuse treatment program, licensed pursuant to Iowa Code sections 125.13 and 125.21. Close proximity is defined as within a ten-mile radius of the substance abuse treatment program.

b. A project must be developed using low-income housing tax credits.

c. Applicants must satisfy all of the requirements of the applicable qualified allocation plan, including the plan, application and application instructions, all applicable attachments and exhibits, and applicable provisions of the Internal Revenue Code and the accompanying Treasury regulations.

d. Assistance provided under this program must enable the project to maintain financial feasibility and affordability for at least the term of the assistance.

e. Operating and replacement reserve funds must be adequately funded in the amounts required by the applicable qualified allocation plan.

23.4(2) The following types of activities are eligible for assistance:

a. Acquisition and rehabilitation.

b. New construction.

c. Such other similar activities as may be determined by the authority to fall within the guidelines and purposes established for this program.

23.4(3) Assistance will be provided upon the following terms and conditions:

a. Generally, the minimum loan amount is $100,000, and the maximum loan amount is $700,000. The maximum loan term and amortization period are each 20 years. Notwithstanding the above loan term and amortization period, the authority may, in its sole discretion, extend the loan term and amortization period to no more than 30 years.

b. The debt service ratio must be at least 1.25:1, as calculated by the authority. In addition, the loan-to-value ratio of the project, as calculated by the authority, will be considered. Notwithstanding the above debt service ratio, the authority may, in its sole discretion, accept a lower debt service ratio based on the final underwriting of the project.

c. Interest rates will be set by the authority, in its sole discretion.

d. Loans shall be secured by a first mortgage. Construction financing may be awarded to projects.

e. Recipients of assistance must agree to observe several covenants and restrictions, including but not limited to recorded affordability and transfer restrictions, all in accordance with such loan and mortgage documents as may be required by the authority under this program.

f. The recipient must provide adequate evidence that its title in the real estate on which the project is to be located is a marketable title pursuant to Iowa Land Title Examination Standards, or other applicable law. Adequate evidence of marketable title is demonstrated by either (1) a title opinion of an attorney authorized to practice law in Iowa showing that the loan recipient has marketable title, or (2) a title guaranty certificate issued by the title guaranty division of the Iowa finance authority showing the recipient as the guaranteed.

g. Recipients must execute such documents and instruments and must provide such information, certificates and other items as determined necessary by the authority, in its sole discretion, in connection with any assistance.

23.4(4) Loan fees.

a. Loan fees are as follows:

(1) Commitment fee (construction period) – 1.0 percent of loan amount.

(2) Commitment fee (permanent loan) – 2.0 percent of loan amount.

(3) Inspection fee (construction loan) – 0.5 percent of loan amount.

b. The authority may, in limited cases, reduce such fees if necessary in connection with assistance provided under this program. Such decision will be made in the sole discretion of the authority.

265—23.5(16) Authority analysis of applications. Authority staff will analyze and underwrite each potential project and will make recommendations for funding assistance to the board of the authority. Authority staff will use such procedures and processes in its underwriting and analysis as it deems necessary and appropriate in connection with furthering the purposes of this program. In addition, the authority anticipates that, because of the complex nature of each transaction and the particular sets of circumstances attributable to each particular application/transaction, the terms and conditions of loans will vary from project to project. The authority will make available its general operating procedures and guidelines for this program.

265—23.6(16) Discretion of authority board. The authority board of directors has the sole and final discretion to award or not award assistance and to approve final loan terms.

265—23.7(16) Closing/advance of funds. If all requirements of the authority are not met in accordance with any time frames set by the authority and to the complete satisfaction of the authority, all in the sole discretion of the authority, the authority may determine to cease work on an approved project and, accordingly, not advance any funds for such project.

These rules are intended to implement Iowa Code section 16.48.

[Filed 9/9/05, Notice 8/3/05—published 9/28/05, effective 11/2/05]
[Filed ARC 2002C (Notice ARC 1856C, IAB 2/4/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 26
WATER POLLUTION CONTROL WORKS AND DRINKING WATER FACILITIES FINANCING

265—26.1(16) Statutory authority. The authority to provide loans to eligible applicants to assist in financing drinking water and wastewater treatment facilities and water pollution control projects is provided by Iowa Code sections 16.131 through 16.133.

265—26.2(16) Purpose. The Iowa finance authority provides financing to carry out the functions of the state revolving fund (SRF) loan programs. Under an agreement with the United States Environmental Protection Agency, the Iowa SRF is administered by the Iowa department of natural resources in partnership with the Iowa finance authority.
[**ARC 8457B**, IAB 1/13/10, effective 2/17/10]

265—26.3(16) Definitions.

"Authority" or *"IFA"* means the Iowa finance authority.

"Clean Water Act" or *"CWA"* means the federal Water Pollution Control Act of 1972, as amended by the Water Quality Act of 1987.

"Commission" means the environmental protection commission of the Iowa department of natural resources.

"Common ownership" means the ownership of an animal feeding operation as a sole proprietor, or a majority ownership interest held by a person, in each of two or more animal feeding operations as a joint tenant, tenant in common, shareholder, partner, member, beneficiary, or other equity interest holder. The majority ownership interest is a common ownership interest when it is held directly, indirectly through a spouse or dependent child, or both.

"Department" or *"DNR"* means the Iowa department of natural resources.

"Director" means the director of the authority.

"DWSRF" means the drinking water state revolving fund.

"Eligible costs" means all costs related to the completion of a project as defined in the CWA and SDWA and 567—Chapters 40 and 90.

"EPA" means the United States Environmental Protection Agency.

"Intended use plan" or *"IUP"* means the program document identifying the intended uses of funds available for loans pursuant to the WPCSRF and the DWSRF.

"Nonpoint source" means any project described in Section 319 of the Clean Water Act.

"Recipient" means the entity receiving funds from the SRF.

"Safe Drinking Water Act" or *"SDWA"* means Title XIV of the federal Public Health Service Act, commonly known as the "Safe Drinking Water Act," as amended by the Safe Drinking Water Amendments of 1996.

"SRF" means the state revolving fund.

"WPCSRF" means the water pollution control state revolving fund.
[**ARC 8457B**, IAB 1/13/10, effective 2/17/10]

265—26.4(16) Project funding.

26.4(1) *Intended use plans/state project priority lists.* The state project priority lists shall include projects eligible for SRF loans as provided in 567—Chapters 44 and 92. The authority will consider the following when determining whether to provide a loan to an eligible recipient:

a. Recipient's financial capability to repay the loan and to provide operation and maintenance, replacement reserves, and, if required, debt service reserves;

b. Recipient's statement of willingness to accept all loan terms and conditions;

c. The priority of the project;

d. Funds available; and

e. The technical review and approval of the project by the department.

26.4(2) *Phased or segmented projects.* Loan funds for future portions of phased or segmented projects cannot be ensured, although subsequent segments of a project which has been awarded financial assistance will receive priority over other new projects. Loans made for separate phases or segments of a project will be administered separately.

26.4(3) *Loan adjustments.* Loan amounts may be adjusted to reflect eligible costs.

26.4(4) *Recipient record keeping.* The recipient shall maintain records that document all costs associated with the project. Moneys from the SRF and those contributed by the recipient shall be accounted for separately. Accounting procedures shall conform to generally accepted government accounting standards. The recipient shall agree to provide access to these records to the department, the authority, the state auditor, the state or EPA, and the Office of the Inspector General at the EPA. The recipient shall retain such records and documents for inspection and audit purposes for a period of three years from the date of the final loan payment.

26.4(5) *Site access.* The recipient shall agree to provide the department and the department's agent access to the project site at all times to verify that the loan funds are being used for the intended purpose and that the construction work meets all applicable state and federal requirements. Recipients shall also agree to provide the department periodic access to the project site for the duration of the loan to ensure that the project is being operated and maintained as designed.

26.4(6) *Cross-cutting laws.* Other federal and state statutes and programs may affect an SRF project. Loan agreements will include an assurance that a recipient will comply with all applicable federal and state requirements.

265—26.5(16) WPCSRF/DWSRF infrastructure construction loans.

26.5(1) *Loan agreements.* The authority will prepare a loan agreement when the application has been determined to be in compliance with the requirements of the CWA/SDWA and applicable state rules for SRF funding. The loan shall be accompanied by an enforceability opinion in a form acceptable to the authority and, if applicable, a bond counsel opinion as to the status of interest on the obligation, in a form acceptable to the authority. A copy of the current form of the loan agreement shall be provided to the applicant upon request.

26.5(2) *Loan rates and terms.* Loan terms for point source projects shall include the following:

a. *Interest rates.* Loan interest rates shall be established in the IUP and shall be established by taking into account factors including, but not limited to, the following:

(1) Interest rate cost of funds to the SRF;

(2) Availability of other SRF funds;

(3) Prevailing market interest rates of comparable non-SRF loans; and

(4) Long-term SRF viability.

b. *Loan initiation fee.* The loan initiation fee shall be established in the IUP. The fee shall be payable on the closing date of the loan agreement.

c. *Annual loan servicing fee.* The annual loan servicing fee shall be established in the IUP.

d. *Revenue pledge.* The recipient shall establish sufficient revenue sources that are acceptable to the director for the repayment of the loan. To ensure repayment of obligations according to the terms of the loan agreement, the recipient shall agree to impose, collect, and increase, if necessary, user charges, taxes, or other dedicated revenue sources identified for the loan repayment in order to maintain annual net revenues at a level equal to at least 110 percent of the amount necessary to pay debt service on all revenue obligations during the next fiscal year, provided, however, that, at the discretion of the director, the authority may allow other revenue sources and coverage of less than 110 percent as security. In case of loan default, the authority shall have authority to require revenue adjustment, through the manner described above, to collect delinquent loan payments.

e. *Security.* The loan shall be secured by a first lien upon the dedicated source of repayment which may rank on a parity basis with other obligations. The dedicated source of repayment is expected to be the net revenues of the recipient's system and the loan is expected to be secured by a first lien on said net revenues. Loans secured by revenues of a system may rank on a parity basis with other outstanding obligations or, with the approval of the director, may be subordinate in right of payment to the recipient's

other outstanding revenue obligations. Loans may also be secured by a general obligation of the recipient through the provision for a levy of taxes to repay the loan.

f. *Construction payment schedules.* An estimated construction drawdown schedule provided by the recipient shall be part of the loan agreement.

26.5(3) *Loan commitments.* A loan agreement shall be a binding commitment of the recipient.

26.5(4) *Purpose of payments.* The recipient shall use the proceeds of the WPCSRF/DWSRF loan solely for the purpose of funding the approved project.

26.5(5) *Costs.* All eligible costs must be documented to the satisfaction of the authority and the department before proceeds of the loan will be disbursed.

26.5(6) *Loan amount and repayment period.* All loans shall be made contingent on the availability of funds, the maximum loan term will be that allowed by EPA, and repayment of the loan must begin no later than one year after the project is completed or by the date specified in the loan agreement.

26.5(7) *Prepayment.* The loan may be prepaid, in whole or in part, on any date with the prior written consent of the authority.

[**ARC 8457B**, IAB 1/13/10, effective 2/17/10; **ARC 0245C**, IAB 8/8/12, effective 7/12/12; **ARC 0431C**, IAB 10/31/12, effective 12/5/12]

265—26.6(16) Planning and design loans.

26.6(1) *Timing of loan.* Prior to a recipient's execution of a loan agreement for project construction, funds may be loaned to the recipient to pay for initial eligible costs, including the cost of facility planning and design engineering.

26.6(2) *Duration.* Planning and design loans may not have a duration of longer than three years from their date of execution, unless the director provides written consent to a longer term.

26.6(3) *Interest rate.* The interest rate will be that rate specified in the most recent IUP.

26.6(4) *Rollover to construction loan.* All funds borrowed by the recipient as a planning and design loan may be financed as a part of a construction loan agreement upon expiration of the term of the planning and design loan.

26.6(5) *Repayment.* If the recipient does not execute an SRF construction loan, the planning and design loan shall be paid in full at the end of the three-year term, unless the loan term is extended by written consent of the director.

[**ARC 8079B**, IAB 8/26/09, effective 8/7/09]

265—26.7(16) Disadvantaged community status.

26.7(1) *Criteria for disadvantaged community status.* The authority, in conjunction with the department, may develop criteria to determine disadvantaged community status. Factors included in the criteria include, but are not limited to, the community's median household income and target user charges. Criteria to determine disadvantaged community status shall be established in the IUP.

26.7(2) *Interest rate.* Interest rates for disadvantaged communities shall be established in the IUP.

[**ARC 8457B**, IAB 1/13/10, effective 2/17/10]

265—26.8(16) WPCSRF nonpoint source set-aside loan programs.

26.8(1) *Nonpoint source loan assistance.* Loan assistance for nonpoint source projects shall be in the form of low-interest loans or through linked deposits or loan participations through participating lending institutions.

26.8(2) *Application for loan assistance.* Application for loan assistance may be made at any participating lending institution or submitted to the authority or the authority's agent, as applicable. A list of participating lending institutions will be made available by the authority, financial agent or other entity that the authority may use to administer this program. Application for loan assistance shall be made on forms provided by the authority or its agent.

26.8(3) *Project approval.* Each project must be approved by the appropriate environmental or conservation agency as determined by the department.

26.8(4) *Loan approval.* For linked deposit programs, the participating lending institution shall, upon receipt of a completed loan application form, either approve or deny the loan in accordance with the

program requirements. If the loan is approved, the lending institution shall notify the authority or its agent in order to reserve funds in that amount to ensure that funds are available at the time of disbursement. If the loan is denied, the lending institution shall notify the loan applicant, clearly stating the reasons for the loan denial. For low-interest loans with the authority, the authority, or its agent, shall notify the applicant of the loan approval or denial.

26.8(5) *Availability of funds.* Before acting on a loan application, the lending institution shall ensure that adequate funds are available for the project and that the completed project has been inspected and approved by the appropriate environmental or conservation agency as determined by the department.

26.8(6) *Property transfer.* In the event of property transfer from the applicant to another person or entity during the repayment period specified in the loan agreement, the balance of the loan shall be immediately due in full.

26.8(7) *Loan amount and period.* All loans shall be made contingent on the availability of funds in the applicable fund or set-aside program as indicated in the IUP. The minimum and maximum loan amounts that will be considered are dependent on project type and are set forth as follows:

Type of Project	Type of Assistance	Minimum Loan Amount	Maximum Outstanding Balance	Maximum Loan Term	Project Approval Agency
General Nonpoint Source	Low-interest loans, Linked deposit or Loan participations	$5,000	No maximum	20 years	DNR
Local Water Protection	Linked deposit	$5,000	$500,000 per common ownership	10 years	Division of Soil Conservation
Livestock Water Quality Facilities	Linked deposit	$10,000	$500,000 per common ownership	15 years*	Division of Soil Conservation
Onsite Wastewater Systems Assistance	Linked deposit	$2,000	No maximum	10 years	County

*If the loan is made only for preparation of a comprehensive nutrient management plan, the loan period shall not exceed 5 years.

26.8(8) *Prepayment.* For direct loans, prepayment of the loan principal in whole or in part shall be allowed without penalty.

26.8(9) *Loan adjustments.* If the eligible costs exceed the loan amount, the recipient may request an increase in the loan amount. The lending institution is authorized to execute a loan for a principal amount of up to 10 percent above the amount of the loan application if the eligible costs exceed the application amount. To determine the appropriate action, the authority will evaluate the request by considering available moneys in the fund as well as the financial risk. Should the eligible costs be less than the loan amount, the loan shall be appropriately adjusted.

26.8(10) *Disbursement of funds.* Funds shall be disbursed in accordance with the loan agreement. The loan agreement may allow for periodic disbursement of funds.

[**ARC 8457B**, IAB 1/13/10, effective 2/17/10; **ARC 8906B**, IAB 6/30/10, effective 6/10/10]

265—26.9(16) Termination and rectification of disputes.

26.9(1) *Termination.* The authority shall have the right to terminate any loan if a term of the agreement has been violated. Loans are subject to termination if construction has not begun within one year of the execution of a loan agreement. The director will establish a repayment schedule for funds already loaned to the recipient. Every termination must be in writing.

26.9(2) *Rectification and disputes.* Failure of the recipient to implement the approved project or to comply with the applicable requirements constitutes grounds for the authority, the authority's agent, or

the participating lending institution to withhold loan disbursements. The recipient is responsible for ensuring that the identified problem(s) is rectified. Once the deficiency is corrected, the loan funds can be released. A recipient that disagrees with the director's withholding of loan funds may request a formal review of the action. The recipient must submit to the director a written request for a formal review of the action within 30 days of receiving notice that loan disbursements will not be released.

These rules are intended to implement Iowa Code sections 16.5(1)*"r"* and 16.133.

[Filed 1/13/06, Notice 9/28/05—published 2/1/06, effective 3/8/06]
[Filed emergency 12/11/07—published 1/2/08, effective 12/11/07]
[Filed 2/8/08, Notice 1/2/08—published 2/27/08, effective 4/2/08]
[Filed Emergency ARC 8079B, IAB 8/26/09, effective 8/7/09]
[Filed ARC 8457B (Notice ARC 8193B, IAB 10/7/09), IAB 1/13/10, effective 2/17/10]
[Filed Emergency ARC 8906B, IAB 6/30/10, effective 6/10/10]
[Filed Emergency ARC 0245C, IAB 8/8/12, effective 7/12/12]
[Filed ARC 0431C (Notice ARC 0244C, IAB 8/8/12), IAB 10/31/12, effective 12/5/12]
[Filed ARC 2003C (Notice ARC 1866C, IAB 2/4/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 29
JUMP-START HOUSING ASSISTANCE PROGRAM

265—29.1(16) Purpose. This chapter defines and structures the jump-start housing assistance program to aid individuals whose homes, located in parts of Iowa declared by the President of the United States to be disaster areas, were destroyed or damaged by the natural disasters of 2008. Under the program, the authority may grant funds in accordance with this chapter to local government participants, including certain Iowa councils of governments, cities, and counties. The local government participants shall, in turn, loan funds to eligible residents under the conditions specified in this chapter to assist those eligible residents in purchasing homes generally comparable to those they lived in prior to the occurrence of the natural disasters of 2008, in repairing or rehabilitating disaster-affected homes, and in making mortgage payments and paying for other eligible property-carrying costs while the eligible residents await a property acquisition of their disaster-affected homes.

265—29.2(16) Definitions. For purposes of this chapter, the following definitions apply.

"Authority" means the Iowa finance authority.

"COG" means an Iowa council of governments as identified by Iowa Code chapter 28H.

"Disaster-affected home" means a primary residence that was destroyed or damaged by the natural disasters of 2008.

"Disaster compensation" means moneys received by an eligible resident as a result of damage caused to the eligible resident's disaster-affected home by the natural disasters of 2008 from any of the following sources: (1) FEMA, (2) any other governmental assistance, or (3) proceeds of any insurance policy. "Disaster compensation" shall not include rental assistance received from FEMA or other sources.

"Eligible energy-efficient home appliances and improvements" means energy-efficient furnaces, boilers, appliances, air conditioners, hot water heaters, windows, and insulation that meet standards set by the office of energy independence.

"Eligible property-carrying costs" means the following expenses associated with the ownership of a disaster-affected home: liability insurance premiums, flood insurance premiums, property tax payments, installment payments on a real estate purchase contract for the disaster-affected home provided that the real estate purchase contract was executed prior to the first date on which the disaster-affected home sustained damage as a result of the natural disasters of 2008, and special assessments.

"Eligible repair expenses" means the reasonable cost of repairing damage to a disaster-affected home necessitated by the natural disasters of 2008. "Eligible repair expenses" shall not include additions to or expansions of a disaster-affected home or the purchase or installation of luxury items that were not part of the disaster-affected home prior to the natural disasters of 2008.

"Eligible resident" means an individual or family who resided in a disaster-affected home at the time of the natural disasters of 2008 and who:

1. Is the owner of record of a right, title or interest in the disaster-affected home; and
2. Has been approved by FEMA for housing assistance as a result of the natural disasters of 2008.

In cases where multiple persons own a disaster-affected home together, such as by a tenancy in common or joint tenancy, such persons will generally be deemed collectively to be the "eligible resident," provided the requirements set forth above are met. In the event that multiple persons assert inconsistent claims as to who the owner of a disaster-affected home is, the local government participant shall review the facts and, if necessary, make an allocation among the various applicants.

"FEMA" means the Federal Emergency Management Agency.

"Forgivable loan" means a loan made to an eligible resident pursuant to the requirements of this chapter.

"Local government participant" means:

1. Any of the following Iowa cities: Ames, Cedar Falls, Cedar Rapids, Council Bluffs, Davenport, Des Moines, Dubuque, Iowa City, Waterloo, and West Des Moines;

2. Any COG whose territory encompasses one or more Iowa counties that have been declared by the President of the United States to be disaster areas; and

3. Any county that is not part of any Iowa council of governments and has been declared by the President of the United States to be a disaster area.

"Natural disasters of 2008" means the severe storms, tornadoes, and flooding that occurred in Iowa between May 25, 2008, and August 13, 2008, and designated by FEMA as FEMA-1763-DR.

"Program" means the jump-start housing assistance program described in this chapter.

"Retention agreement" means an agreement, to be recorded as a lien against the property for which assistance is provided, requiring that if an eligible resident sells a home that was purchased or repaired or for which a mortgage loan was paid with the assistance of a loan made under this chapter, then that portion of the original principal amount that has not been forgiven, if any, shall be repaid.

265—29.3(16) Grants to local government participants.

29.3(1) *Allocation criteria.*

a. Initial allocation, loans to local government participants. The authority shall make an initial allocation of the funds made available for the program to the local government participants pro rata based on the funds awarded by FEMA under its housing assistance program to each local government participant's jurisdiction as a percentage of the total amount of funds awarded as a result of the natural disasters of 2008. The authority shall enter into a grant agreement with each local government participant, pursuant to which the authority may disburse funds to the local government participant for the purposes described in this chapter. The grant agreement shall be prepared by the authority and may contain such terms and conditions, in addition to those specified in this chapter, as the executive director may deem to be necessary and convenient to the administration of the program and to the efficient and responsible use of the granted funds.

b. Funds made available pursuant to 2009 Iowa Acts, Senate File 376. The authority shall allocate program funds made available under 2009 Iowa Acts, Senate File 376, section 29, Disaster Damage Housing Assistance Grant Fund, by inviting local government participants to submit an application for funding. The authority shall award program funding made available under this paragraph based upon priority criteria to be specified in the application form including, but not limited to, the following:

(1) The applicant's demonstrated maximum use and leverage of other disaster recovery resources; and

(2) Provision of program assistance to the maximum number of potential eligible residents with priority given to eligible residents who:

1. Have not received any moneys under the program;

2. Are in need of an interim mortgage assistance extension meeting the conditions specified in subrule 29.5(2); and

3. Are not eligible for assistance under the requirements of other available disaster recovery assistance programs.

29.3(2) *Review of requests for assistance.* The local government participant shall accept and review each request for assistance and shall determine whether the requesting party is an eligible resident. If the requesting party is determined an eligible resident, the local government participant shall determine whether the funds are being requested for a use permitted under the program and the amount available to the eligible resident under the terms of the program.

29.3(3) *Coordination with the jump-start business assistance program.* For presidentially declared disaster areas outside a COG region, counties may elect to apply singly, join with other counties, or join with an adjacent COG region. Likewise, a city named in the definition of "local government participant" in rule 265—29.2(16) may join with a COG, county, or multicounty entity. To the extent local government participants act jointly or cooperatively in their participation in the small business disaster recovery financial assistance program administered by the Iowa department of economic development pursuant to 261—Chapter 78, Iowa Administrative Code, the authority may require the local government participants to similarly act jointly or cooperatively in their participation under this chapter.

29.3(4) *Reallocation of unused funds.* Following one year, or following any three-month period during which a local government participant has requested no draws, the authority may reallocate all or part of any remaining portion of funds allocated to that local government participant to another local government participant with a demonstrated need for program funds.

29.3(5) *Administrative fees.* Each local government participant shall be entitled to receive an administrative fee equal to 5 percent of its initial disbursement, which shall consist of 30 percent of the local government participant's initial allocation. Subsequent thereto, each local government participant shall receive 5 percent of the funds loaned by the local government participant to eligible residents under the program from subsequent disbursements. The administrative fee shall be paid from the allocation made to each such local government participant by the authority pursuant to subrule 29.3(1).

29.3(6) *Proceeds of repayments.* All loan amounts repaid to a local government participant by an eligible resident pursuant to this chapter shall be returned to the authority's housing assistance fund created by Iowa Code Supplement section 16.40.

[**ARC 7899B**, IAB 7/1/09, effective 6/10/09; **ARC 8074B**, IAB 8/26/09, effective 9/30/09; **ARC 2004C**, IAB 5/27/15, effective 7/1/15]

265—29.4 Reserved.

265—29.5(16) Eligible uses.

29.5(1) *Forgivable loans.* Local government participants may make forgivable loans, pursuant to the conditions set forth in rule 265—29.7(16), to eligible residents for the following eligible uses:

a. Down payment assistance. An eligible resident whose disaster-affected home was destroyed or damaged beyond reasonable repair may be provided down payment assistance for the purchase of replacement housing located within the local government participant's jurisdiction and, if necessary, for the cost of making reasonable repairs to the home being purchased to make it safe, decent, and habitable. The amount of down payment assistance available to an eligible resident shall generally not exceed 25 percent of the purchase price of the home being purchased and, in no event, shall the down payment assistance and any amount allowed for repairs collectively exceed $50,000.

(1) For purposes of calculating the amount of down payment assistance available to the eligible resident, the amount of the down payment assistance shall be reduced by the amount of any disaster compensation received by the eligible resident in excess of any amount necessary to pay off a mortgage or real estate purchase contract on the disaster-affected home.

(2) As a condition of receiving down payment assistance, the eligible resident shall agree that any disaster compensation received subsequent to the closing of the forgivable loan, if not applied toward repayment of a mortgage on the disaster-affected home, shall be used by the eligible resident to pay down the balance of the forgivable loan outstanding at the time the eligible resident receives such disaster compensation.

(3) Down payment assistance shall be allowed only for the purchase of a primary residence by means of a fully amortized mortgage loan from a regulated lender featuring a rate of interest that is fixed for at least 5 years and that has a term not to exceed 30 years.

(4) Eligible residents who receive down payment assistance under this subrule may also receive the assistance available under subrule 29.5(2), but not the assistance available under paragraph 29.5(1)*"b."*

(5) An eligible resident shall not use the assistance allowed under this subrule for the purchase of more than one home.

b. Housing repair or rehabilitation. An eligible resident whose disaster-affected home is not proposed, or located in an area proposed, by a municipality or county to the Iowa homeland security and emergency management division for property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or under any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008) may receive financial assistance to pay for eligible repair expenses up to an amount not to exceed the lesser of $50,000 or 60 percent of the latest available assessed value of the disaster-affected home, not including the assessed value of the land on which it is situated, dated prior to the natural disasters of 2008; provided, however, that for application purposes under paragraph 29.3(1)*"b"* allocating program funds under 2009 Iowa Acts, Senate File 376,

section 29, the local government participant may elect to establish its own measure of housing repair or rehabilitation financial feasibility in lieu of 60 percent of the latest available assessed value of the disaster-affected home, not including the assessed value of the land on which it is situated, dated prior to the natural disasters of 2008. The eligible resident shall establish the necessity and reasonable cost of the repairs or rehabilitation to the reasonable satisfaction of the local government participant.

(1) For purposes of calculating the amount of assistance available to the eligible resident pursuant to this paragraph, the cost of repairs to, or rehabilitation of, the disaster-affected home shall be reduced by the amount of any disaster compensation received.

(2) As a condition of receiving assistance pursuant to this paragraph, the eligible resident shall agree that any disaster compensation received subsequent to the closing of the forgivable loan shall be used by the eligible resident to pay down the balance of the forgivable loan outstanding at the time the eligible resident receives such disaster compensation.

(3) An eligible resident who receives assistance pursuant to this paragraph shall not be eligible for assistance under either paragraph 29.5(1)*"a"* or subrule 29.5(2).

29.5(2) *Interim mortgage assistance loans.* An eligible resident whose disaster-affected home is proposed, or is located in an area proposed, by a municipality or county to the Iowa homeland security and emergency management division for property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008) may receive financial assistance equivalent to an amount of up to $1,000 per month for the purpose of paying mortgage payments and other eligible property-carrying costs for the disaster-affected home for a period not to exceed 12 months. An eligible resident who receives assistance pursuant to this subrule shall not be eligible for assistance under paragraph 29.5(1)*"b."* If, however, it subsequently is determined by the Iowa homeland security and emergency management division that the disaster-affected home of the eligible resident will not be acquired under the hazard mitigation grant program, then the eligible resident shall be eligible for assistance under paragraph 29.5(1)*"b"* on the condition that the amount of assistance available under that paragraph shall be reduced by the amount of assistance received by the eligible resident under subrule 29.5(2). Financial assistance provided pursuant to this subrule shall be in the form of a forgivable loan.

a. Notwithstanding the foregoing, with the approval of the applicable local government participant, an eligible resident may receive financial assistance under this subrule for up to an additional 6 months (beyond the usual 12-month limit set forth above), provided that all of the following conditions are met:

(1) The eligible resident must reapply for or request an extension of financial assistance on forms to be provided by the applicable local government participant;

(2) The disaster-affected home for which an extension of financial assistance is sought must continue to be on the current hazard mitigation grant program (or comparable program) property acquisition list (i.e., it must continue to be proposed for buyout);

(3) The disaster-affected home for which an extension of financial assistance is sought must have been destroyed or damaged beyond reasonable repair such that the eligible resident is displaced from the home;

(4) The eligible resident must have contacted or must agree to contact the mortgage holder or an Iowa Mortgage Help counseling agency (Web site: www.iowamortgagehelp.com) to discuss the situation and, if possible, negotiate better terms.

b. Local government participants may fund extensions of financial assistance only from funds already allocated to their region. Local government participants shall give priority for extensions of financial assistance to those eligible residents who are supporting the costs of both the disaster-affected home and a new primary residence through a second mortgage payment or a rental payment.

29.5(3) *Energy efficiency assistance.* An eligible resident who receives either down payment assistance pursuant to paragraph 29.5(1)*"a"* or housing repair or rehabilitation assistance pursuant to paragraph 29.5(1)*"b"* shall also be eligible to receive an additional loan amount, up to a maximum of $10,000, as reimbursement for the purchase and installation costs for eligible energy-efficient home

appliances and improvements. Any amount allowed pursuant to this subrule shall be added to the principal balance of the forgivable loan. Amounts loaned pursuant to this subrule may be loaned either at the time the forgivable loan is first made or subsequent thereto within three months.

29.5(4) *Expenses incurred prior to September 19, 2008.* In the event an eligible resident purchased a home, made or caused to be made repairs to a disaster-affected home, or made mortgage payments (or paid for other eligible property-carrying costs) for a disaster-affected home located within the jurisdiction of a local government participant prior to September 19, 2008 (the effective date of this chapter), the eligible resident shall be eligible for reimbursement therefor under this chapter as though the purchase, repairs, or payments had taken place following September 19, 2008.

29.5(5) *Applications for assistance.* To apply for down payment assistance or down payment assistance plus interim mortgage assistance, the eligible resident shall apply to the local government participant in whose jurisdiction the home being purchased is located. To apply for assistance for repair or rehabilitation of a disaster-affected home, the eligible resident shall apply to the local government participant in whose jurisdiction the disaster-affected home is located. To apply for interim mortgage assistance only, the eligible resident shall apply to the local government participant in whose jurisdiction the disaster-affected home is located.

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09; **ARC 7899B**, IAB 7/1/09, effective 6/10/09; **ARC 8074B**, IAB 8/26/09, effective 9/30/09; **ARC 8075B**, IAB 8/26/09, effective 9/30/09; **ARC 8907B**, IAB 6/30/10, effective 6/10/10; **ARC 9029B**, IAB 8/25/10, effective 9/29/10]

265—29.6(16) Loan terms. Loans made under the program shall, at a minimum, contain the following terms:

29.6(1) *Forgivability.* Forgivable loans made pursuant to the program shall be forgivable over a five-year period. One-fifth of the total principal amount loaned shall be forgiven following each full year the eligible resident owns the home for which the loan was made, beginning on the date of the final disbursement of forgivable loan proceeds.

29.6(2) *Zero percent interest.* Loans made pursuant to the program shall bear no interest.

29.6(3) *Five-year term.* All loans made pursuant to the program shall be for a term of five years.

29.6(4) *Repayment due upon sale of home.* Any principal of a forgivable loan that has not yet been forgiven at the time the home for which the forgivable loan was made is sold by the eligible resident (including property acquisitions) shall be due and payable upon such sale.

29.6(5) *Retention agreement.* Each loan made pursuant to this program shall be secured by a retention agreement which shall constitute a lien on the title of the real property for which the forgivable loan is made until such time as the forgivable loan has either been fully forgiven or paid in full; provided, however, that in the case of a property acquisition under the hazard mitigation grant program set forth in Iowa Code chapter 29C (or under any other comparable program implemented in whole or in part to assist in recovery from the natural disasters of 2008), payment of the following shall be waived:

a. That portion of the repayment due for a down payment assistance loan made under paragraph 29.5(1)*"a"* or an interim mortgage assistance loan made under subrule 29.5(2), provided that the amount so waived shall not exceed $25,000;

b. That portion of the repayment due for a housing repair or rehabilitation assistance loan made under paragraph 29.5(1)*"b"* for which the eligible resident provides documentation that the assistance was expended for the purpose for which it was awarded; and

c. That portion of the repayment due for an energy efficiency assistance loan made under subrule 29.5(3) for which the eligible resident provides documentation that the assistance was expended for the purpose for which it was awarded.

[**ARC 7842B**, IAB 6/17/09, effective 5/14/09; **ARC 8075B**, IAB 8/26/09, effective 9/30/09; **ARC 8323B**, IAB 12/2/09, effective 11/4/09; **ARC 8546B**, IAB 2/24/10, effective 3/31/10; **ARC 8907B**, IAB 6/30/10, effective 6/10/10; **ARC 9029B**, IAB 8/25/10, effective 9/29/10; **ARC 2004C**, IAB 5/27/15, effective 7/1/15]

265—29.7(16) Financial assistance subject to availability of funding. All financial assistance authorized pursuant to this chapter shall be subject to funds being made available to the authority for the purposes set forth herein.

265—29.8(16) Funds allocated pursuant to 2009 Iowa Acts, House File 64, division I. Notwithstanding the foregoing, the following additional restrictions shall apply to loans made pursuant to program funding allocated under 2009 Iowa Acts, House File 64, division I:

29.8(1) *Income.* An eligible resident must have a family income equal to or less than 150 percent of the area median family income.

29.8(2) *Application deadline.* An eligible resident must submit an application for assistance by September 1, 2009.

29.8(3) *Priorities.* Forgivable loans awarded under this rule shall be awarded pursuant to the following priorities:

a. *First priority.* First priority shall be given to eligible residents who have not received any moneys under the program.

b. *Second priority.* Second priority shall be given to eligible residents who have received less than $24,999 under the program.

c. *Third priority.* Third priority shall be given to eligible residents who have received $24,999 under the program and who continue to have unmet needs for down payment assistance, emergency housing repair or rehabilitation, interim mortgage assistance, or energy efficiency assistance. An eligible resident shall not receive more than an additional $24,999 under this paragraph.

29.8(4) *Maximum assistance.* Except as provided in paragraph 29.8(3)*"c,"* an eligible resident who meets the area median family income requirement shall not receive more than $24,999 under the program.

[**ARC 7899B**, IAB 7/1/09, effective 6/10/09; **ARC 8074B**, IAB 8/26/09, effective 9/30/09; **ARC 2004C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code sections 16.5(1)*"r,"*16.40, and 16.56, 2009 Iowa Acts, Senate File 376, section 29, and 2009 Iowa Acts, House File 64, division I.

[Filed emergency 9/19/08—published 10/8/08, effective 9/19/08]
[Filed emergency 10/1/08—published 10/22/08, effective 10/1/08]
[Filed Emergency ARC 7842B, IAB 6/17/09, effective 5/14/09]
[Filed Emergency ARC 7899B, IAB 7/1/09, effective 6/10/09]
[Filed ARC 8074B (Notice ARC 7900B, IAB 7/1/09), IAB 8/26/09, effective 9/30/09]
[Filed ARC 8075B (Notice ARC 7843B, IAB 6/17/09), IAB 8/26/09, effective 9/30/09]
[Filed Emergency ARC 8323B, IAB 12/2/09, effective 11/4/09]
[Filed ARC 8546B (Notice ARC 8324B, IAB 12/2/09), IAB 2/24/10, effective 3/31/10]
[Filed Emergency ARC 8907B, IAB 6/30/10, effective 6/10/10]
[Filed ARC 9029B (Notice ARC 8908B, IAB 6/30/10), IAB 8/25/10, effective 9/29/10]
[Filed ARC 2004C (Notice ARC 1865C, IAB 2/4/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 31
COUNCIL ON HOMELESSNESS

265—31.1(16) Organization.

31.1(1) *Location.* The main office of the council is located at 2015 Grand Avenue, Des Moines, Iowa 50312, the Iowa Finance Authority. Office hours for the council shall be 8 a.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. Written requests may be submitted to the council at this address. Information about the council is available at this Web site address: http://www.iowafinanceauthority.gov. The council's telephone numbers are: (515)725-4900 (general); 1-800-432-7230 (toll-free); 1-800-618-4718 (TTY); and (515)725-4901 (facsimile).

31.1(2) *Council members and staff.* The powers of the council are vested in and exercised by 38 voting members appointed by the governor in accordance with Iowa Code section 16.2D. The 26 voting members selected from the general public shall each serve a two-year term. Terms shall be staggered so half of the voting members are appointed in one year and half are appointed in the year thereafter. Initially, the council shall, as soon as all members have been appointed, promptly elect a chairperson and a vice chairperson, both to a term not to exceed two years ending in May. The chairperson and vice chairperson shall not both be either general public members or agency director members. Thereafter, the chairperson and vice chairperson positions shall rotate between agency director members and general public members so that the chairperson and vice chairperson shall not both be either general public members or agency director members at the same time. Staff assistance and administrative support shall be provided by the Iowa finance authority as approved by the executive director.

31.1(3) *Council action.* A majority of the members of the council shall constitute a quorum. Any action taken by the council must be adopted by an affirmative vote of a majority of its membership.

31.1(4) *Meetings.* Regular meetings of the council shall be held on the third Friday of the following months: January, March, May, July, September, and November, unless another time of meeting is designated by the council. Meetings may also be held at the call of the chairperson or whenever a majority of the members so request. The council shall comply with the requirements of Iowa Code chapters 21 and 22. Interested parties are encouraged to attend and participate in council meetings where feasible.

31.1(5) *Committees.* The council shall form an executive committee consisting of the council's chairperson, vice chairperson, and seven members, one of whom shall be the immediate past chairperson if a current member of the council. The chairperson shall appoint the remaining members of the executive committee. The executive committee shall be responsible for reviewing and making recommendations for amendments or changes to the internal rules of procedure. The executive committee shall carry out the business of the council between regularly scheduled council meetings. A majority of the members of the executive committee shall constitute a quorum. Any action taken by the executive committee must be adopted by an affirmative vote of a majority of its members.

a. *Nominating committee.* The nominating committee shall initially consist of all 12 agency director members. Following the initial appointment of the general public members to the council, the council shall annually at its March meeting elect six members, three of whom shall be agency director members and three of whom shall be general public members. The chairperson of the council shall also be a voting member. The nominating committee shall nominate persons to the governor to fill the general public member positions when they become open. A majority of the members of the nominating committee shall constitute a quorum. Any action taken by the nominating committee must be adopted by an affirmative vote of a majority of its members.

b. *Other committees.* Other committees may be assembled by the executive committee to carry out various responsibilities of the council. A majority of the members of such a committee shall constitute a quorum. Any action taken by a committee must be adopted by an affirmative vote of a majority of its members.

c. *Informal working groups.* Informal working groups may be assembled from time to time by the chairperson for various tasks.

[**ARC 7704B**, IAB 4/8/09, effective 5/13/09; **ARC 2005C**, IAB 5/27/15, effective 7/1/15]

265—31.2(16) Duties of the council. The duties of the council shall be to:

1. Develop a process for evaluating state policies, programs, statutes, and rules to determine whether any state policies, programs, statutes, or rules should be revised to help prevent and alleviate homelessness.
2. Evaluate whether state agency resources could be more efficiently coordinated with other state agencies to prevent and alleviate homelessness.
3. Work to develop a coordinated and seamless service delivery system to prevent and alleviate homelessness.
4. Use existing resources to identify and prioritize efforts to prevent persons from becoming homeless and to eliminate factors that keep people homeless.
5. Identify and use federal and other funding opportunities to address and reduce homelessness within the state.
6. Work to identify causes and effects of homelessness and increase awareness among policymakers and the general public.
7. Advise the governor's office, the Iowa finance authority, state agencies, and private organizations on strategies to prevent and eliminate homelessness.
8. Make annual recommendations to the governor regarding matters which impact homelessness on or before September 15.
9. Prepare and file with the governor and the general assembly on or before the first day of December in each odd-numbered year a report on homelessness in Iowa.
10. Assist in the completion of the state's continuum of care application to the U.S. Department of Housing and Urban Development.

[**ARC 7704B**, IAB 4/8/09, effective 5/13/09]

These rules are intended to implement Iowa Code sections 16.5(1)*"r"* and 16.2D.

[Filed emergency 12/22/08—published 1/14/09, effective 12/22/08]

[Filed ARC 7704B (Notice ARC 7514B, IAB 1/14/09), IAB 4/8/09, effective 5/13/09]

[Filed ARC 2005C (Notice ARC 1864C, IAB 2/4/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 33
WATER QUALITY FINANCIAL ASSISTANCE PROGRAM

265—33.1(16,83GA,SF376) Overview.

33.1(1) *Statutory authority.* The authority to provide financial assistance to communities for water quality and wastewater improvement projects is provided by 2009 Iowa Acts, Senate File 376, section 13(4). The water quality financial assistance fund shall consist of funds appropriated from the revenue bonds capitals fund created in Iowa Code section 12.88.

33.1(2) *Purpose.* The purpose of the program shall be to provide grants to enhance water quality and to assist communities with water and wastewater improvement projects. Financial assistance under the program shall be used to provide additional assistance to communities receiving loans from the Iowa water pollution control works and drinking water facilities financing program.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09; **ARC 2006C**, IAB 5/27/15, effective 7/1/15]

265—33.2(16,83GA,SF376) Definitions.

"Authority" or *"IFA"* means the Iowa finance authority as established by chapter 16 of the Code of Iowa.

"Community" means a city, county, sanitary district, water district, state agency, or other governmental body or corporation empowered to provide sewage collection and treatment services, or any combination of two or more of the governmental bodies or corporations acting jointly, in connection with a project.

"Department" or *"DNR"* means the Iowa department of natural resources.

"Director" means the director of the authority.

"Program" means the water quality financial assistance program created in 2009 Iowa Acts, Senate File 376, section 13(4).

"Recipient" means the entity receiving funds from the program.

"SRF" means the Iowa water pollution control works and drinking water facilities financing program, which is jointly administered by IFA pursuant to Iowa Code section 16.131 and DNR pursuant to Iowa Code section 455B.294.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09; **ARC 2006C**, IAB 5/27/15, effective 7/1/15]

265—33.3(16,83GA,SF376) Small community assistance fund.

33.3(1) *Program fund.* Of the amount appropriated, $35 million shall be allocated to the small community assistance fund. The maximum award for a recipient under the small community assistance fund shall be $2 million.

33.3(2) *Project eligibility.* Financial assistance shall only be available under the program for projects that are also receiving funding from the SRF.

33.3(3) *Eligible applicants.* Only communities with a population of 10,000 or less, as determined by the most recent federal census, may apply for the small community assistance fund.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

265—33.4(16,83GA,SF376) Large community assistance fund.

33.4(1) *Program fund.* Of the amount appropriated, $20 million shall be allocated to the large community assistance fund. The maximum award for a recipient under the large community assistance fund shall be $100 per capita. For purposes of these rules, the population of a community shall be assumed to be the United States Census Bureau's 2008 population estimate for that community.

33.4(2) *Project eligibility.* Eligible projects are those projects that are also receiving funding from the SRF.

33.4(3) *Eligible applicants.* Only communities with a population of more than 10,000, as determined by the most recent federal census, may apply for the large community assistance fund.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09; **ARC 8510B**, IAB 2/10/10, effective 1/14/10; **ARC 8725B**, IAB 5/5/10, effective 6/9/10]

265—33.5(16,83GA,SF376) Project priority.

33.5(1) *Priority for all projects.* Priority shall be given to projects that will provide significant improvement to water quality in the relevant watershed; this criterion will be determined by the score given to a project by the department pursuant to the project priority rating system used for the water pollution control state revolving fund set forth in 567—Chapter 91, Iowa Administrative Code. For drinking water projects, priority will be determined by the project priority system used for the drinking water state revolving fund set forth in 567—Chapter 44, Iowa Administrative Code. Priority will also be given to projects based on the date upon which construction could begin.

33.5(2) *Small community assistance fund priority.* Under the small community assistance fund, priority shall also be given to communities that have the greatest financial need. Factors used to determine need will include, but are not limited to: median household income as a percentage of the statewide median household income; residential user rates as a percentage of median household income; the existing and forecasted debt of the system; and the unemployment rate of the community.

33.5(3) *Large community assistance fund priority.* Under the large community assistance fund, priority will be given to communities that did not receive funds from the I-Jobs disaster recovery program, the community development block grant (CDBG) disaster allocation or the State Revolving Fund (SRF) federal American Recovery and Reinvestment Act (ARRA).

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09; **ARC 8510B**, IAB 2/10/10, effective 1/14/10; **ARC 8725B**, IAB 5/5/10, effective 6/9/10]

265—33.6(16,83GA,SF376) Project funding.

33.6(1) *Applications.* Applications will be accepted on forms developed by IFA and available at www.iowafinanceauthority.gov. IFA will coordinate with other applicable state or federal financing programs when possible. Applications for the large community assistance fund will be due October 30, 2009. Applications for the small community assistance fund will be due March 30, 2010.

33.6(2) *Costs.* All eligible costs must be documented to the satisfaction of the authority before proceeds may be disbursed.

33.6(3) *Record retention.* The recipient shall maintain records that document all costs associated with the project. Recipients shall agree to provide the authority access to these records. The recipient shall retain such records and documents for inspection and audit purposes for a period of three years from the date of the final grant payment.

33.6(4) *Site access.* The recipient shall agree to provide the authority, the department and the department's agent access to the project site at all times during the construction process to verify that the funds are being used for the purpose intended and that the construction work meets applicable state and federal requirements.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

265—33.7(16,83GA,SF376) Termination and rectification of disputes.

33.7(1) *Termination.* The authority shall have the right to terminate any grant when terms of the agreement have been violated. Grants are subject to termination if construction has not begun within one year of the execution of a grant agreement. The director will establish a repayment schedule for funds already disbursed to the recipient. All terminations will be in writing.

33.7(2) *Rectification of disputes.* Failure of the recipient to implement the approved project or to comply with the applicable requirements constitutes grounds for the authority to recapture or withhold funds. The recipient is responsible for ensuring that the identified problem(s) is rectified. Once the deficiency is corrected, the funds can be released. A recipient that disagrees with the director's withholding of funds may request a formal review of the action. The recipient must submit a request in writing to the director within 30 days of notification by the authority of its planned action.

[**ARC 8080B**, IAB 8/26/09, effective 9/30/09]

These rules are intended to implement Iowa Code sections 16.5(1)*"r"* and 16.131 and 2009 Iowa Acts, Senate File 376, section 13(4).

[Filed ARC 8080B (Notice ARC 7896B, IAB 7/1/09), IAB 8/26/09, effective 9/30/09]

[Filed Emergency ARC 8510B, IAB 2/10/10, effective 1/14/10]

[Filed ARC 8725B (Notice ARC 8511B, IAB 2/10/10), IAB 5/5/10, effective 6/9/10]

[Filed ARC 2006C (Notice ARC 1906C, IAB 3/4/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 34
Reserved

CHAPTER 35
AFFORDABLE HOUSING ASSISTANCE GRANT FUND
Rescinded **ARC 2007C**, IAB 5/27/15, effective 7/1/15

CHAPTER 43
COMMUNITY HOUSING AND SERVICES FOR PERSONS WITH DISABILITIES REVOLVING LOAN PROGRAM

265—43.1(16) Purpose. Through its community housing and services for persons with disabilities revolving loan program, the authority seeks to further the availability of affordable housing and supportive services for Medicaid waiver-eligible individuals with behaviors that provide significant barriers to accessing traditional rental and supportive service opportunities. Loans from the community housing and services for persons with disabilities revolving loan program fund are to be used to provide financing to construct permanent supportive housing or develop infrastructure in which to provide supportive services, including through new construction, acquisition and rehabilitation of existing housing or infrastructure, or conversion or adaptive reuse. This chapter is intended to implement Iowa Code sections 16.5(1) and 16.49.

Pursuant to Iowa Code section 16.49(4)*"d,"* housing provided through a project under this chapter is exempt from the requirements of Iowa Code chapter 135O, Boarding Homes.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12; **ARC 2008C**, IAB 5/27/15, effective 7/1/15]

265—43.2(16) Definitions. When used in this chapter, unless the context otherwise requires:

"Authority" means the Iowa finance authority.

"Department" means the Iowa department of human services.

"HOME" means the HOME Investment Partnership Program, authorized by the Cranston-Gonzalez National Affordable Housing Act of 1990.

"Infrastructure" means the building and permanent improvements necessary for the support of Medicaid waiver-eligible individuals.

"Medicaid waiver-eligible" means eligible to receive 19 United States Code Section 1915(c) home- and community-based services waivers under Iowa Administrative Code 441—Chapter 83.

"Permanent supportive housing" means a community-based dwelling that has supportive services for persons with disabilities. This type of supportive housing enables special needs populations to live as independently as possible in a permanent setting.

"PMIC" means psychiatric medical institutions for children.

"Program" means the community housing and services for persons with disabilities revolving loan program.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.3(16) Award of loan funds. It is the authority's intent to award loans under the program to those applicants that meet all of the requirements of this chapter and the published underwriting standards of the loan program. When an applicant for loan funds also qualifies for HOME program funds, the project must satisfy all application requirements of the HOME program adopted by the authority pursuant to rule 265—39.6(16). The authority intends to award the available funds under this program each year if applicants meet all applicable requirements.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.4(16) Application process. The authority anticipates that it will, at least annually, publicize the approximate amount of funds available under this program for the applicable fiscal year on the authority's Web site at www.iowafinanceauthority.gov. Any unallocated or recovered funds, or payments of interest and principal, or any combination thereof, may be awarded or may be carried over to the next year's cycle of loans at the discretion of the authority. The authority will take such applications from time to time and will analyze and award loans to applicants on an ongoing basis, beginning on or after September 1, 2011. It is the position of the authority that such flexibility in taking and reviewing applications and making awards will best serve to develop and expand community housing and services for Medicaid waiver-eligible individuals.

Applicants may apply for joint funding of a project using both HOME program funds and funds loaned pursuant to this chapter.
[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.5(16) Program guidelines. For-profit and nonprofit sponsors are eligible to apply for assistance under this program based on the following program guidelines; however, prior to submission of the loan application, a service provider must receive approval of a service plan to benefit the Medicaid waiver-eligible individuals who reside in the project. The service provider may apply for the loan fund; however, the service provider does not have to be the applicant for the loan fund. If the service provider is not the loan applicant, a memorandum of understanding must exist between the loan applicant and the service provider which shows an obligation on behalf of the service provider to deliver services to the Medicaid waiver-eligible individuals residing in the project and which shows that the loan applicant is obligated to offer housing to the Medicaid waiver-eligible individuals who need the services provided by the service provider.

43.5(1) Projects eligible for assistance must meet the following criteria:

a. Written approval must be obtained from the department for the proposed project prior to application for loan funds.

b. In order to be approved by the department, the project must demonstrate all of the following components:

(1) The project serves one of the following Medicaid waiver-eligible populations:

1. Individuals who are currently underserved in community settings, including individuals who are physically aggressive or have behaviors that are difficult to manage or individuals who meet the PMIC level of care; or

2. Individuals who are currently placed out of state by the department; or

3. Individuals who are currently receiving care in an Iowa-licensed health care facility.

(2) A plan to provide each Medicaid waiver-eligible individual with crisis stabilization services to ensure that the individual's behavioral issues are appropriately addressed by the provider.

(3) Policies and procedures that prohibit discharge of the Medicaid waiver-eligible individual from the waiver services provided by the project provider unless an alternative placement that is acceptable to the individual or the individual's guardian is identified.

c. In order to be approved by the department for application for funding for development of infrastructure in which to provide supportive services under this chapter, a project shall include all of the following components:

(1) Provision of services to Medicaid waiver-eligible individuals who meet the PMIC level of care.

(2) Policies and procedures that prohibit discharge of the Medicaid waiver-eligible individual from the waiver services provided by the project provider unless an alternative placement that is acceptable to the individual or the individual's guardian is identified.

43.5(2) The following types of activities are eligible for assistance:

a. Acquisition and rehabilitation.

b. New construction.

c. Such other similar activities as may be determined by the authority to fall within the guidelines and purposes established for this program.

43.5(3) Assistance will be provided upon the following terms and conditions:

a. Generally, the minimum loan amount is $50,000, and the maximum loan amount is $500,000. The maximum loan term and amortization period are each 30 years.

b. The debt service ratio must be at least 1.25:1 for the authority's first mortgage, as calculated by the authority. In addition, the loan-to-value ratio of the project, as calculated by the authority, will be considered. Notwithstanding the above, the authority may, in its sole discretion, accept a lower debt service ratio based on the final underwriting of the project.

c. Interest rates will be set by the authority, in its sole discretion.

d. Loans shall be secured by a first mortgage, to the extent possible. Construction financing may be awarded to projects.

e. Recipients of assistance must agree to observe several covenants and restrictions all in accordance with such loan and mortgage documents as may be required by the authority under this program.

f. The recipient must provide adequate evidence that its title in the real estate on which the project is to be located is a marketable title pursuant to Iowa Land Title Examination Standards, or other applicable law. Adequate evidence of marketable title is demonstrated by either (1) a title opinion of an attorney authorized to practice law in Iowa showing that the loan recipient has marketable title, or (2) a title guaranty certificate issued by the title guaranty division of the Iowa finance authority showing the recipient as the guaranteed.

g. Recipients must execute such documents and instruments and must provide such information, certificates and other items as determined necessary by the authority, in its sole discretion, in connection with any assistance.

43.5(4) Loan fees.

a. Loan fees are as follows:

(1) Application fee – 0.3 percent of loan amount.

(2) Commitment fee (construction period) – 1.0 percent of loan amount.

(3) Commitment fee (permanent loan) – 2.0 percent of loan amount.

(4) Inspection fee (construction loan) – 0.5 percent of loan amount.

b. The authority may, in limited cases, reduce such fees if necessary in connection with assistance provided under this program. Such decision will be made in the sole discretion of the authority.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.6(16) Authority analysis of applications. Authority staff will analyze and underwrite each potential project and will make recommendations for funding assistance to the authority board of directors. Authority staff will use such procedures and processes in its underwriting and analysis as it deems necessary and appropriate in connection with furthering the purposes of this program. In addition, the authority anticipates that, because of the complex nature of each transaction and the particular set of circumstances attributable to each particular application/transaction, the terms and conditions of loans will vary from project to project. The authority will make available its general operating procedures and guidelines for this program.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.7(16) Discretion of authority board. The authority board of directors has the sole and final discretion to award or not to award assistance and to approve final loan terms.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

265—43.8(16) Closing/advance of funds. If all requirements of the authority are not met in accordance with any time frames set by the authority and to the complete satisfaction of the authority, all in the sole discretion of the authority, the authority may determine to cease work on an approved project and, accordingly, not advance any funds for such project.

[**ARC 9690B**, IAB 8/24/11, effective 8/18/11; **ARC 9878B**, IAB 11/30/11, effective 1/4/12]

These rules are intended to implement Iowa Code sections 16.5(1) and 16.49.

[Filed Emergency ARC 9690B, IAB 8/24/11, effective 8/18/11]

[Filed ARC 9878B (Notice ARC 9692B, IAB 8/24/11), IAB 11/30/11, effective 1/4/12]

[Filed ARC 2008C (Notice ARC 1903C, IAB 3/4/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 44
IOWA AGRICULTURAL DEVELOPMENT DIVISION

265—44.1(16) General.

44.1(1) *Description of Iowa agricultural development division (IADD) board.* The IADD board consists of five members appointed by the governor. The executive director of the Iowa finance authority or the executive director's designee shall serve as an ex officio nonvoting member. Members are appointed for staggered six-year terms. The appointed members shall elect a chairperson and vice chairperson annually, and other officers as the appointed members determine. The executive director of the authority may organize the division and employ necessary qualified personnel.

44.1(2) *General course and method of operations.* The IADD board generally meets on a monthly basis or at the call of the chairperson or whenever two appointed members so request. The purpose of the meetings shall be to review progress in implementation and administration of programs, to consider and act upon proposals for assistance, and take other actions as necessary and appropriate.

44.1(3) *Location where public may submit requests for assistance or obtain information.* Requests for assistance or information should be directed to the Iowa Finance Authority, 2015 Grand Avenue, Des Moines, Iowa 50312; telephone (515)725-4900. Requests may be made personally, by telephone, U.S. mail or any other medium available, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday. Special arrangements for accessibility to the authority at other times will be provided as needed.

[**ARC 1112C**, IAB 10/16/13, effective 9/26/13; **ARC 1400C**, IAB 4/2/14, effective 5/7/14; **ARC 2009C**, IAB 5/27/15, effective 7/1/15]

265—44.2(16) Definitions.

"Act" means Iowa Code chapter 16.

"Agricultural asset" means agricultural land, agricultural improvements, depreciable agricultural property, crops or livestock used for farming purposes.

"Agricultural asset transfer agreement" means any commonly accepted written agreement which specifies the terms of the transfer of operation of the agricultural asset. The agreement may be made on a cash basis or a commodity share basis.

"Agricultural improvements" means any improvements, buildings, structures or fixtures suitable for use in farming which are located on agricultural land. "Agricultural improvements" includes a single-family dwelling located on agricultural land which is or will be occupied by the beginning farmer and structures attached to or incidental to the use of the dwelling.

"Agricultural land" means land suitable for use in farming and which is or will be operated as a farm.

"Application" means a completed instrument on a form approved by IADD.

"BFCF" means beginning farmer custom farming tax credit program.

"BFCF eligible applicant" means an individual, partnership, family farm corporation or family farm limited liability company that has a net worth of not more than the maximum allowable net worth. The applicant must also satisfy all of the criteria contained in Iowa Code sections 16.79 and 16.81 and the provisions of these rules relating to recipient eligibility as they relate to who operates or will operate a farm.

"BFLP" means beginning farmer loan program.

"BFLP eligible applicant" means an individual who has a net worth of not more than the maximum allowable net worth. The applicant must also be a beginning farmer, as defined in Iowa Code section 16.75, who satisfies all of the criteria contained in the Act and provisions of these rules relating to recipient eligibility as they relate to who operates or will operate a farm.

"BFTC" means beginning farmer tax credit program.

"BFTC eligible applicant" means an individual, partnership, family farm corporation or family farm limited liability company that has a net worth of not more than the maximum allowable net worth. The applicant must also satisfy all of the criteria contained in Iowa Code sections 16.79 and 16.80 and the provisions of these rules relating to recipient eligibility as they relate to who operates or will operate a farm.

"Bond purchaser" means any lender or any person, as defined in Iowa Code section 4.1(20), who purchases an authority bond under the individual agricultural development bond program.

"Cash basis agreement" means an agreement whereby operation of the agricultural asset is transferred via a fixed cash payment per annum.

"Commodity share basis" means an agreement whereby operation of the agricultural asset is transferred via a risk-sharing mechanism, whereby the agricultural asset owner receives a portion of the production and payment for use of the agricultural asset.

"Custom farming contract" means any commonly accepted written contract which specifies the terms of the work to be performed by the beginning farmer for an Iowa landowner or tenant or livestock owner. The contract must provide for the production of crops or livestock located on agricultural land. The taxpayer will pay the BFCF eligible applicant on a cash basis, and the total amount paid must equal at least $1,000. The contract must be in writing for a term of not more than 12 months. A contract is not allowed if the taxpayer and BFCF eligible applicant are: persons who hold a legal or equitable interest in the same agricultural land or livestock; related family members, such as spouse, child, stepchild, brother, or sister; or partners in the same partnership which holds a legal or equitable interest.

"Farm" means a farming enterprise which is generally recognized as a farm rather than a rural residence.

"Farming" means the cultivation of land for the production of agricultural crops, the raising of poultry, the production of eggs, the production of milk, the production of fruit or other horticultural crops, grazing, the production of livestock, aquaculture, hydroponics, the production of forest products, or other activities designated by the authority.

"IADD" means the Iowa agricultural development division of the Iowa finance authority.

"Lender" means any regulated bank, trust company, bank holding company, mortgage company, national banking association, savings and loan association, life insurance company, state or federal governmental agency or instrumentality, or other financial institution or entity authorized and able to make mortgage loans or secured loans in this state.

"Low-income farmer" means a farmer who cannot obtain financing to purchase agricultural property without the assistance of an LPP loan with the authority.

"LPP" means loan participation program.

"LPP eligible applicant" means an individual who has a net worth of not more than the maximum allowable net worth. The applicant must be a low-income farmer who satisfies all of the criteria contained in the Act and the provisions of these rules relating to recipient eligibility as they relate to who operates or will operate a farm.

"LPP loan" means the "last-in/last-out" loan participation requested by the lender from the authority.

"Maximum allowable net worth" for calendar year 2013 is $691,172. The maximum allowable net worth for each calendar year shall be increased or decreased as of January 1 of such calendar year by an amount equal to the percentage increase or decrease (September to September) in the United States Department of Agriculture "Index of Prices Paid for Commodities and Services, Interest, Taxes, and Farm Wage Rates" reported as of October 1 of the immediately preceding calendar year.

"Net worth" means total assets minus total liabilities as determined in accordance with generally accepted accounting principles with appropriate exceptions and exemptions reasonably related to an equitable determination of the net worth of the individual, partnership, limited liability company or corporation. Assets shall be valued at fair market value.

"Participated loan" means a loan, any portion of which is participated to the authority by the lender.

"Projected gross income" means the total of all nonfarm income plus gross farm revenues which include revenue from cash sales, inventory and receivable charges, crops, livestock products, government program payments, and other farm income received by the borrower during the next calendar year.

"Term debt coverage ratio" means the total of net farm income from operations plus total nonfarm income plus depreciation/amortization expense plus interest on term debt plus interest on capital leases minus total income tax expense minus withdrawals for family living multiplied by 100 and divided by the sum of annual scheduled principal and interest payments on term debt and the annual scheduled principal and interest payments on capital leases. The ratio provides a measure of the ability of the borrower to

cover all term debt and capital lease payments. The greater the ratio over 100 percent, the greater the margin to cover the payments.

"Total assets" means all assets including but not limited to cash, crops or feed on hand, livestock held for sale, breeding stock, marketable bonds and securities, securities not readily marketable, accounts receivable, notes receivable, cash invested in growing crops, net cash value of life insurance, machinery, equipment, cars, trucks, farm and other real estate including life estates and personal residence, value of beneficial interest in a trust, government payments or grants, and any other assets.

"Total assets" shall not include items used for personal, family or household purposes by the applicant; but in no event shall any property be excluded, to the extent a deduction for depreciation is allowable for federal income tax purposes. All assets shall be valued at fair market value by the lender. The value shall be what a willing buyer would pay a willing seller in the locality. A deduction of 10 percent may be made from fair market value of farm and other real estate.

"Total liabilities" means all liabilities including but not limited to accounts payable, notes or other indebtedness owed, taxes, rent, amount owed on any real estate contract or real estate mortgage, judgments, accrued interest payable, and any other liabilities. Liabilities shall be determined on the basis of generally accepted accounting principles.

In only those cases where the liabilities include an amount for deferred tax liability that causes the applicant's net worth to change from exceeding the maximum allowable net worth to an amount no greater than the maximum allowable net worth, the applicant is required to have a certified public accountant prepare the financial statement and provide supporting calculations and documentation acceptable to the board.

"Veteran" means the same as defined in Iowa Code section 35.1.

[**ARC 1112C**, IAB 10/16/13, effective 9/26/13; **ARC 1400C**, IAB 4/2/14, effective 5/7/14; **ARC 2009C**, IAB 5/27/15, effective 7/1/15]

265—44.3(16) General recipient eligibility.

44.3(1) *Residence.* The eligible applicant must be a resident of Iowa. The project must be located in Iowa.

44.3(2) *Training and experience.* The eligible applicant must have documented to the satisfaction of the authority sufficient education, training, and experience for the anticipated farm operations.

44.3(3) *Access to capital.* The eligible applicant must demonstrate to the satisfaction of the authority access to the following as may be needed: adequate working capital, farm machinery, livestock, and agricultural land.

[**ARC 1112C**, IAB 10/16/13, effective 9/26/13; **ARC 1400C**, IAB 4/2/14, effective 5/7/14; **ARC 2009C**, IAB 5/27/15, effective 7/1/15]

265—44.4(16) Beginning farmer loan program.

44.4(1) *Individual agricultural development bond program description.* This program is intended to allow BFLP eligible applicants to obtain lower interest rate loans for qualified purposes by obtaining loan funds from the proceeds of a tax-exempt bond issued by the authority and purchased by the bond purchaser. The authority will enter into a loan agreement with the BFLP eligible applicant and assign that BFLP loan to the bond purchaser. At the same time, the authority will issue a tax-exempt bond in the amount of the BFLP loan, and the bond purchaser will purchase that bond, which is used to fund the BFLP loan assigned to the bond purchaser. The bond which is issued by the authority and purchased by the bond purchaser is a nonrecourse obligation. The only security for the bond purchaser is the underlying security on the assigned BFLP loan.

44.4(2) *Application procedures.* The BFLP eligible applicant may apply for a BFLP loan with any bond purchaser. Any BFLP loan approved will be assigned to that bond purchaser. BFLP loan eligibility is determined by the requirements of the Act and the rules of the authority.

a. If a BFLP eligible applicant meets the BFLP loan eligibility requirements, the decision on whether to enter into the loan agreement is between the BFLP eligible applicant and the bond purchaser. The BFLP eligible applicant and bond purchaser must agree on the terms of the loan, such as interest rates, length of loan, down payment, service fees, origination charges and repayment schedule. The terms may not be more onerous than terms charged to similar customers for similar loans, taking into account the tax-exempt nature of interest on the BFLP loan.

b. Following completion of the BFLP loan application by the BFLP eligible applicant and approval by the bond purchaser, the BFLP loan application must be submitted to the authority for its review and approval.

c. The authority's review will include, but not be limited to, whether:

(1) The BFLP loan applicant is a BFLP eligible applicant;

(2) The BFLP loan proceeds will be used for a qualified purpose under the Act, rules of the authority, and the Internal Revenue Code and IRS regulations relating to private activity bonds;

(3) The terms of the BFLP loan comply with these rules; and

(4) The bond purchaser meets the definition of a lender or bond purchaser.

d. The authority may require that the bond purchaser furnish any information which the authority deems necessary to determine whether the bond purchaser qualifies as either a lender or bond purchaser. If the authority determines that the bond purchaser does not qualify as either a lender or bond purchaser, it may deny the application.

e. Following approval and issuance of the bond, the authority will enter into a loan agreement with the BFLP eligible applicant and then assign the BFLP loan without recourse to the bond purchaser. The authority may charge fees as needed to defray its costs for processing the BFLP loan and bond.

44.4(3) *Issuance of bond.* All bonds issued by the authority will conform to all applicable requirements of the United States Internal Revenue Code of 1986 as amended, and its regulations.

a. Public hearings may be held by a staff member, board member of the IADD, an appointee or employee of the authority, or other qualified hearing officer.

b. Following approval of the BFLP loan by the authority, and upon completion of a public hearing and approval of the bond issuance by the governor or another elected state official designated by the governor, the authority will issue a bond, to be purchased by the bond purchaser, in the amount and fitting the terms of the BFLP loan to the BFLP eligible applicant. The principal and interest on the bond are a limited obligation payable solely out of the revenues derived from the BFLP loan to the BFLP eligible applicant and the underlying collateral or other security furnished by or on behalf of the BFLP eligible applicant. The bond purchaser shall have no other recourse against the authority. The principal and interest on the bond do not constitute an indebtedness of the authority or a charge against its general credit or general fund.

44.4(4) *Priority of applications.* Applications shall be processed by the authority on a first-come, first-served basis, based upon the receipt of all completed documents by the authority.

44.4(5) *Procedures following bond issuance.* No bond proceeds may be used for a nonqualified purpose or by a nonqualified user. Following disbursement of the bond proceeds, the bond purchaser and BFLP eligible applicant may be required to certify to the authority that the proceeds were used by the BFLP eligible applicant for a qualified purpose.

44.4(6) *Assignment of BFLP loans by bond purchasers.* A bond purchaser may assign a BFLP loan in whole or in part to any person, as defined in Iowa Code section 4.1(20). Serving of the BFLP loan may also be assigned. The authority must be notified in writing prior to assignment of the BFLP loan.

44.4(7) *Assumption of BFLP loans, substitution of collateral and transfer of property.* BFLP loans may not be assumed without the prior approval of the authority, and then only if the purchaser of the property is a BFLP eligible applicant for a BFLP loan. Equipment and other depreciable property may be exchanged or traded for similar property, and other property such as breeding livestock may be added or substituted as collateral at the discretion of the bond purchaser without the prior approval of the authority.

44.4(8) *Right to audit.* The authority shall have at any time the right to audit the records of the bond purchaser and the BFLP eligible applicant relating to the BFLP loan and bond to ensure that bond proceeds were used for a qualified purpose by a qualified user.

[**ARC 1112C**, IAB 10/16/13, effective 9/26/13; **ARC 1400C**, IAB 4/2/14, effective 5/7/14; **ARC 2009C**, IAB 5/27/15, effective 7/1/15]

265—44.5(16) Loan participation program.

44.5(1) *Program summary.* The loan participation program is intended to assist lenders and LPP eligible applicants (hereinafter referred to as "borrower(s)") by purchasing a portion of a loan made by a lender to a borrower for the purchase of agricultural property.

a. Supplement to borrower's down payment. The LPP loan can be used to supplement the borrower's down payment so that the borrower can more readily secure a loan (the "participated loan") from a lender.

b. Last-in/last-out collateral position. The program enables lenders to request a "last-in/last-out" LPP loan from the authority. The lender, on behalf of the borrower, shall apply for the LPP loan on application forms provided by the authority.

c. Lender's certification. The lender and the borrower shall certify that the information included in the application and any other documents submitted for consideration is true and correct to the best of their knowledge.

d. LPP loan in conjunction with BFLP loan. The loan participation program may be used in conjunction with the authority's beginning farmer loan program, provided the borrower meets the criteria for both programs.

44.5(2) *Underwriting criteria.* Commercial underwriting criteria will be used as determined by the authority.

44.5(3) *Eligible projects and activities.*

a. Use of project. LPP loans must be for new purchases or new construction. Assets purchased or constructed with LPP loan funds must be used for agricultural purposes.

b. Agricultural land. The participated loan can be used for the purchase of agricultural land, which may include small acreages on which sufficient agricultural improvements are located to conduct a livestock operation. If a house is located on land for which an LPP loan is requested, an appraisal of the house will be made. If the appraised value of the house exceeds 50 percent of the appraised value of the property or total collateral, then the property will not be eligible for an LPP loan.

c. Agricultural improvements. The participated loan can be used for the construction or purchase of improvements located on agricultural land (which is suitable for use in farming). Examples of such improvements include, but are not limited to, the following: confinement systems for swine, cattle, or poultry; barns or other outbuildings; and grain storage facilities and silos.

d. Livestock used for breeding purposes. The participated loan can be used for the purchase of livestock for which an income tax deduction for depreciation is allowed in computing state and federal income taxes.

e. Machinery and equipment. The participated loan can be used for the purchase of agricultural machinery and equipment for which an income tax deduction for depreciation is allowed in computing state and federal income taxes. This machinery and equipment must be used in the borrower's farming operation.

f. Interim financing by lender. Interim financing by the lender may be done.

44.5(4) *Ineligible projects and activities.* The following program activities are ineligible:

a. Refinancing of existing debt. Refinancing of existing debt or new purchases which have been incurred by the borrower more than 60 days prior to approval of the LPP loan by the authority.

b. Financing personal expenses. Financing personal or living expenses and working capital to purchase such items as feed, seed, fertilizer, fuel, and feeder livestock.

c. Down payment funds for contract sale. Down payment for a contract sale, or in connection with a loan from a nonregulated lender.

44.5(5) *Program parameters.*

a. Purchase price impact. Maximum LPP loan amount is the lesser of:

(1) Thirty percent of the purchase price; or

(2) $150,000.

b. LPP loan terms. The authority has established the following with respect to LPP loan terms:

(1) The maximum amortization period for the LPP loan is 7 years for depreciable agricultural property. When a participated loan is made for livestock, the length of the LPP loan is restricted to the expected useful life of the animal being purchased.

(2) LPP loan payments on participated real estate loans will be equally amortized for the term of the LPP loan, but shall not exceed a 20-year amortization, including a 10-year term with balloon payment

and the balance of the LPP loan paid in full by the end of the tenth year. If utilized in conjunction with federal programs, the amortization will be consistent with federal rules.

(3) The IADD board will set the interest rate on the LPP loan.

c. LPP loans outstanding. Loans under the program may be issued more than once, provided that the outstanding LPP loan totals do not exceed $150,000 to any single borrower.

44.5(6) *LPP loan application procedures.*

a. Financial statement. Lenders may use their own form of financial statement and other forms deemed necessary and appropriate to document the eligibility of the borrower and the borrower's ability to make principal and interest payments. A copy of the borrower's most current financial statement (generally prepared one month preceding application submission), the prior two years' financial statements, and a projected after-closing financial statement must be submitted with the application.

If the borrower or the borrower's spouse is involved in a business, partnership, limited liability company, or corporation, either related or unrelated to the borrower's farming operation, a financial statement from this entity must also be submitted with the application.

b. Income statement. A copy of the borrower's prior three years' federal income tax returns (if available) shall be submitted.

c. Background letter. The application will also include a background letter on the borrower, documenting to the satisfaction of the authority sufficient training, experience and access to capital.

d. Credit evaluation. The lender will submit a credit evaluation of the project for which an LPP loan is sought. The lender will evaluate the borrower's net worth and ability to pay principal and interest and certify the sufficiency of security for the participated loan. The authority will review the application and make its own credit evaluation prior to issuance of an LPP loan. Such evaluation will center on whether:

(1) The borrower adequately demonstrates the ability to service the debt requirements of the participated loan based on cash flow, net worth, down payment, and collateral pledged for the participated loan.

(2) The borrower provides sufficient collateral to adequately secure the participated loan and keep the participated loan collateralized throughout its term.

(3) The lender certifies that all of the borrower's debts will be current at the time the participated loan is closed.

(4) The applicant is a low-income farmer who cannot obtain financing to purchase agricultural property without the assistance of an LPP loan with the authority.

(5) The lender certifies that no other private or state credit is available or can be obtained in a timely manner.

e. Processing LPP loan applications. Applications for the program will be taken and processed by the authority on a first-come, first-served basis. The authority reserves the right to change the program or terminate the approval of LPP loans under the program at any time. Grounds for termination/suspension of the program would include, but not be limited to, reaching the maximum allowable limit for total outstanding LPP loans as established by the authority or changing the program by order of the Iowa general assembly or by rules promulgated by the authority.

f. Security for participated loans and use of security documents. The lender shall take any security, cosignatures, guarantees or sureties that are deemed necessary for any participated loan. Any guarantee of repayment or pledge of additional collateral required by the lender to secure the participated loan shall secure the entire participated loan.

g. Recording documents and fees. Any recording or filing fees or transfer taxes associated with the participated loan will be paid by the borrower or lender and not the authority. Also, the authority will have no responsibility with respect to the preparation, execution, or filing of any declaration of value or groundwater hazard statements.

44.5(7) *Loan administration procedures.*

a. Lender's responsibilities. The lender is responsible for servicing the participated loan following accepted standards of loan servicing and for transferring LPP loan payments to the authority.

(1) At the request of IADD, the lender shall:

1. On an annual basis, provide the authority with copies of a current financial statement or a current tax return, or both.

2. Provide copies of insurance to the authority with the lender named as loss payee. The lender will apply payments to the participated loan on a pro-rata basis.

(2) The lender shall not, without prior consent of the authority:

1. Make or consent to any substantial alterations in the terms of any participated loan instrument;

2. Make or consent to releases of security or collateral unless replaced with collateral of equal value on the participated loan;

3. Use the collateral purchased with funds from the participated loan as security for any other loan without prior written consent of the authority;

4. Accelerate the maturity of the participated loan;

5. Sue upon any participated loan instrument;

6. Waive any claim against any borrower, cosignor, guarantor, obligor, or standby creditor arising out of any instruments.

b. Payment due dates. Payment due dates for the LPP loan will be the same as for the lender's share of the loan.

c. Prepayment penalty. There is no penalty for early repayment of principal or interest.

d. Repayment proceeds and collateral. Without limitation, the repayment of proceeds and collateral shall include rights of setoff and counterclaim, which the lender or the authority jointly or severally may at any time recover on any participated loan.

e. Subsequent loans. Any loan or advance made by a lender to a borrower subsequent to obtaining an LPP loan under the program and secured by collateral or security pledged for the participated loan will be subordinate to the participated loan.

f. Events of loan default.

(1) Default will occur when the participated loan payment is 30 days past due. Notice to cure will be sent to the borrower with a copy sent to the authority; and the lender will take appropriate steps to cure the default through mediation, liquidation, or foreclosure if needed.

(2) After a participated loan is in default for a period of 30 days, the lender shall file with the authority monthly reports regarding the status of the participated loan.

(3) The authority may, anytime a participated loan is in default, purchase the unpaid portion of the participated loan from the lender including the note, security agreements, additional guarantees, and other documents. The authority would become the servicer of the participated loan in such case.

g. Applying principal and interest payments. Lenders shall receive all payments of principal and interest. All payments made prior to liquidation or foreclosure shall be made on a pro-rata basis. All accrued interest must be paid to zero at least annually on the anniversary date of the note.

h. Application of proceeds of loan liquidation. Application of proceeds of loan liquidation will be determined after a written liquidation plan is approved by the authority or the authority's loan committee. All amounts recovered upon liquidation or foreclosure will be applied first to the unpaid balance of the lender's portion and then to the unpaid portion of the LPP loan's portion. All funds received from liquidation or foreclosure procedures shall be applied in the following order of priority:

First Priority: To the payment of the outstanding principal of and accrued interest on the lender's portion of the participated loan;

Second Priority: To the payment of the outstanding principal of and accrued interest on the authority's LPP loan;

Third Priority: To the payment on a pro-rata basis of all reasonable and necessary expenses incurred by the lender or the authority in connection with such liquidation or foreclosure procedures.

44.5(8) *Right to audit.* The authority shall have, at any time, the right to audit records of the lender and the borrower relating to any participated loan made under the program.

[**ARC 1112C**, IAB 10/16/13, effective 9/26/13; **ARC 1400C**, IAB 4/2/14, effective 5/7/14; **ARC 2009C**, IAB 5/27/15, effective 7/1/15]

265—44.6(16) Beginning farmer tax credit program.

44.6(1) *General provisions.*

a. *Term.* The term of the credit shall be equal to the term of the agricultural assets transfer agreement, except that any unused credit may be carried forward for a period of ten years if unused in the tax year the credits are earned. Credits may not be carried back to past tax years.

b. *Fees.* The authority may charge reasonable and necessary fees to defray the costs of this program.

c. *Expiration of lease.* The BFTC eligible applicant will continue to be eligible for the term of the lease. Upon expiration of the lease, both the taxpayer and BFTC eligible applicant must reapply to continue the tax credit.

44.6(2) *Application procedures.*

a. The authority shall prepare and make available appropriate forms to be used in making application for the tax credit, including forms for both the taxpayer and the BFTC eligible applicant.

b. Each application shall include, but not be limited to, the following:

(1) Taxpayer information: name and address, e-mail address if available, social security number, length of the lease, type of lease, and location of the agricultural asset to be leased. In addition, the application shall have attached to it a copy of the lease agreement between the parties.

(2) BFTC eligible applicant information: name and address, e-mail address if available, social security number, and location of the asset to be leased. In addition, the application shall have attached to it a copy of the BFTC eligible applicant's most recent financial statement (generally prepared one month preceding application submission). The application will also include a background letter on the BFTC eligible applicant documenting to the satisfaction of the authority sufficient training, experience and access to capital. This letter may be submitted by one or more of the following: the BFTC eligible applicant, the taxpayer or another third party.

c. Complete applications shall be processed in the order they are received by the authority.

44.6(3) *Execution of an agricultural assets transfer agreement.* In addition to the requirements of rule 265—44.6(16), both the taxpayer and the BFTC eligible applicant shall execute an agricultural assets transfer agreement. This form shall be in a format used by the Iowa State Bar Association or other commonly accepted form and signed by all parties.

44.6(4) *Procedures following tax credit approval.* Either the BFTC eligible applicant or the taxpayer shall immediately notify the authority of any material changes in the agricultural assets transfer agreement. The authority shall act upon these changes pursuant to Iowa Code section 16.80. Material changes cannot result in an increase in the original tax credit amount approved.

[**ARC 1112C**, IAB 10/16/13, effective 9/26/13; **ARC 1400C**, IAB 4/2/14, effective 5/7/14; **ARC 2009C**, IAB 5/27/15, effective 7/1/15]

265—44.7(16) Beginning farmer custom farming tax credit program.

44.7(1) *General provisions.*

a. *Term.* The term of the credit shall not exceed one year, except that any unused credit may be carried forward for a period of ten years if unused in the tax year the credits are earned. Credits may not be carried back to past tax years.

b. *Fees.* The authority may charge reasonable and necessary fees to defray the costs of this program.

c. *Expiration of custom hire contract.* The BFCF eligible applicant will continue to be eligible during the year of the custom farming contract. Upon expiration of the contract, both the taxpayer and BFCF eligible applicant must reapply to qualify for subsequent tax credits.

44.7(2) *Application procedures.*

a. The authority shall prepare and make available appropriate forms to be used in making application for the tax credit, including forms for both the taxpayer and the BFCF eligible applicant.

b. Each application shall include, but not be limited to, the following:

(1) Taxpayer information: name and address, e-mail address if available, social security number, and description and location of the custom hire work completed. In addition, the application shall have attached to it a copy of the custom hire contract between the parties.

(2) BFCF eligible applicant information: name and address, e-mail address if available, social security number, and location of where custom hire work was completed. In addition, the application shall have attached to it a copy of the BFCF eligible applicant's most recent financial statement (generally prepared one month preceding application submission). The application will also include a background letter on the BFCF eligible applicant documenting to the satisfaction of the authority sufficient training, experience and access to capital. This letter may be submitted by one or more of the following: the BFCF eligible applicant, the taxpayer or another third party.

c. Complete applications shall be processed in the order they are received by the authority.

44.7(3) *Execution of custom farming contract.* In addition to the requirements set forth in rule 265—44.7(16), both the taxpayer and the BFCF eligible applicant shall execute a custom farming contract. This form shall be in a format provided by the authority or other commonly accepted forms and signed by all parties.

44.7(4) *Calculation of custom hire tax credit.* The taxpayer and BFCF eligible applicant will submit a completed application to the authority, including a list of all custom work completed by the BFCF eligible applicant. The application will also include verification of all payments made to the BFCF eligible applicant for work completed.

44.7(5) *Procedures following tax credit approval.* Either the BFCF eligible applicant or the taxpayer shall immediately notify the authority of any material changes in the custom hire contract. The authority shall act upon these changes pursuant to Iowa Code section 16.81. Material changes cannot result in an increase in the original tax credit amount approved. Death of a party to the contract, divorce, or sale of the property will be considered eligible material changes.

[**ARC 1112C**, IAB 10/16/13, effective 9/26/13; **ARC 1400C**, IAB 4/2/14, effective 5/7/14; **ARC 2009C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code sections 16.4A, 16.4B, and 16.75 to 16.84.

[Filed Emergency ARC 1112C, IAB 10/16/13, effective 9/26/13]

[Filed ARC 1400C (Notice ARC 1113C, IAB 10/16/13), IAB 4/2/14, effective 5/7/14]

[Filed ARC 2009C (Notice ARC 1905C, IAB 3/4/15), IAB 5/27/15, effective 7/1/15]

INSPECTIONS AND APPEALS DEPARTMENT[481]

CHAPTER 1
ADMINISTRATION

CHAPTER 2
PETITIONS FOR RULE MAKING

CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

CHAPTER 6
UNIFORM WAIVER AND VARIANCE RULES

CHAPTER 7
CONSENT FOR THE SALE OF GOODS
AND SERVICES

CHAPTER 8
LICENSING ACTIONS FOR NONPAYMENT OF CHILD SUPPORT
AND STUDENT LOAN DEFAULT/NONCOMPLIANCE
WITH AGREEMENT FOR PAYMENT OF OBLIGATION

CHAPTER 9
Reserved

CHAPTER 10
CONTESTED CASE HEARINGS

CHAPTER 11
PROCEDURE FOR CONTESTED CASES INVOLVING PERMITS TO CARRY WEAPONS AND ACQUIRE FIREARMS

CHAPTERS 12 to 19
Reserved

AUDITS DIVISION

CHAPTERS 20 and 21
Reserved

CHAPTER 22
HEALTH CARE FACILITY AUDITS

CHAPTERS 23 and 24
Reserved

CHAPTER 25
IOWA TARGETED SMALL BUSINESS CERTIFICATION PROGRAM

CHAPTERS 26 to 29
Reserved

INSPECTIONS DIVISION

CHAPTER 30
FOOD AND CONSUMER SAFETY

CHAPTER 31
FOOD ESTABLISHMENT AND FOOD
PROCESSING PLANT INSPECTIONS

CHAPTERS 32 and 33
Reserved

CHAPTER 34
HOME FOOD ESTABLISHMENTS

CHAPTER 35
CONTRACTOR REQUIREMENTS

CHAPTER 36
Reserved

CHAPTER 37
HOTEL AND MOTEL INSPECTIONS

CHAPTERS 38 and 39
Reserved

CHAPTER 40
FOSTER CARE FACILITY INSPECTIONS

CHAPTER 41
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)

CHAPTERS 42 to 49
Reserved

CHAPTER 50
HEALTH CARE FACILITIES ADMINISTRATION

CHAPTER 51
HOSPITALS

CHAPTER 57
RESIDENTIAL CARE FACLITIES

CHAPTER 58
NURSING FACILITIES

58.4(135C)	General requirements
58.5(135C)	Notifications required by the department
58.6	Reserved
58.7(135C)	Licenses for distinct parts
58.8(135C)	Administrator
58.9(135C)	Administration
58.10(135C)	General policies
58.11(135C)	Personnel
58.12(135C)	Admission, transfer, and discharge
58.13(135C)	Contracts
58.14(135C)	Medical services
58.15(135C)	Records
58.16(135C)	Resident care and personal services
58.17	Reserved
58.18(135C)	Nursing care
58.19(135C)	Required nursing services for residents
58.20(135C)	Duties of health service supervisor
58.21(135C)	Drugs, storage, and handling
58.22(135C)	Rehabilitative services
58.23(135C)	Dental, diagnostic, and other services
58.24(135C)	Dietary
58.25(135C)	Social services program
58.26(135C)	Resident activities program
58.27(135C)	Certified volunteer long-term care ombudsman program
58.28(135C)	Safety
58.29(135C)	Resident care
58.30	Reserved
58.31(135C)	Housekeeping
58.32(135C)	Maintenance
58.33(135C)	Laundry
58.34(135C)	Garbage and waste disposal
58.35(135C)	Buildings, furnishings, and equipment
58.36(135C)	Family and employee accommodations
58.37(135C)	Animals
58.38(135C)	Supplies
58.39(135C)	Residents' rights in general
58.40(135C)	Involuntary discharge or transfer
58.41(135C)	Residents' rights
58.42(135C)	Financial affairs—management
58.43(135C)	Resident abuse prohibited
58.44(135C)	Resident records
58.45(135C)	Dignity preserved
58.46(135C)	Resident work
58.47(135C)	Communications
58.48(135C)	Resident activities
58.49(135C)	Resident property
58.50(135C)	Family visits
58.51(135C)	Choice of physician and pharmacy
58.52(135C)	Incompetent resident
58.53(135C)	County care facilities
58.54(73GA,ch 1016)	Special unit or facility dedicated to the care of persons with chronic confusion or a dementing illness (CCDI unit or facility)

CHAPTER 59
TUBERCULOSIS (TB) SCREENING

CHAPTER 60
MINIMUM PHYSICAL STANDARDS
FOR RESIDENTIAL CARE FACILITIES

CHAPTER 61
MINIMUM PHYSICAL STANDARDS FOR NURSING FACILITIES

CHAPTER 62
RESIDENTIAL CARE FACILITIES
FOR PERSONS WITH MENTAL ILLNESS (RCF/PMI)

CHAPTER 63
RESIDENTIAL CARE FACILITIES FOR THE
INTELLECTUALLY DISABLED

CHAPTER 64
INTERMEDIATE CARE FACILITIES FOR THE
INTELLECTUALLY DISABLED

CHAPTER 65
INTERMEDIATE CARE FACILITIES
FOR PERSONS WITH MENTAL ILLNESS (ICF/PMI)

CHAPTER 66
BOARDING HOMES

CHAPTER 67
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS,
AND ADULT DAY SERVICES

CHAPTER 68
ELDER GROUP HOMES

CHAPTER 69
ASSISTED LIVING PROGRAMS

CHAPTER 70
ADULT DAY SERVICES

CHAPTER 72
PUBLIC ASSISTANCE
FRONT END INVESTIGATIONS

CHAPTER 73
MEDICAID FRAUD CONTROL BUREAU

CHAPTER 74
ECONOMIC ASSISTANCE FRAUD BUREAU

CHAPTER 75
DIVESTITURE UNIT

CHAPTERS 76 to 89
Reserved

CHAPTER 90
PUBLIC ASSISTANCE DEBT RECOVERY UNIT

CHAPTERS 91 to 99
Reserved

GAMES OF SKILL, CHANCE, BINGO AND RAFFLES

CHAPTER 100
ADMINISTRATION

QUALIFIED ORGANIZATION

RAFFLES CONDUCTED AT A FAIR

ANNUAL GAME NIGHT
BINGO MANUFACTURERS AND DISTRIBUTORS

CHAPTER 101
AMUSEMENT CONCESSIONS

CHAPTER 102
SOCIAL GAMBLING

CHAPTER 103
BINGO

CHAPTER 104
GENERAL PROVISIONS FOR ALL AMUSEMENT DEVICES

CHAPTER 105
REGISTERED AMUSEMENT DEVICES

CHAPTER 106
CARD GAME TOURNAMENTS BY VETERANS ORGANIZATIONS

CHAPTER 107
GAME NIGHTS

CHAPTER 10
CONTESTED CASE HEARINGS

[Prior to 2/10/88, see Inspections and Appeals Department[481],Ch 4]

481—10.1(10A) Definitions.

"Administrative law judge (ALJ)" means the person who presides over contested cases and other proceedings.

"Agency" means the agency as defined in Iowa Code subsection 17A.2(1) which has original subject matter jurisdiction in the contested case.

"Appointing authority" means the appointed or elected chief administrative head of a department, commission, board, independent agency, or statutory office or that person's designee or in the case of gubernatorial appointees, the governor.

"Board" means a licensing board as defined in Iowa Code chapter 272C.

"Department" means the department of inspections and appeals (DIA).

"Division" means the division of administrative hearings in the department of inspections and appeals.

"Ex parte" means a communication, oral or written, to an ALJ or other decision maker in a contested case without notice and an opportunity for all parties to be heard.

"Filing" is defined in subrule 10.12(3) except where otherwise specifically defined by law.

"Issuance" means the date of mailing of a decision or order or date of delivery if service is by other means.

"Party" means a party as defined in Iowa Code subsection 17A.2(5).

"Personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case.

"Presiding officer" means, as used in the code of administrative judicial conduct, all persons who preside in contested case proceedings under Iowa Code section 17A.11(1) as amended by 1998 Iowa Acts, chapter 1202, section 15.

"Proposed decision" means the administrative law judge's recommended findings of fact, conclusions of law, and decision and order in contested cases where the agency did not preside.

481—10.2(10A,17A) Time requirements. Time shall be computed as provided in Iowa Code subsection 4.1(22). For good cause, the administrative law judge may extend or shorten the time to take any action, except as provided otherwise by rule or law.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.3(10A) Requests for a contested case hearing. Requests for a contested case hearing are made to the agency with subject matter jurisdiction. That agency shall determine whether to initiate a contested case proceeding.

This rule is intended to implement Iowa Code section 10A.202(1).

481—10.4(10A) Transmission of contested cases.

10.4(1) In every proceeding filed with the division, the agency shall complete a transmittal form. The following information is required:

a. The name of the transmitting agency;

b. The name, address and telephone number of the contact person in the transmitting agency;

c. The name or title of the proceeding, which may include a file number;

d. Any agency docket or reference number;

e. A citation to the jurisdictional authority of the agency regarding the matter in controversy;

f. Any anticipated special features or requirements which may affect the hearing;
g. Whether the hearing should be held in person or by telephone conference call;
h. Any special legal or technical expertise needed to resolve the issues in the case;
i. The names and addresses of all parties and their attorneys or other representatives;
j. The date the request for a contested case hearing was received by the agency;
k. A statement of the issues involved and a reference to statutes and rules involved;
l. Any mandatory time limits that apply to the processing of the case;
m. Earliest appropriate hearing date; and
n. Whether a petition or answer is required.

10.4(2) The agency and the department determine by agreement whether the agency or the department shall issue the notice of hearing.

a. If agreed by the agency and the department, the agency shall attach a notice of hearing to the transmittal form.

b. If the division by agreement issues the notice of hearing, the agency must provide the information required by Iowa Code section 17A.12(2) (except for the date, time and place of the hearing) for inclusion in the notice.

c. The agency, and not the division, shall prepare:
(1) The citation to the jurisdictional authority of the agency regarding the matter in controversy;
(2) A statement of the issues involved;
(3) A reference to statutes and rules involved; and
(4) The remaining information required by the transmittal form as stated in subrule 10.4(1).

10.4(3) The following documents shall be attached to the completed transmittal form when it is sent to the division:
a. A copy of the document showing the agency action in controversy; and
b. A copy of any document requesting a contested case hearing.

10.4(4) When a properly transmitted case is received, it is marked with the date of receipt by the division. An identifying number shall be assigned to each contested case upon receipt.

This rule is intended to implement Iowa Code section 10A.202(1).

481—10.5(17A) Notices of hearing.

10.5(1) Responsibility for issuance of notice of hearing and the manner of service shall be resolved by agreement between the division and the transmitting agency.

10.5(2) Notices of hearing shall contain the information required by Iowa Code subsection 17A.12(2) and any additional information required by statute or rule. Notices shall be served by first-class mail, unless otherwise required by statute or rule, or agreed pursuant to subrule 10.5(1).

This rule is intended to implement Iowa Code sections 17A.12(1) and 17A.12(2).

481—10.6(10A) Waiver of procedures. Unless otherwise precluded, the parties in a contested case may waive any provision of this chapter pursuant to Iowa Code section 17A.10.

This rule is intended to implement Iowa Code section 10A.202(2).

481—10.7(10A,17A) Telephone proceedings. A prehearing conference or a hearing may be held by telephone conference call pursuant to a notice of hearing or an order of the ALJ. The division shall determine the location of the parties and witnesses in telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, shall be considered when location is chosen.

481—10.8(10A,17A) Scheduling. Contested case hearings are scheduled according to the following criteria:

10.8(1) *Agency hearings.* The division shall promptly schedule hearings. The availability of an administrative law judge and any special circumstances shall be considered.

10.8(2) *Board hearings.* Boards are requested to consult with the division prior to scheduling hearings to determine the availability of an administrative law judge. The board shall determine the time and place of hearing.

481—10.9(17A) Disqualification.

10.9(1) An administrative law judge shall withdraw from contested cases for lack of impartiality or other legally sufficient cause including, but not limited to, cases where:

a. The ALJ has a personal bias or prejudice concerning a party, or personal knowledge of disputed evidentiary facts concerning the case;

b. The ALJ has prosecuted or advocated in connection with the case, the specific controversy underlying the case, or another pending factually related contested case or pending factually related controversy that may culminate in a contested case involving the same parties;

c. A private party is a client or has been a client of the ALJ within the past two years;

d. The ALJ has a financial interest in the case or any other interest that could be substantially affected by the outcome of the case; or

e. The ALJ, the ALJ's spouse, or relative within the third degree of relationship:

(1) Is a party to the case or an officer, director or trustee of a party;

(2) Is a lawyer in the case;

(3) Is known by the ALJ to have an interest that could be substantially affected by the outcome of the case; or

(4) Is to the ALJ's knowledge likely to be a material witness in the case.

10.9(2) If an ALJ does not withdraw, the ALJ shall disclose on the record any information relevant to the grounds listed in subrule 10.9(1).

10.9(3) If a party asserts disqualification on any appropriate ground, including those listed in subrule 10.9(1), the party shall file an affidavit pursuant to Iowa Code subsection 17A.17(4). The affidavit must be filed with the division within 15 days of the date of the notice of hearing, or as soon as the reason alleged in the affidavit becomes known to the party, but in any case shall be filed prior to the hearing.

This rule is intended to implement Iowa Code section 17A.17.

481—10.10(10A,17A) Consolidation—severance.

10.10(1) *Consolidation.* The administrative law judge may, upon motion by any party or the ALJ's own motion, consolidate any or all matters at issue in two or more proceedings docketed under these rules where:

a. There exist common parties or common questions of fact or law;

b. Consolidation would expedite and simplify consideration of the issues; and

c. Consolidation would not adversely affect the rights of parties engaged in otherwise separate proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

10.10(2) *Severance.* The administrative law judge may, upon motion by any party or upon the ALJ's own motion, for good cause shown, order any proceeding or portion thereof severed.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.11(10A,17A) Pleadings. Pleadings may be required by the notice of hearing or by order of the administrative law judge. If pleadings are required, they shall be filed as follows:

10.11(1) *Petition.* When an action of the agency is appealed and pleadings are required under subrule 10.10(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

b. The petition shall state in separately numbered paragraphs the following:

(1) The relief demanded and the facts and law relied upon for relief;

(2) The particular provisions of the statutes and rules involved;

(3) On whose behalf the petition is filed; and

(4) The name, address and telephone number of the petitioner and the petitioner's attorney, if any.

10.11(2) *Answer.* If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

b. The answer shall show on whose behalf it is filed and specifically admit, deny or otherwise answer all material allegations of the pleading to which it responds. It shall state any facts deemed to show an affirmative defense and may contain as many defenses as the pleader may claim.

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

d. Any allegation in the petition not denied in the answer is considered admitted. Any defense not raised which could have been raised on the basis of facts known when the answer was written may be waived unless manifest injustice would result.

10.11(3) *Amendment.* Any petition, notice of hearing or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed may be allowed at the discretion of the ALJ or board if applicable. The presiding ALJ or board may impose terms or grant a continuance without terms, as a condition of allowing late amendments.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.12(6)*"a."*

481—10.12(17A) Service and filing of documents.

10.12(1) *When service is required.* Except where otherwise specifically authorized by law, every pleading, motion, or other document filed in the contested case proceeding and every document relating to discovery in the proceeding shall be served upon each of the parties to the proceeding, including the originating agency. Except for the notice of the hearing and an application for rehearing as provided in Iowa Code subsection 17A.16(2), the party filing a document is responsible for service on all parties.

10.12(2) *Methods of performing service.* Service upon a party represented in the contested case proceeding by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivering, mailing, or transmitting by facsimile (fax) or by electronic mail (e-mail) a copy to the party or attorney at the party's or attorney's last-known mailing address, fax number, or e-mail address. Service by first-class mail is complete upon mailing, except where otherwise specifically provided by statute, rule or order. Service by fax or electronic mail is complete upon transmission unless the party making service learns that the attempted service did not reach the person to be served.

10.12(3) *Filing with the division.* After a matter has been assigned to the division, and until a proposed decision is issued, every pleading, motion, or other document shall be filed with the division, rather than the originating agency. All documents that are required to be served upon a party shall be filed simultaneously with the division.

a. Except where otherwise provided by law, a document is deemed filed with the division at the time it is:

(1) Delivered to the division at the Wallace State Office Building, Third Floor, 502 East Ninth Street, Des Moines, Iowa, and date-stamped received;

(2) Delivered to an established courier service for immediate delivery to the division;

(3) Mailed to the division by first-class mail or by state interoffice mail so long as there is adequate proof of mailing; or

(4) Transmitted by facsimile (fax) to (515)281-4477, by electronic mail (e-mail) to adminhearings@dia.iowa.gov, or by other electronic means approved by the division, as provided in subrule 10.12(3), paragraph *"b."*

b. All documents filed with the division pursuant to these rules, except a person's request or demand for a contested case proceeding (see Iowa Code subsection 17A.12(9)), may be filed by facsimile (fax), electronic mail (e-mail), or other electronic means approved by the division. A document filed by fax, e-mail, or other approved electronic means is presumed to be an accurate reproduction of the original. If a document filed by fax, e-mail, or other approved electronic means is illegible, a legible copy may

be substituted and the date of filing shall be the date the illegible copy was received. The date of filing by fax, e-mail, or other approved electronic means shall be the date the document is received by the division. The division will not provide a mailed file-stamped copy of documents filed by fax, e-mail, or other approved electronic means.

10.12(4) *Proof of mailing.* Adequate proof of mailing includes the following:

a. A legible United States postal service postmark on the envelope;

b. A certificate of service;

c. A notarized affidavit; or

d. A certification in substantially the following form:

> I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Department of Inspections and Appeals, Administrative Hearings Division, Wallace State Office Building, Third Floor, 502 East Ninth Street, Des Moines, Iowa 50319, and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed) or (state interoffice mail).
>
> (date) (signature)

[**ARC 1993C**, IAB 5/27/15, effective 7/1/15]

481—10.13(17A) Discovery.

10.13(1) Pursuant to Iowa Code section 17A.13, discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by rules of the agency or by a ruling by the ALJ, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

10.13(2) Any motion relating to discovery shall allege that the moving party has made a good faith attempt to resolve the issues raised by the motion with the opposing party. Motions in regard to discovery shall be ruled on by the ALJ. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule 10.13(1). The ALJ may rule on the basis of the written motion and any response or may order argument on the motion.

This rule is intended to implement Iowa Code section 17A.13.

481—10.14(10A,17A) Subpoenas.

10.14(1) *Issuance.*

a. Pursuant to Iowa Code subsection 17A.13(1), the division shall issue an agency subpoena to a party on request unless otherwise excluded pursuant to this rule. A request for a subpoena shall be in writing. The request may be made in person, or by mail, fax, or electronic mail. The request shall include the names of the parties, the case number, the name and address of the requested witness, and a description or list of any documents or other items requested. A request for a subpoena shall be received by the division at least seven calendar days before the scheduled hearing. The request shall include the name, address and telephone number of the requesting party.

b. The division shall provide the subpoena to the requesting party by regular mail, fax, or electronic mail or allow for pickup during the department's regular business hours. Parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

c. When authorized by law, an administrative law judge (ALJ) may issue a subpoena on the ALJ's own motion.

d. When there is reasonable ground to believe a subpoena is requested for the purpose of harassment, or that the subpoena requests irrelevant evidence or is untimely, the ALJ may refuse to issue the subpoena. The ALJ may require the requesting party to provide a statement of testimony expected to be elicited from the subpoenaed witness and a showing of relevancy. If the ALJ refuses to issue a subpoena, the ALJ shall provide a written statement of the ground for refusal. A party to whom a refusal is issued may obtain a prompt hearing regarding the refusal by filing a written request with the division.

10.14(2) *Motion to quash or modify.*

a. A subpoena may be quashed or modified upon motion for any lawful ground in accordance with the Iowa Rules of Civil Procedure.

b. A motion to quash or modify a subpoena shall be served on all parties of record.

c. The motion may be set for argument at the discretion of the ALJ.

This rule is intended to implement Iowa Code sections 10A.104(6) and 17A.13.

[**ARC 9616B**, IAB 7/13/11, effective 8/17/11]

481—10.15(10A,17A) Motions.

10.15(1) No technical form is required for motions. Prehearing motions, however, must be written, state the grounds for relief and state the relief sought. Any motion for summary judgment shall be filed in compliance with the requirements of Iowa Rules of Civil Procedure.

10.15(2) Any party may file a written resistance or response to a motion within 14 days after the motion is served, unless the time period is extended or shortened by rules of the agency or the administrative law judge. The ALJ may consider a failure to respond within the required time period in ruling on a motion.

10.15(3) The administrative law judge may schedule oral argument on any motion on the request of any party or the ALJ's own motion.

10.15(4) Except for good cause, all motions pertaining to the hearing must be filed and served at least ten days prior to the hearing date unless the time period is shortened or lengthened by rules of the agency or the administrative law judge.

481—10.16(17A) Prehearing conference.

10.16(1) Any party may request a prehearing conference. A request for prehearing conference or an order for prehearing conference on the ALJ's own motion shall be filed in writing and served on all parties of record not less than ten days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Notice of the prehearing conference shall be given by the division to all parties. For good cause the ALJ may permit variances from this rule.

10.16(2) Each party shall bring to the prehearing conference:

a. A final list of witnesses who the party reasonably anticipates will testify at the hearing. Witnesses not listed may be excluded from testifying.

b. A final list of exhibits which the party reasonably anticipates will be introduced at the hearing. Exhibits not listed, except rebuttal exhibits, may be excluded from admission into evidence.

10.16(3) In addition to the requirements of subrule 10.16(2), the parties at a prehearing conference may:

a. Enter into stipulations of law;

b. Enter into stipulations of fact;

c. Enter into stipulations on the admissibility of exhibits;

d. Identify matters which the parties intend to request be officially noticed;

e. Unless precluded by statute, enter into stipulations for waiver of the provisions of Iowa Code chapter 17A allowed by Iowa Code section 17A.10(2) or waiver of agency rules; and

f. Consider any additional matters which will expedite the hearing.

10.16(4) A prehearing conference shall be conducted by telephone conference call unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists prior to a telephone prehearing conference.

This rule is intended to implement Iowa Code section 17A.10.

481—10.17(10A) Continuances. Unless otherwise provided, application for continuance shall be made to the ALJ or to the division if an ALJ has not been assigned.

10.17(1) A written application for continuance shall:

a. Be made before the hearing;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or their representative.

10.17(2) If the ALJ waives the requirement for a written motion, an oral application for continuance may be made. A written application shall be submitted no later than five days after the oral request. The ALJ may waive this requirement. No application for continuance will be made or granted ex parte without notice except in an emergency where notice is not feasible. The agency may waive notice of requests for a case or a class of cases.

10.17(3) Except where otherwise provided, a continuance may be granted at the discretion of the ALJ. The administrative law judge shall consider, in addition to the grounds stated in the motion:

a. Any prior continuances;

b. The interests of all parties;

c. The likelihood of informal settlement;

d. Existence of emergency;

e. Objection to the continuance;

f. Any applicable state or federal statutes or regulations;

g. The existence of a conflict in the schedules of counsel or parties or witnesses; and

h. The timeliness of the request.

The ALJ may require documentation of any ground for continuance.

This rule is intended to implement Iowa Code section 10A.202(1).

481—10.18(10A,17A) Withdrawals. The party which requested an evidentiary hearing regarding agency action may withdraw prior to the hearing only in accordance with agency rules. Requests for withdrawal may be oral or written. If oral, the ALJ may require the party to submit a written request after the oral request. Unless otherwise provided, a withdrawal shall be with prejudice.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.19(10A,17A) Intervention.

10.19(1) *Motion.* A motion for leave to intervene shall be served on all parties and shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within ten days of service of the motion to intervene unless the time period is extended or shortened by the ALJ.

10.19(2) *When filed.* Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the disposition of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if one is held, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. The intervenor shall be bound by any agreement, arrangement or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the hearing will be denied.

10.19(3) *Grounds for intervention.* The movant shall demonstrate that:

a. Intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties;

b. The movant will be aggrieved or adversely affected by a final order; and

c. The interests of the movant are not being adequately represented by existing parties; or that it is otherwise entitled to intervene.

10.19(4) *Effect of intervention.* If appropriate, the ALJ may order consolidation of petitions and briefs and limit the number of representatives allowed to participate in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues to be raised or otherwise condition the intervenor's participation in the proceeding.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.20(17A) Hearing procedures.

10.20(1) When an ALJ has been appointed as the presiding officer in a contested case, the ALJ may:

a. Rule on motions;

b. Preside at the hearing;

c. Require the parties to submit briefs;

d. Issue a proposed decision; and

e. Issue orders and rulings to ensure the orderly conduct of the proceedings.

10.20(2) All objections to procedures, admission of evidence or any other matter shall be timely made and stated on the record.

10.20(3) Parties in a contested case have the right to participate or to be represented in all hearings or prehearing conferences related to their case. Partnerships, corporations or associations may be represented by any member, officer, director or duly authorized agent. Any party may be represented by an attorney or as otherwise authorized by law.

10.20(4) Parties in a contested case have the right to introduce evidence on points at issue, to cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, to present evidence in rebuttal and to submit briefs.

10.20(5) The ALJ shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly or disruptive.

10.20(6) Witnesses may be sequestered during the hearing.

10.20(7) The ALJ shall conduct the hearing in the following manner:

a. The ALJ shall give an opening statement briefly describing the nature of the proceeding;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the ALJ;

d. Each witness shall be sworn or affirmed by the ALJ or the court reporter, and be subject to examination. The ALJ may limit questioning consistent with Iowa Code section 17A.14;

e. The ALJ has the authority to fully and fairly develop the record and may inquire into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material; and

f. When all parties and witnesses have been heard, parties shall be given the opportunity to present final arguments.

This rule is intended to implement Iowa Code sections 17A.11 to 17A.14.

481—10.21(17A) Evidence.

10.21(1) The ALJ shall rule on admissibility of evidence in accordance with Iowa Code section 17A.14 and may take official notice of facts pursuant to Iowa Code subsection 17A.14(4).

10.21(2) Stipulation of facts is encouraged. The ALJ may make a decision based on stipulated facts.

10.21(3) Evidence shall be confined to the issues on which there has been fair notice prior to the hearing. The ALJ may take testimony on a new issue if the parties waive the right to notice and no other objection is made. If there is objection, the ALJ may refuse to hear the new issue and may make a decision on the original issue in the notice, or may grant a continuance to allow the parties adequate time to amend pleadings and prepare their cases on the additional issue.

10.21(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should be provided to opposing parties.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

10.21(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. The party objecting shall briefly state the grounds for the objection. The objection, the ruling on the objection and the reasons for the ruling shall be noted in the record. The ALJ may rule on the objection at the time it is made or may reserve a ruling until the written decision.

10.21(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly

summarize the testimony. If the evidence excluded consists of a document or exhibits, it shall be marked as part of an offer of proof and inserted in the record.

This rule is intended to implement Iowa Code sections 17A.11 to 17A.14.

481—10.22(17A) Default.

10.22(1) If a party fails to appear in a contested case proceeding after proper service of notice, the ALJ may, if no adjournment is granted, proceed with the hearing and make a decision in the absence of the party.

10.22(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested an evidentiary hearing to contest adverse agency action which has already occurred, but has failed to file a required pleading or has failed to appear after proper service.

10.22(3) Where authorized by law, an ALJ may issue a default order.

481—10.23(17A) Ex parte communication.

10.23(1) Ex parte communication is prohibited as provided in Iowa Code section 17A.17. Parties or their representatives and ALJs shall not communicate directly or indirectly in connection with any issue of fact or law in a contested case except upon notice and an opportunity for all parties to participate. The ALJ may communicate with persons who are not parties as provided in subrule 10.23(2).

10.23(2) However, the ALJ may communicate with members of the agency and may have the aid and advice of persons other than those with a personal interest in, or those prosecuting or advocating in the case under consideration or a factually related case involving the same parties.

10.23(3) Any party or ALJ who receives prohibited communication shall submit the written communication or a summary of the oral communication for inclusion in the record. Copies shall be sent to all parties. There shall be opportunity to respond.

10.23(4) Prohibited communications may result in sanctions as provided in agency rule. In addition, the department, through the ALJ, may censure the person or may prohibit further appearance before the department.

This rule is intended to implement Iowa Code sections 17A.14 and 17A.17.

481—10.24(10A,17A) Decisions.

10.24(1) *Proposed decisions.* The ALJ shall issue a proposed decision which includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case.

The record in a contested case shall include all materials specified in Iowa Code subsection 17A.12(6). This shall include any request for a contested case hearing and other relevant procedural documents regardless of their form.

A ruling dismissing all of a party's claims or a voluntary dismissal is a proposed decision under Iowa Code section 17A.15.

10.24(2) *Review of proposed decisions.* Request for review of a proposed decision shall be made to the agency in which the contested case originated in the manner and within the time specified by that agency's rules. In contested cases in which the director of DIA has final decision-making authority, request for review shall be made as provided in rule 481—10.25(10A,17A).

10.24(3) *Final decisions.* If there is no appeal from or review of the proposed decision, the ALJ's proposed decision becomes the final decision of the agency.

10.24(4) *Agency reports.* The agency shall send a copy of any request for review of a proposed decision to the division. The agency shall notify the division of the results of the review, the final decision and any judicial decision issued.

481—10.25(10A,17A) DIA appeals.

10.25(1) A request for review of a proposed decision in which DIA is the final decision maker shall be made within 15 days of issuing the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas

State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews on its own motion as follows. The department may review a proposed decision upon its own motion within 15 days of its issuance.

10.25(2) A review shall be based on the record and limited to issues raised in the hearing. The issues shall be specified in the party's request for review.

10.25(3) Each party shall have opportunity to file exceptions and present briefs. The director or a designee may set a deadline for submission of briefs. When the director or designee consents, oral arguments may be presented. A party wishing to make an oral argument shall specifically request it. All parties shall be notified in advance of the scheduled time and place.

10.25(4) The director or designee shall not take any further evidence with respect to issues of fact heard in the hearing except as set forth below. Application may be filed for leave to present evidence in addition to that found in the record of the case. If it is shown to the satisfaction of the director or designee that the additional evidence is material and that there were good reasons for failure to present it in the hearing, the director or designee may order the additional evidence taken upon conditions determined by the director or designee.

10.25(5) Final decisions shall be issued by the director or the director's designee.

10.25(6) Requests for rehearing shall be made to the director of the department within 20 days of issuing a final decision. A rehearing may be granted when new legal issues are raised, new evidence is available, an obvious mistake is corrected, or when the decision failed to include adequate findings or conclusions on all issues.

A request for rehearing is not necessary to exhaust administrative remedies.

10.25(7) Judicial review of department final decisions may be sought in accordance with Iowa Code section 17A.19.

This rule is intended to implement Iowa Code sections 17A.15 and 17A.19.

481—10.26(10A,17A,272C) Board hearings. In scheduling hearings, boards should consult with the division to determine the availability of an ALJ. The board shall determine the time and place of hearing. At the request of the board, an ALJ shall assist in the conduct of a contested case.

10.26(1) The ALJ may rule on preliminary matters, including motions, and conduct prehearing conferences referred by the board.

10.26(2) The ALJ may conduct the hearing for the board, and may, when delegated by the board, perform duties including, but not limited to, the following:

a. Open the record and receive appearances;
b. Administer oaths and issue subpoenas;
c. Enter the notice of hearing into the record;
d. Enter the statement of charges into the record;
e. Receive testimony and exhibits presented by the parties;
f. Rule on objections and motions;
g. Close the hearing; and
h. Prepare findings of fact, conclusions of law and decision and order.

This rule is intended to implement Iowa Code sections 10A.202, 17A.11 and 272C.6.

[1]**481—10.27(10A) Transportation hearing fees.** Any hearing on an application required by Iowa Code Supplement chapter 325A shall require:

10.27(1) The applicant and any persons objecting to the granting of a certificate to submit a hearing fee of $350 to be shared equally to cover payment of all costs and expenses of the hearing. The department may require additional amounts as necessary and shall provide a written itemized account of all additional expenses to the parties. The hearing fee shall be made by check payable to the Iowa Department of Inspections and Appeals.

10.27(2) The hearing fee to be received no later than 14 days after the notice of hearing, unless otherwise ordered. Failure to timely submit the hearing fee may result in cancellation of the hearing and denial of the application.

10.27(3) If a scheduled hearing is canceled, that the hearing fee, less expenses incurred by the department, be refunded to the payers. This shall not be interpreted to authorize a refund to an applicant who fails to appear at a scheduled hearing.

10.27(4) The applicant and any persons objecting to the granting of a certificate to submit a hearing fee of $150 to be shared equally if the hearing is held by a summary proceeding conducted without a personal appearance before the ALJ and where pleadings, affidavits, records, or other documents are submitted to the division for a decision by an ALJ.

[1] Hearing fees under jurisdiction of Department of Transportation [761] prior to 5/16/90. See IAB 6/26/91 for rescission of 761—525.5(3) and 528.4(3).

481—10.28(10A) Recording costs. The department may provide a copy of the tape-recorded hearing or a printed transcript of the hearing when a record of the hearing is requested. The cost of preparing the tape or transcript shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters shall bear the cost, unless otherwise provided by law.

481—10.29(10A) Code of administrative judicial conduct. The code of administrative judicial conduct is designed to govern the conduct, in relation to their adjudicative functions in contested cases, of all persons who act as presiding officers under the authority of Iowa Code section 17A.11(1). The canons are rules of reason. The canons shall be applied consistent with constitutional requirements, statutes, administrative rules, and decisional law and in the context of all relevant circumstances. The canons must be harmonized with the dictates of the administrative process as established by the legislature. While Canons 1, 2, and 3 are generally applicable to both administrative law judges and agency heads or members of multimember agency heads when these persons act as presiding officers, these canons shall be applied to agency heads and members of multimember agency heads only as expressly mandated by statute and as reasonably practicable when taking into account the fact that agency heads and members of multimember agency heads, unlike administrative law judges, have multiple duties imposed upon them by law. The provisions of Canon 4 concerning the regulation of extrajudicial activities are not applicable to agency heads or members of multimember agency heads. This code is to be construed so as to promote the essential independence of presiding officers in making judicial decisions.

Whether disciplinary action is appropriate, and the degree of discipline to be imposed, shall be determined by the appointing authority through a reasonable and reasoned application of the text and shall depend on such factors as the seriousness of the transgression, whether there is a pattern of improper activity, and the effect of improper activity on others or on the administrative system. This code is not designed or intended as a basis for civil liability or criminal prosecution.

10.29(1) *Canon 1.* A presiding officer shall uphold the integrity and independence of the administrative judiciary.

a. An independent and honorable administrative judiciary is indispensable to justice in society.

b. A presiding officer shall participate in establishing, maintaining, and enforcing high standards of conduct and shall personally observe those standards so that the integrity and independence of the administrative judiciary will be preserved.

c. The provisions of this code are to be construed and applied to further that objective.

10.29(2) *Canon 2.* A presiding officer shall avoid impropriety and the appearance of impropriety in all adjudicative functions in contested cases.

a. A presiding officer shall respect and comply with the law and at all times shall act in a manner that promotes public confidence in the integrity and impartiality of the administrative judiciary.

b. A presiding officer shall not allow family, social, political, or other relationships to influence the presiding officer's judicial conduct or judgment. This provision shall not be construed as prohibiting the development of public policy by contested case adjudication. A presiding officer shall not lend the prestige of the office to advance the private interests of the presiding officer or others; nor shall a presiding

officer convey or permit others to convey the impression that they are in a special position to influence the presiding officer.

c. A presiding officer shall not hold membership in any organization that the presiding officer knows practices invidious discrimination on the basis of race, sex, religion or national origin.

10.29(3) *Canon 3.* A presiding officer shall perform the duties of the office impartially and diligently.

a. *Adjudicative responsibilities.* A presiding officer in the performance of adjudicative duties in contested case proceedings shall follow these standards:

(1) A presiding officer shall be faithful to the law, unswayed by partisan interests, public clamor, or fear of criticism.

(2) A presiding officer shall maintain order and decorum in proceedings before the presiding officer.

(3) A presiding officer shall be patient, dignified, and courteous to litigants, witnesses, attorneys, representatives, and others with whom the presiding officer deals in an official capacity, and shall require similar conduct of attorneys, representatives, staff members and others subject to the presiding officer's direction and control.

(4) A presiding officer shall not, in the performance of adjudicative duties by words or conduct, manifest bias or prejudice, including but not limited to bias or prejudice based upon sex, race, national origin or ethnicity and shall not permit staff and others subject to the presiding officer's direction and control to do so.

(5) A presiding officer shall accord to all persons who are legally interested in a proceeding, or their representatives, full right to be heard according to law, and neither initiate nor consider ex parte communications prohibited by Iowa Code section 17A.17.

(6) A presiding officer shall dispose of all adjudicative matters promptly, efficiently and fairly.

(7) A presiding officer shall abstain from public comment about a pending or impending contested case proceeding that might reasonably be expected to affect the outcome or impair the fairness of the proceeding, and shall require similar abstention by agency personnel subject to the presiding officer's direction and control. This subparagraph does not prohibit a presiding officer from making public statements in the course of official duties or from explaining for public information the hearing procedures of agencies.

(8) A presiding officer shall not disclose or use, for any purpose unrelated to adjudicative duties, nonpublic information acquired in an adjudicative capacity except as lawfully permissible in the performance of official duties by an agency head or member of a multimember agency head.

(9) A presiding officer shall report any violation of this code to the appropriate authority for any disciplinary proceedings provided by law.

b. *Disqualification.* A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

(1) Has a personal bias or prejudice concerning a party or a representative of a party;

(2) Has personally investigated, prosecuted or advocated, in connection with that case, the specific controversy underlying that case, or another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

(3) Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

(4) Has acted as counsel to any person who is a private party to that proceeding within the past two years;

(5) Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

(6) Has a spouse or relative within the third degree of relationship that:

1. Is a party to the case, or an officer, director or trustee of a party;
2. Is an attorney in the case;
3. Is known to have an interest that could be substantially affected by the outcome of the case; or
4. Is likely to be a material witness in the case; or

(7) Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

c. *Disclosure on record.* In a situation where a presiding officer knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, the presiding officer shall disclose the relevant information on the record and shall state reasons why voluntary withdrawal is unnecessary.

10.29(4) *Canon 4.* An administrative law judge shall regulate extrajudicial activities to minimize the risk of conflict with judicial duties.

In general, an administrative law judge shall conduct all of the administrative law judge's extrajudicial activities so that the administrative law judge does not:

1. Cast reasonable doubt on the administrative law judge's capacity to act impartially as a judge;
2. Create the appearance of impropriety or demean the adjudicative office; or
3. Interfere with the proper performance of adjudicative duties.

These rules are intended to implement Iowa Code sections 10A.104, 10A.202, 17A.10 to 17A.17, 17A.19, 17A.22, 272C.1 and 272C.6.

[Filed emergency 7/1/86—published 7/16/86, effective 7/1/86]
[Filed 2/6/87, Notice 10/8/86—published 2/25/87, effective 4/1/87]
[Filed without Notice 3/26/87—published 4/22/87, effective 5/27/87]
[Filed 1/22/88, Notice 12/16/87—published 2/10/88, effective 3/16/88]
[Filed 4/26/90, Notice 1/24/90—published 5/16/90, effective 6/20/90][1]
[Filed emergency 8/1/90—published 8/22/90, effective 8/1/90]
[Filed emergency 9/27/96—published 10/23/96, effective 9/27/96]
[Filed emergency 2/6/98—published 2/25/98, effective 2/6/98]
[Filed 4/29/99, Notice 3/24/99—published 5/19/99, effective 7/1/99]
[Filed 12/6/01, Notice 10/31/01—published 12/26/01, effective 1/30/02]
[Filed ARC 9616B (Notice ARC 9514B, IAB 5/18/11), IAB 7/13/11, effective 8/17/11]
[Filed ARC 1993C (Notice ARC 1934C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[1] Effective date of first unnumbered paragraph of Ch 10, Scope and applicability, delayed 70 days by the Administrative Rules Review Committee at its 6/13/90 meeting; this paragraph rescinded IAB 8/22/90, effective 8/1/90.

CHAPTER 11
PROCEDURE FOR CONTESTED CASES INVOLVING PERMITS TO CARRY WEAPONS AND ACQUIRE FIREARMS

481—11.1(17A,724) Definitions.

"Agency" means the commissioner of public safety or the sheriff of the county in which the aggrieved party resides.

"Applicant" means a person who has applied for a permit to carry weapons or acquire firearms.

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5).

"Division" means the division of administrative hearings of the Iowa department of inspections and appeals.

"Party" means each person or agency named or admitted as a party.

"Permittee" means a person who has received a permit to carry weapons or acquire firearms.

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.2(724) Appeals. An applicant or permittee may appeal a decision by an agency to deny an application for a permit to carry weapons or acquire firearms or to suspend or revoke a permit to carry weapons or acquire firearms.

11.2(1) *Written appeal.* The appeal shall be in writing and should state the reasons for rebutting the denial, suspension, or revocation.

11.2(2) *Filing of appeal.* Within 30 days of the applicant's or permittee's receipt of the agency's decision, the applicant or permittee shall file the appeal, a copy of the agency's written decision, and a fee of $10 with the Iowa Department of Inspections and Appeals, Division of Administrative Hearings, 502 East 9th Street, Des Moines, Iowa 50319.

11.2(3) *Service on the agency.* The applicant or permittee shall serve a copy of the appeal on the agency at the time the appeal is filed with the division.

11.2(4) *Denial of appeal.* The division may deny any appeal that does not meet each of the requirements in subrules 11.2(1) to 11.2(3).

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.3(17A,724) Notice of hearing. The division shall prepare and serve the notice of hearing.

11.3(1) The notice of hearing shall contain the following information:

a. A statement of the time, place, and nature of the hearing;

b. A statement of the legal authority and jurisdiction under which the hearing is to be held;

c. A reference to the agency decision on appeal;

d. Identification of the parties;

e. Reference to the procedural rules governing the contested case proceeding;

f. Identification of the administrative law judge, including the judge's address and telephone number; and

g. Notification that failure to appear and participate in the contested case proceeding may result in the entry of a default judgment.

11.3(2) Service of the notice of hearing shall be accomplished by first-class mail.

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.4(17A,724) Agency record.

11.4(1) Upon receipt of a copy of the notice of hearing, the agency shall file with the division:

a. A copy of all documents used by the agency in reaching the decision; and

b. A form identifying the name, address, and telephone number of the agency's contact person or attorney representative.

11.4(2) The agency shall provide to the applicant or permittee a copy of all documents used by the agency in reaching the decision.

[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.5(17A) Contested case hearing. The hearing shall be conducted pursuant to the standards established in Iowa Code chapter 17A for contested case hearings. The hearing shall be held by telephone conference call, unless a party to the proceeding requests an in-person hearing from the administrative law judge no later than five days before the hearing. All in-person hearings shall be held at the division's headquarters in Des Moines, Iowa. If the administrative law judge grants an in-person hearing, the administrative law judge may allow one party to appear by telephone.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.6(17A) Service and filing of documents.

11.6(1) *When service is required.* Every pleading, motion, or other document filed in the contested case proceeding shall be served on each of the parties to the proceeding, including the agency. Except for an application for rehearing as provided in rule 481—11.14(17A) and Iowa Code subsection 17A.16(2), the party filing a document is responsible for service on all parties.

11.6(2) *Methods of performing service.* Service upon a party represented in the contested case proceeding by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivering, mailing, or transmitting by facsimile (fax) or by electronic mail (e-mail) a copy to the party or attorney at the party's or attorney's last-known mailing address, fax number, or e-mail address. Service by first-class mail is complete upon mailing. Service by fax or electronic mail is complete upon transmission unless the party making service learns that the attempted service did not reach the person to be served.

11.6(3) *Filing with the division.* Every pleading, motion, or other document in the contested case proceeding shall be filed with the division. All documents that are required to be served upon a party shall be filed simultaneously with the division.

a. Except where otherwise provided by law, a document is deemed filed with the division at the time it is:

(1) Delivered to the division at the Wallace State Office Building, Third Floor, 502 East Ninth Street, Des Moines, Iowa, and date-stamped received;

(2) Delivered to an established courier service for immediate delivery to the division;

(3) Mailed to the division by first-class mail or by state interoffice mail so long as there is adequate proof of mailing; or

(4) Transmitted by facsimile (fax) to (515)281-4477, by electronic mail (e-mail) to adminhearings@dia.iowa.gov, or by other electronic means approved by the division, as provided in subrule 11.6(3), paragraph *"b."*

b. All documents filed with the division pursuant to these rules, except a person's written appeal pursuant to rule 481—11.2(724), may be filed by facsimile (fax), electronic mail (e-mail), or other electronic means approved by the division. A document filed by fax, e-mail, or other approved electronic means is presumed to be an accurate reproduction of the original. If a document filed by fax, e-mail, or other approved electronic means is illegible, a legible copy may be substituted and the date of filing shall be the date the illegible copy was received. The date of filing by fax, e-mail, or other approved electronic means shall be the date the document is received by the division. The division will not provide a mailed file-stamped copy of documents filed by fax, e-mail, or other approved electronic means.

11.6(4) *Proof of mailing.* Adequate proof of mailing includes the following:

a. A legible United States postal service postmark on the envelope;

b. A certificate of service;

c. A notarized affidavit; or

d. A certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the Department of Inspections and Appeals, Administrative Hearings Division, Wallace State Office Building, Third Floor, 502 East Ninth Street, Des Moines, Iowa 50319, and to the names and addresses of the parties listed below by depositing the same in a United States post office mailbox with correct postage properly affixed.

(date) (signature)

This rule is intended to implement Iowa Code section 724.21A.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11; **ARC 1993C**, IAB 5/27/15, effective 7/1/15]

481—11.7(17A) Witness lists and exhibits. No later than five days before the hearing, a party shall serve on all parties and shall file with the division a witness list and a copy of any exhibit(s) the party intends to introduce into evidence during the contested case proceeding. If a party fails to serve on all parties and file with the division a witness list or any exhibit five days before the hearing, the party may be precluded from calling the witness at hearing or introducing the exhibit(s) into the record at hearing.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11; **ARC 1993C**, IAB 5/27/15, effective 7/1/15]

481—11.8(17A) Evidence. The administrative law judge shall rule on the admissibility of evidence and may take official notice of facts in accordance with applicable requirements of law. Evidence in the proceeding shall be confined to the issues for which the parties received notice prior to the hearing.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.9(17A) Withdrawals and dismissals. A request for withdrawal or dismissal of the appeal may be made with the division prior to the hearing. Either request must be in writing or secured on the record.

11.9(1) *Withdrawals.* An applicant or permittee who requested a contested case proceeding may request a withdrawal of the appeal. Upon receipt of a request for withdrawal of the appeal, the administrative law judge shall issue an order dismissing the appeal and closing the case.

11.9(2) *Dismissals.* An agency may request a dismissal of the appeal by agreeing to grant the entire relief sought by the applicant or permittee. The administrative law judge shall review a request for dismissal to determine whether it grants all relief requested in the appeal. If the request grants all relief requested in the appeal, the administrative law judge shall issue an order dismissing the appeal, ordering the agency to grant the relief requested, and closing the case.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.10(17A) Default. If a party fails to appear after proper service of notice, the administrative law judge may enter a default order against the party or may proceed with the hearing and make a decision in the absence of the party.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.11(10A) Costs. Costs of the contested case hearing shall be paid by the agency.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.12(724) Probable cause. Probable cause to deny an initial or renewal application for a permit to carry weapons or acquire firearms or to suspend or revoke a permit to carry weapons or acquire firearms means a reasonable ground exists for supposing that the basis for the denial, suspension or revocation is well-founded.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.13(724) Clear and convincing evidence. Clear and convincing evidence means there is no serious or substantial doubt about the correctness of the conclusion drawn from the evidence.
[**ARC 9299B**, IAB 12/29/10, effective 1/1/11; **ARC 9400B**, IAB 3/9/11, effective 4/13/11]

481—11.14(17A) Rehearing. An applicant, permittee, or agency aggrieved by an administrative law judge's final decision rescinding or sustaining the agency's denial, suspension, or revocation may request

rehearing. A request for rehearing shall be made by filing an application for rehearing with the division within 20 days of the date of the administrative law judge's final decision and must state the specific grounds for the rehearing and the relief sought. An application for rehearing shall be deemed to have been denied unless the administrative law judge grants the application within 20 days after its filing. A request for rehearing is not necessary to exhaust administrative remedies.

This rule is intended to implement Iowa Code sections 724.21A and 17A.16.

[**ARC 1993C**, IAB 5/27/15, effective 7/1/15]

These rules are intended to implement Iowa Code section 724.21A.

[Filed Emergency ARC 9299B, IAB 12/29/10, effective 1/1/11]

[Filed ARC 9400B (Notice ARC 9298B, IAB 12/29/10), IAB 3/9/11, effective 4/13/11]

[Filed ARC 1993C (Notice ARC 1934C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 67
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS, AND ADULT DAY SERVICES

481—67.1(231B,231C,231D) Definitions. The following definitions apply to this chapter and to 481—Chapters 68, 69, and 70.

"Activities of daily living" means the following self-care tasks: bathing, dressing, grooming, eating, transferring, toileting, and ambulation.

"Ambulatory" or *"ambulation"* means physically and cognitively able to walk without aid of another person.

"Applicable requirements" means Iowa Code chapters 135C, 231B, 231C, 231D, 235B, 235E, and 562A, this chapter, and 481—Chapters 68, 69, and 70, as applicable, and includes any other applicable administrative rules and provisions of the Iowa Code.

"Assignment" means the distribution of work for which each staff member, regardless of certification or licensure status, is responsible during a given work period and includes a nurse directing an individual to do something the individual is already authorized to do.

"Assistance" means aid to a tenant who self-directs or participates in a task or activity or who retains the mental or physical ability, or both, to participate in a task or activity. Cueing of the tenant regarding a particular task or activity shall be construed to mean the tenant has participated in the task or activity.

"Blueprint" means copies of all completed drawings, schedules, and specifications that have been certified, sealed, and signed by an Iowa-licensed architect or Iowa-licensed engineer of record. The department may allow electronic transfer of blueprints pursuant to policy.

"Certified staff" means certified nursing assistants (CNAs) and certified medication assistants (CMAs) employed by the program.

"Dementia" means an illness characterized by multiple cognitive deficits which represent a decline from previous levels of functioning and includes memory impairment and one or more of the following cognitive disturbances: aphasia, apraxia, agnosia, and disturbance in executive functioning.

"Department" means the department of inspections and appeals.

"Director" means the director of the department of inspections and appeals.

"Direct supervision" means the provision of guidance and oversight of a delegated nursing task through the physical presence of the licensed nurse to observe and direct certified and noncertified staff.

"Elope" means that a tenant who has impaired decision-making ability leaves the program without the knowledge or authorization of staff.

"Global Deterioration Scale" or *"GDS"* means the seven-stage scale for assessment of primary degenerative dementia developed by Dr. Barry Reisberg.

"Health care professional" means a physician, physician assistant, registered nurse or advanced registered nurse practitioner licensed in Iowa by the respective licensing board.

"Health-related care" means services provided by a registered nurse or a licensed practical nurse, on a part-time or intermittent basis, and services provided by other licensed health care professionals, on a part-time or intermittent basis. "Health-related care" includes nurse-delegated assistance.

"Human service professional" means an individual with a bachelor's degree in a human service field including, but not limited to: human services, gerontology, social work, sociology, psychology, or family science. Two years of experience in a human service field may be substituted for up to two years of the required education. For example, an individual with an associate's degree in a human service field and two years of experience in a human service field is a human service professional.

"Impaired decision-making ability" means a lack of capacity to make safe and prudent decisions regarding one's own routine safety as determined by the program manager or nurse or means having a GDS score of four or above.

"Independent reviewer" means an attorney licensed in the state of Iowa who is not currently and has not been employed by the department in the past eight years, or has not appeared in front of the department on behalf of a health care facility in the past eight years. Preference shall be given to an attorney with background knowledge, experience or training in long-term care.

"Indirect supervision" means the provision of guidance and oversight of a delegated nursing task through means other than direct supervision, including written and verbal communication.

"Instrumental activities of daily living" means those activities that reflect the tenant's ability to perform household and other tasks necessary to meet the tenant's needs within the community, which may include but are not limited to shopping, housekeeping, chores, and traveling within the community.

"Medication setup" means assistance with various steps of medication administration to support a tenant's autonomy, which may include but is not limited to routine prompting, cueing and reminding, opening containers or packaging at the direction of the tenant, reading instructions or other label information, or transferring medications from the original containers into suitable medication dispensing containers, reminder containers, or medication cups.

"Modification" means any addition to or change in physical dimensions or structure, except as incidental to the customary maintenance of the physical structure of the program's facility.

"Monitoring" means an on-site evaluation of a program, a complaint investigation, or a program-reported incident investigation performed by the department to determine compliance with applicable requirements. A monitor who performs a monitoring for the department shall be a registered nurse, human service professional, or another person with program-related expertise.

"Noncertified staff" means unlicensed and uncertified personnel employed by the program.

"Nurse delegation" means the action of a registered nurse, advanced registered nurse practitioner, or licensed practical nurse to direct competent certified and noncertified staff to perform selected nursing tasks in selected situations. The decision of a nurse to delegate is based on the delegation process, including assessment, planning, implementation, supervision, and evaluation of the tenant, nursing tasks, personnel, and the situation. The nurse, as a licensed professional, retains accountability for the delegation process and the decision to delegate. Licensed practical nurses may delegate within the scope of their license with the supervision of a registered nurse.

"Occupancy agreement" or *"contractual agreement"* means a written contract entered into between a program and a tenant that clearly describes the rights and responsibilities of the program and the tenant and other information required by applicable requirements. An occupancy agreement may include a separate signed lease and signed service agreement.

"Part-time or intermittent care" means licensed nursing services and professional therapies that are provided no more than 5 days per week; or licensed nursing services and professional therapies that are provided 6 or 7 days per week for a temporary period of time with a predictable end within 21 days; or licensed nursing services and professional therapies that do not exceed 28 hours per week or, for adult day services, 4 hours per day and are provided in combination with nurse-delegated assistance with medications or activities of daily living.

"Personal care" means assistance with the essential activities of daily living which may include but are not limited to transferring, bathing, personal hygiene, dressing, and grooming that are essential to the health and welfare of a tenant.

"Physician extender" means nurse practitioners, clinical nurse specialists, and physician assistants.

"Preponderance of the evidence" means that the evidence, considered and compared with the evidence opposed to it, produces the belief in a reasonable mind that the allegations are more likely true than not true.

"Program" means one or more of the following, as applicable: an elder group home as defined in Iowa Code section 231B.1 and 481—Chapter 68, an assisted living program as defined in Iowa Code section 231C.1 and 481—Chapter 69, or adult day services as defined in Iowa Code section 231D.1 and 481—Chapter 70.

"Program staff" means all employees of the program, regardless of certification or licensure status.

"Qualified professional" means a facility plant engineer familiar with the type of program being provided, or a licensed plumbing, heating, cooling, or electrical contractor who furnishes regular service to such equipment.

"Recognized accrediting entity" means a nationally recognized accrediting entity that the department recognizes as having specific program standards equivalent to the program standards established by the department.

"Regulatory insufficiency" means a violation of an applicable requirement.

"Remodeling" means a modification of any part of an existing building, an addition of a new wing or floor to an existing building, or a conversion of an existing building.

"Routine" means more often than not or on a regular customary basis.

"Self-administration" means a tenant's taking personal responsibility for all phases of medication except for any component assigned to the program under medication setup, and may include the tenant's use of an automatic pill dispenser.

"Service plan" means the document that defines all services necessary to meet the needs and preferences of a tenant, whether or not the services are provided by the program or other service providers.

"Significant change" means a major decline or improvement in the tenant's status which does not normally resolve itself without further interventions by staff or by implementing standard disease-related clinical interventions that have an impact on the tenant's mental, physical, or functional health status.

"Substantial compliance" means a level of compliance with applicable requirements such that any identified regulatory insufficiency poses no greater risk to tenant health or safety than the potential for causing minimal harm.

"Tenant" means an individual who receives services through a program. In the context of adult day services, "tenant" means a participant as defined in 481—Chapter 70.

"Tenant advocate" means the office of long-term care resident's advocate established in Iowa Code section 231.42.

"Tenant's legal representative" means a person appointed by the court to act on behalf of a tenant or a person acting pursuant to a power of attorney. In the context of adult day services, "tenant's legal representative" means a participant's legal representative as defined in 481—Chapter 70.

"Waiver" means action taken by the department that suspends in whole or in part the requirements or provisions of a rule.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 0961C**, IAB 8/21/13, effective 9/25/13; **ARC 1055C**, IAB 10/2/13, effective 1/1/14; **ARC 1994C**, IAB 5/27/15, effective 7/1/15]

481—67.2(231B,231C,231D) Program policies and procedures, including those for incident reports. A program's policies and procedures must meet the minimum standards set by applicable requirements. The program shall follow the policies and procedures established by a program. All programs shall have policies and procedures related to the reporting of incidents including allegations of dependent adult abuse.

67.2(1) The program's policies and procedures on incident reports, at a minimum, shall include the following:

a. The program shall have available incident report forms for use by program staff.

b. An incident report shall be in detail and shall be provided on an incident report form.

c. The person in charge at the time of the incident shall prepare and sign the report.

d. The incident report shall include statements from individuals, if any, who witnessed the incident.

e. All accidents or unusual occurrences within the program's building or on the premises that affect tenants shall be reported as incidents.

f. A copy of the completed incident report shall be kept on file on the program's premises for a minimum of three years.

67.2(2) The program's policies and procedures on allegations of dependent adult abuse shall be consistent with Iowa Code chapter 235E and rules adopted pursuant to that chapter and, at a minimum, shall include:

a. Reporting requirements for staff and employees, and

b. Requirements that the victim and alleged abuser be separated.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10]

481—67.3(231B,231C,231D) Tenant rights. All tenants have the following rights:

67.3(1) To be treated with consideration, respect, and full recognition of personal dignity and autonomy.

67.3(2) To receive care, treatment and services which are adequate and appropriate.

67.3(3) To receive respect and privacy in the tenant's medical care program. Personal and medical records shall be confidential, and the written consent of the tenant shall be obtained for the records' release to any individual, including family members, except as needed in case of the tenant's transfer to a health care facility or as required by law or a third-party payment contract.

67.3(4) To be free from mental and physical abuse.

67.3(5) To receive from the manager and staff of the program a reasonable response to all requests.

67.3(6) To associate and communicate privately and without restriction with persons and groups of the tenant's choice, including the tenant advocate, on the tenant's initiative or on the initiative of the persons or groups at any reasonable hour.

67.3(7) To manage the tenant's own financial affairs unless a tenant's legal representative has been appointed for the purpose of managing the tenant's financial affairs.

67.3(8) To present grievances and recommend changes in program policies and services, personally or through other persons or in combination with others, to the program's staff or person in charge without fear of reprisal, restraint, interference, coercion, or discrimination.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10]

481—67.4(231B,231C,231D) Program notification to the department. The director or the director's designee shall be notified within 24 hours, or the next business day, by the most expeditious means available:

67.4(1) Of any accident causing major injury. For the purposes of this rule, "major injury" shall also mean a substantial injury.

a. "Major injury" shall be defined as any injury which:

(1) Results in death; or

(2) Requires admission to a higher level of care for treatment, other than for observation; or

(3) Requires consultation with the attending physician, designee of the physician, or physician extender who determines, in writing on a form designated by the department, that an injury is a "major injury" based upon the circumstances of the accident, the previous functional ability of the tenant, and the tenant's prognosis.

b. The following are not reportable accidents:

(1) An ambulatory tenant who falls when neither the program nor its employees have culpability related to the fall, even if the tenant sustains a major injury; or

(2) Spontaneous fractures; or

(3) Hairline fractures.

67.4(2) When damage to the program is caused by a natural or other disaster.

67.4(3) When there is an act that causes major injury to a tenant or when a program has knowledge of a pattern of acts committed by the same tenant on another tenant that results in any physical injury. For the purposes of this subrule, "pattern" means two or more times within a 30-day period.

67.4(4) When a tenant elopes from a program.

67.4(5) When a tenant attempts suicide, regardless of injury.

67.4(6) When a fire occurs in a program and the fire requires the notification of emergency services, requires full or partial evacuation of the program, or causes physical injury to a tenant.

67.4(7) When a defect or failure occurs in the fire sprinkler or fire alarm system for more than 4 hours in a 24-hour period. (This reporting requirement is in addition to the requirement to notify the state fire marshal.)

NOTE: Additional reporting requirements are created by other rules and statutes, including but not limited to Iowa Code chapters 235B and 235E, which require reporting of dependent adult abuse.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10]

481—67.5(231B,231C,231D) Medications. Each program shall follow its own written medication policy, which shall include the following:

67.5(1) The program shall not prohibit a tenant from self-administering medications.

67.5(2) A tenant shall self-administer medications unless:

a. The tenant or the tenant's legal representative delegates in the occupancy agreement or signed service plan any portion of medication setup to the program.

b. The tenant delegates medication setup to someone other than the program.

c. The program assumes partial control of medication setup at the direction of the tenant. The medication plan shall not be implemented by the program unless the program's registered nurse deems it appropriate under applicable requirements, including those in Iowa Code section 231C.16A and subrule 67.9(4). The program's registered nurse must agree to the medication plan.

67.5(3) A tenant shall keep medications in the tenant's possession unless the tenant or the tenant's legal representative, if applicable, delegates in the occupancy agreement or signed service plan partial or complete control of medications to the program. The service plan shall include the tenant's choice related to storage.

67.5(4) When a tenant has delegated medication administration to the program, the program shall maintain a list of the tenant's medications. If the tenant self-administers medications, the tenant may choose to maintain a list of medications in the tenant's apartment or to disclose a current list of medications to the program for the purpose of emergency response. If the tenant discloses a medication list to the program in case of an emergency, the tenant remains responsible for the accuracy of the list.

67.5(5) When medication setup is delegated to the program by the tenant, staff via nurse delegation may transfer medications from the original prescription containers or unit dosing into medication reminder boxes or medication cups.

67.5(6) When medications are administered traditionally by the program:

a. The administration of medications shall be provided by a registered nurse, licensed practical nurse or advanced registered nurse practitioner registered in Iowa or by certified and noncertified staff in accordance with subrule 67.9(4) or a physician assistant (PA) in accordance with 645—Chapter 327. Injectable medications shall be administered as permitted by Iowa law by a registered nurse, licensed practical nurse, advanced registered nurse practitioner, physician, pharmacist, or physician assistant (PA).

b. Medications shall be kept in a locked place or container that is not accessible to persons other than employees responsible for the administration or storage of such medications.

c. The program shall maintain a list of each tenant's medications and document the medications administered.

67.5(7) Narcotics protocol shall be determined by the program's registered nurse.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 0961C**, IAB 8/21/13, effective 9/25/13; **ARC 1050C**, IAB 10/2/13, effective 11/6/13]

481—67.6(231B,231C,231D) Another business or activity located in a program.

67.6(1) A business or activity serving persons other than tenants of a program is allowed in a designated part of the physical structure in which the program is located if the other business or activity meets the requirements of applicable state and federal codes, administrative rules, and federal regulations.

67.6(2) A business or activity conducted in the designated part of the physical structure in which the program is located shall not interfere with the use of the program by tenants or with services provided to tenants or disturb tenants.

67.6(3) A business or activity conducted in the designated part of the physical structure in which the program is located shall not reduce access, space, services, or staff available to tenants or necessary to meet the needs of tenants.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10]

481—67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program.

67.7(1) *Time-limited waiver.* Upon receipt of a program's request for waiver of the criteria for retention of a tenant, the department may grant a waiver of the criteria under applicable requirements

for a time-limited basis. Absent extenuating circumstances, a waiver of the criteria for retention of a tenant is limited to a period of six months or less.

67.7(2) *Waiver petition procedures.* The following procedures shall be used to request and to receive approval of a waiver from criteria for the retention of a tenant:

a. A program shall submit the waiver request on a form and in a manner designated by the department as soon as it becomes apparent that a tenant exceeds retention criteria pursuant to an evaluation by a health care or human service professional.

b. The department shall respond in writing to a waiver request within 15 working days of receipt of all required documentation. In consultation with the program, the department may take an additional 15 working days to report its determination regarding the waiver request.

c. The program shall provide to the department within 5 working days written notification of any changes in the condition of the tenant as described in the approved waiver request.

67.7(3) *Factors for consideration for waiver of criteria for retention of a tenant.* In addition to the criteria established in Iowa Code subsection 17A.9A(2), the following factors may be demonstrative in determining whether the criteria for issuance of a waiver have been met.

a. It is the informed choice of the tenant or the tenant's legal representative, if applicable, to remain in the program;

b. The program is able to provide the staff necessary to meet the tenant's service needs in addition to the service needs of the other tenants;

c. The department shall only issue a waiver if the waiver will not jeopardize the health, safety, security or welfare of the tenant, program staff, or other tenants; and

d. The tenant has been diagnosed with a terminal illness and has been admitted to hospice, and the tenant exceeds the criteria for retention and admission for a temporary period of less than six months. A terminal diagnosis means the tenant is within six months of the end of life.

67.7(4) *Conditional waiver.* A conditional waiver may be granted contingent upon the department's receipt of additional information or performance of monitoring.

a. If a waiver has been in effect for six months, a monitoring shall be conducted to determine whether the tenant meets the criteria to continue on a waiver.

b. The department may seek additional information during the period to determine if a waiver should be granted.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10]

481—67.8(231B,231C,231D) All other waiver requests. Waiver requests relating to topics other than retention of a tenant in a program shall be filed in accordance with 481—Chapter 6.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10]

481—67.9(231B,231C,231D) Staffing.

67.9(1) *Number of staff.* A sufficient number of trained staff shall be available at all times to fully meet tenants' identified needs.

67.9(2) *Emergency procedures.* All program staff shall be able to implement the accident, fire safety, and emergency procedures.

67.9(3) *Training documentation.* The program shall have training records and staffing schedules on file and shall maintain documentation of training received by program staff, including training of certified and noncertified staff on nurse-delegated procedures.

67.9(4) *Nurse delegation procedures.* The program's registered nurse shall ensure certified and noncertified staff are competent to meet the individual needs of tenants. Nurse delegation shall, at a minimum, include the following:

a. The program's newly hired registered nurse shall within 60 days of beginning employment as the program's registered nurse document a review to ensure that staff are sufficiently trained and competent in all tasks that are assigned or delegated.

b. Within 30 days of beginning employment, all program staff shall receive training by the program's registered nurse(s).

c. Training for noncertified staff shall include, at a minimum, the provision of activities of daily living and instrumental activities of daily living.

d. Certified and noncertified staff shall receive training regarding service plan tasks (e.g., wound care, pain management, rehabilitation needs and hospice care) in accordance with medical or nursing directives and the acuity of the tenants' health, cognitive or functional status.

e. The program's registered nurse(s) shall provide direct or indirect supervision of all certified and noncertified staff as necessary in the professional judgment of the program's registered nurse and in accordance with the needs of the tenants and certified and noncertified staff.

f. Services shall be provided to tenants in accordance with the training provided.

g. The program shall have in place a system by which certified or noncertified staff communicate in writing occurrences that differ from the tenant's normal health, functional and cognitive status. The program's registered nurse or designee shall train certified and noncertified staff on reporting to the program's registered nurse or designee and documenting occurrences that differ from the tenant's normal health, functional and cognitive status. The written communication required by this paragraph shall be retained by the program for a period of not less than three years, and shall be accessible to the department upon request.

h. In the absence of the program's registered nurse due to vacation or other temporary circumstances, the nurse assuming the duties of the program's registered nurse shall have access to staff training in relation to tenant needs.

67.9(5) *Prohibited services.* A program staff member shall not be designated as attorney-in-fact, guardian, conservator, or representative payee for a tenant unless the program staff member is related to the tenant by blood, marriage, or adoption.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 0961C**, IAB 8/21/13, effective 9/25/13; **ARC 0963C**, IAB 8/21/13, effective 9/25/13]

481—67.10(17A,231B,231C,231D) Monitoring.

67.10(1) *Frequency of monitoring.* The department shall monitor a certified program at least once during the program's certification period.

67.10(2) *Accessibility of records and program areas.* All records and areas of the program deemed necessary to determine compliance with the applicable requirements shall be accessible to the department for purposes of monitoring.

67.10(3) *Standard for determining whether a regulatory insufficiency exists.* The department shall use a preponderance-of-the-evidence standard when determining whether a regulatory insufficiency exists. A preponderance-of-the-evidence standard does not require that the monitor shall have personally witnessed the alleged violation.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure.

67.11(1) *Complaints.* The process for filing a complaint is as follows:

a. Any person with concerns regarding the operation or service delivery of a program may file a complaint with the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083; by use of the complaint hotline, 1-877-686-0027; by facsimile sent to (515)281-7106; or through the Web site address: https://dia-hfd.iowa.gov/DIA_HFD/Home.do.

b. When the nature of the complaint is outside the department's authority, the department shall forward the complaint or refer the complainant, if known, to the appropriate investigatory entity.

c. The complainant shall include as much of the following information as possible in the complaint: the complainant's name, address and telephone number; the complainant's relationship to the program or tenant; and the reason for the complaint. The complainant's name shall be confidential information and shall not be released by the department. The department shall act on anonymous complaints unless the department determines that the complaint is intended to harass the program. If

the department, upon preliminary review, determines that the complaint is intended as harassment or is without reasonable basis, the department may dismiss the complaint.

67.11(2) *Program-reported incident reports.* When the program is required pursuant to applicable requirements to report an incident, the program shall make the report to the department via:

a. The Web-based reporting tool accessible from the following Internet site, https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Complaints" tab;

b. Mail by sending the complaint to the Department of Inspections and Appeals, Complaints Unit, Lucas State Office Building, Third Floor, 321 E. 12th Street, Des Moines, Iowa 50319-0083;

c. The complaint hotline, 1-877-686-0027; or

d. Facsimile sent to (515)281-7106.

67.11(3) *Time frames for investigation of complaints or program-reported incident reports.* Upon receipt of a complaint or program-reported incident report made in accordance with this rule, the department shall conduct a preliminary review of the complaint or report to determine if a potential regulatory insufficiency has occurred. If a potential regulatory insufficiency exists, the department shall institute a monitoring of the program within 20 working days unless there is the possibility of immediate danger, in which case the department shall institute a monitoring of the program within 2 working days of receipt of the complaint or incident report.

67.11(4) *Standard for determining whether a complaint is substantiated.* The department shall apply a preponderance-of-the-evidence standard in determining whether or not a complaint or program-reported incident report is substantiated.

67.11(5) *Notification of program and complainant.* The department shall notify the program and, if known, the complainant of the final report regarding the complaint investigation.

67.11(6) *Notification of accrediting entity.* In addition, for any credible report of alleged improper or inappropriate conduct or conditions within an accredited program, the department shall notify the accrediting entity by the most expeditious means possible of any actions taken by the department with respect to certification enforcement.

67.11(7) *Notification of complainant when complaint not investigated.* The department shall notify the complainant, if known, if the department does not investigate a complaint. The reasons for not investigating the complaint shall be included in the notification.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.12(17A,231B,231D) Adult day services and elder group homes—preliminary report, plan of correction and request for reconsideration. Rescinded **ARC 1701C**, IAB 10/29/14, effective 1/1/15.

481—67.13(17A,231B,231C,231D,85GA,HF2365) Exit interview, final report, plan of correction.

67.13(1) *Exit interview.* The department shall provide an exit interview in person or by telephone at the conclusion of a monitoring, during which the department shall inform the program's representative of all issues and areas of concern related to insufficient practices. A second exit interview shall be provided if the department identifies additional issues or areas of concern. The program shall have 2 working days from the date of the exit interview to submit additional or rebuttal information to the department.

67.13(2) *Final report.* The department shall issue the final report of a monitoring within 10 working days after completion of the on-site monitoring or the receipt by the department of additional or rebuttal information, by personal service, electronically or by certified mail. The department shall issue a final report regarding a monitoring whether or not any regulatory insufficiency is found.

67.13(3) *Plan of correction.* Within 10 working days following receipt of the final report, the program shall submit a plan of correction to the department.

a. *Contents of plan.* The plan of correction shall include:

(1) Elements detailing how the program will correct each regulatory insufficiency;

(2) The date by which the regulatory insufficiency will be corrected;

(3) What measures will be taken to ensure the problem does not recur;

(4) How the program plans to monitor performance to ensure compliance; and

(5) Any other required information.

The date by which the regulatory insufficiency will be corrected shall not exceed 30 days from receipt of the final report pursuant to subrule 67.13(2) without approval of the department.

b. Review of plan. The department shall review the plan of correction within 10 working days. The department may request additional information or suggest revisions to the plan.

67.13(4) *Monitoring revisit.* The department may conduct a monitoring revisit to ensure that the plan of correction has been implemented and the regulatory insufficiency has been corrected. The department may issue a regulatory insufficiency for failure to implement the plan of correction. A monitoring revisit by the department shall review the program prospectively from the date of the plan of correction to determine compliance.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14; **ARC 1701C**, IAB 10/29/14, effective 1/1/15]

481—67.14(17A,231B,231C,231D,85GA,HF2365) Response to final report. Within 20 working days after the issuance of the final report and assessment of civil penalty, if any, the program shall respond in the following manner.

67.14(1) *If not contesting final report.* If the program does not desire to seek an informal conference or contest the final report and civil penalty, if assessed, the program shall remit to the department of inspections and appeals the amount of the civil penalty, if assessed. If a program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if the requirements of subrule 67.17(5) are met.

67.14(2) *Informal conference.* If the program desires to contest the final report and civil penalty, if assessed, and request an informal conference, the program shall notify the department of inspections and appeals in writing that it desires to contest the final report and civil penalty and request in writing an informal conference with an independent reviewer.

a. Request for informal conference. The request for an informal conference must be in writing and include the following:

(1) Identification of the regulatory insufficiency(ies) being disputed;

(2) The type of informal conference requested: face-to-face or telephone conference; and

(3) A request for monitor's notes for the regulatory insufficiencies being disputed, if desired.

b. Submission of documentation. The program shall submit the following within 10 working days from the date of the program's written request for an informal conference:

(1) The names of those who will be attending the informal conference, including legal counsel; and

(2) Documentation supporting the program's position. The program must highlight or use some other means to identify written information pertinent to the disputed regulatory insufficiency(ies). Supporting documentation that is not submitted with the request for an informal conference will not be considered, except as otherwise permitted by the independent reviewer upon good cause shown. "Good cause" means substantial or adequate grounds for failing to submit documentation in a timely manner. In determining whether the program has shown good cause, the independent reviewer shall consider what circumstances kept the program from submitting the supporting documentation within the required time frame.

c. Face-to-face or telephone conference. A face-to-face or telephone conference, if requested, will be scheduled to occur within 10 working days of the receipt of the written request, all supporting documentation and the plan of correction required by subrule 67.13(3).

(1) Failure to submit supporting documentation will not delay scheduling.

(2) The conference will be scheduled for one hour. The program will informally present information and explanation concerning the contested regulatory insufficiency(ies). The department will have time to respond to the program's presentation. Due to the confidential nature of the conference, attendance may be limited.

(3) If additional information is requested by the independent reviewer during the informal conference, the program will have 2 working days to deliver the additional materials to the independent reviewer.

(4) When extenuating circumstances preclude a face-to-face conference, a telephone conference will be held or the program may be given one opportunity to reschedule the face-to-face conference.

d. *Results.* The results of the informal conference will generally be sent within 10 working days after the date of the informal conference, or within 10 working days after the receipt of additional information, if requested.

(1) The independent reviewer may affirm or may modify or dismiss the regulatory insufficiency and civil penalty. The independent reviewer shall state in writing the specific reasons for the affirmation, modification or dismissal of the regulatory insufficiency.

(2) The department will issue an amended (changes in factual content) or corrected (changes in typographical/data errors) final report if changes result from the informal conference.

(3) The program must submit to the department a new plan of correction for the amended or corrected report within 10 calendar days from the date of the letter conveying the results of the conference.

(4) If the informal conference results in dismissal of a regulatory insufficiency for which a civil penalty was assessed, the corresponding civil penalty will be rescinded.

67.14(3) *Procedure after informal conference.* After the conclusion of an informal conference:

a. If the program does not desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, remit to the department of inspections and appeals the civil penalty, if assessed.

b. If the program does desire to further contest an affirmed or modified final report, the program shall, within 5 working days after receipt of the written decision of the independent reviewer, notify the department of inspections and appeals in writing that it desires to formally contest the final report.

67.14(4) *Appeals.* Formal hearings shall be conducted by the administrative hearings division pursuant to Iowa Code chapter 17A and 481—Chapter 10.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14; **ARC 1701C**, IAB 10/29/14, effective 1/1/15]

481—67.15(17A,231B,231C,231D) Denial, suspension or revocation of a certificate.

67.15(1) *Notice and request for hearing.* The denial, suspension or revocation of a certificate shall be effected by delivering to the applicant or certificate holder by restricted certified mail or by personal service a notice setting forth the particular reasons for such actions. A denial, suspension or revocation shall be effective 30 days after certified mailing or personal service of the notice, unless the applicant or certificate holder gives the department written notice requesting a hearing within the 30-day period. If a timely request for hearing is made, the notice shall be deemed suspended pending the outcome of the hearing, unless subrule 67.15(3) or 67.15(4) applies. If an enforcement action has been implemented immediately in accordance with subrule 67.15(3) or 67.15(4), the enforcement action remains in effect regardless of a request for hearing.

67.15(2) *Hearings.* Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 10.

67.15(3) *Immediate suspension of a certificate.* When the department finds that an imminent danger to the health or safety of tenants of a program exists which requires action on an emergency basis, the department may direct removal of all tenants from the program and suspend the certificate or require additional remedies to ensure the ongoing safety of the program's tenants prior to a hearing.

67.15(4) *Immediate imposition of enforcement action.* When the department finds that an imminent danger to the health or safety of tenants exists which requires action on an emergency basis, the department may immediately impose a conditional certificate and accompanying conditions upon the program in lieu of immediate suspension of the certificate and removal of the tenants from the program if the department finds that tenants' health and safety would still be protected. The program may request a hearing, but the immediate enforcement action remains in effect regardless of the request for hearing.

[**ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.16(17A,231B,231C,231D) Conditional certification.

67.16(1) *Conditional certification.* In lieu of denial, suspension or revocation of a certificate, the department may issue a conditional certificate for a period of up to one year. Notwithstanding subrule

67.15(4), a conditional certificate shall be issued only when regulatory insufficiencies pose no greater risk to tenant health or safety than the potential for causing minimal harm.

a. The department shall specify the reasons for the conditional certificate in the notice issuing the conditional certificate.

b. The department may place conditions upon a certificate, such as requiring additional training; restriction of the program from accepting additional tenants for a period of time; or any other action or combination of actions deemed appropriate by the department.

c. Failure by the program to adhere to the plan of correction or conditions placed on the certificate may result in suspension or revocation of the conditional certification and may result in further enforcement action as available under applicable requirements.

d. A program must be in substantial compliance with applicable requirements before the removal of a conditional certificate by the department. Prior to lifting a conditional certificate, the department may conduct a monitoring to verify substantial compliance. Once the program is in substantial compliance with applicable requirements, the department shall lift the conditional certificate.

67.16(2) *Appeal of conditional certificate.* A written request for hearing must be received by the department within 30 days after the mailing or service of notice. The conditional certificate shall not be suspended pending the hearing. Hearings shall be conducted by the administrative hearings division of the department of inspections and appeals pursuant to Iowa Code chapter 17A and 481—Chapter 10.

[**ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.17(17A,231B,231C,231D) Civil penalties.

67.17(1) *When civil penalties may be issued.* Civil penalties may be issued when the director finds that any of the following has occurred:

a. A program that does not comply with applicable requirements and the noncompliance results in imminent danger or a substantial probability of resultant death or physical harm to a tenant may be assessed a civil penalty of not more than $10,000.

b. A program that continues to fail or refuses to comply with applicable requirements within prescribed time frames established by the department or approved by the department in the program's plan of correction and the noncompliance has a direct relationship to the health, safety, or security of tenants may be assessed a civil penalty of not more than $5,000.

c. A program that prevents, interferes with or attempts to impede in any way any duly authorized representative of the department in the lawful enforcement of applicable requirements may be assessed a civil penalty of not more than $1,000.

d. A program that discriminates or retaliates in any way against a tenant, tenant's family, or an employee of the program who has initiated or participated in any proceeding authorized by Iowa Code chapter 231B, 231C or 231D and the corresponding administrative rules may be assessed a civil penalty of not more than $5,000.

67.17(2) *Duplicate civil penalties prohibited.* The department shall not impose duplicate civil penalties on a program for the same set of facts and circumstances.

67.17(3) *Factors in determining the amount of a civil penalty.* The department shall consider the following factors when determining the amount of a civil penalty:

a. The frequency and length of time the regulatory insufficiency occurred (i.e., whether the regulatory insufficiency was an isolated or a widespread occurrence, practice, or condition);

b. The past history of the program as it relates to the nature of the regulatory insufficiency (the department shall not consider more than the current certification period and the immediately previous certification period);

c. The culpability of the program as it relates to the reasons the regulatory insufficiency occurred;

d. The extent of any harm to the tenants or the effect on the health, safety, or security of the tenants which resulted from the regulatory insufficiency;

e. The relationship of the regulatory insufficiency to any other types of regulatory insufficiencies which have occurred in the program;

f. The actions of the program after the occurrence of the regulatory insufficiency, including when corrective measures, if any, were implemented and whether the program notified the director as required;

g. The accuracy and extent of records kept by the program which relate to the regulatory insufficiency, and the availability of such records to the department;

h. The rights of tenants to make informed decisions;

i. Whether the program made a good-faith effort to address a high-risk tenant's specific needs and whether the evidence substantiates this effort.

67.17(4) *Civil penalties due.* The civil penalty shall be paid to the department within 30 days following the program's receipt of the final report and demand letter. The program may appeal in accordance with rule 481—67.12(17A,231B,231D) or 481—67.14(17A,231C,85GA,SF394). If the program appeals, the civil penalty shall be deemed suspended until the appeal is resolved.

67.17(5) *Reduction of civil penalty amount by 35 percent.* If an assisted living program has been assessed a civil penalty, the civil penalty shall be reduced by 35 percent if both of the following requirements are met:

a. The program does not request a formal hearing pursuant to rule 481—67.12(17A,231B,231D) or 481—67.14(17A,231C,85GA,SF394), or withdraws its request for formal hearing within 30 calendar days of the date that the civil penalty was assessed; and

b. The civil penalty is paid and payment is received by the department within 30 calendar days of receipt of the final report.

[**ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.18(17A,231B,231C,231D) Judicial review. Judicial review shall be conducted pursuant to Iowa Code chapter 17A and 481—Chapter 10.

[**ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks.

67.19(1) *Definitions.* The following definitions apply for the purposes of this rule.

"Background check" or *"record check"* means criminal history, child abuse and dependent adult abuse record checks.

"Direct services" means services provided through person-to-person contact. "Direct services" excludes services provided by individuals such as building contractors, repair workers, or others who are in a program for a very limited purpose, who are not in the program on a regular basis, and who do not provide any treatment or services for residents, patients, tenants, or participants of the provider.

"Employed in a program" or *"employment within a program"* means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An employee of an assisted living program certified under Iowa Code chapter 231C, if the employee provides direct services to consumers;
2. An employee of an elder group home certified under Iowa Code chapter 231B, if the employee provides direct services to consumers;
3. An employee of an adult day services program certified under Iowa Code chapter 231D, if the employee provides direct services to consumers.

"Employee" means any individual who is paid, either by the program or any other entity (i.e., temporary agency, private duty, Medicare/Medicaid or independent contractors).

"Evaluation" means review by the department of human services to determine whether a founded child abuse, dependent adult abuse or criminal conviction warrants the person's being prohibited from employment in a program.

"Indirect services" means services provided without person-to-person contact such as those provided by administration, dietary, laundry, and maintenance.

"Program," for purposes of this rule, means all of the following, if the provider is regulated by the state or receives any federal or state funding:

1. An assisted living program certified under Iowa Code chapter 231C;
2. An elder group home certified under Iowa Code chapter 231B; and

3. An adult day services program certified under Iowa Code chapter 231D.

67.19(2) *Explanation of "crime."* For purposes of this rule, the term "crime" does not include offenses under Iowa Code chapter 321 classified as simple misdemeanor or equivalent simple misdemeanor offenses from another jurisdiction.

67.19(3) *Requirements for employer prior to employing an individual.* Prior to employment of a person in a program, the program shall request that the department of public safety perform a criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state.

a. Informing the prospective employee. A program shall ask each person seeking employment by the program, "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime other than a simple misdemeanor offense relating to motor vehicles and laws of the road under Iowa Code chapter 321 or equivalent provisions in this state or any other state?" The person shall also be informed that a background check will be conducted. The person shall indicate, by signature, that the person has been informed that the background check will be conducted.

b. Conducting a background check. The program may access the single contact repository (SING) to perform the required background check. If the SING is used, the program shall submit the person's maiden name, if applicable, with the background check request. If SING is not used, the program must obtain a criminal history check from the department of public safety and a check of the child and dependent adult abuse registries from the department of human services.

c. If a person considered for employment has been convicted of a crime. If a person being considered for employment in a program has been convicted of a crime under a law of any state, the department of public safety shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the crime warrants prohibition of the person's employment in the program.

d. If a person considered for employment has a record of founded child abuse or dependent adult abuse. If a department of human services child or dependent adult abuse record check shows that a person being considered for employment in a program has a record of founded child or dependent adult abuse, the department of human services shall notify the program that upon the request of the program the department of human services will perform an evaluation to determine whether the founded child or dependent adult abuse warrants prohibition of employment in the program.

e. Employment pending evaluation. The program may employ a person for not more than 60 calendar days pending the completion of the evaluation by the department of human services if all of the following apply. The 60-day period begins on the first day of the person's employment.

(1) The person is being considered for employment other than employment involving the operation of a motor vehicle;

(2) The person does not have a record of founded child or dependent adult abuse;

(3) The person has been convicted of a crime that is a simple misdemeanor offense under Iowa Code section 123.47 or a first offense of operating a motor vehicle while intoxicated under Iowa Code section 321J.2, subsection 1; and

(4) The program has requested an evaluation to determine whether the crime warrants prohibition of the person's employment.

67.19(4) *Validity of background check results.* The results of a background check conducted pursuant to this rule shall be valid for a period of 30 calendar days from the date the results of the background check are received by the program.

67.19(5) *Employment prohibition.* A person who has committed a crime or has a record of founded child or dependent adult abuse shall not be employed in a program unless an evaluation has been performed by the department of human services.

67.19(6) *Transfer of an employee to another program owned or operated by the same person.* If an employee transfers from one program to another program owned or operated by the same person, without a lapse in employment, the program is not required to request additional criminal and child and dependent adult abuse record checks of that employee.

67.19(7) *Transfer of ownership of a program.* If the ownership of a program is transferred, at the time of transfer the background check required by this rule shall be performed for each employee for whom there is no documentation that such background check has been performed. The program may continue to employ such employee pending the performance of the background check and any related evaluation.

67.19(8) *Change of employment—person with criminal or abuse record—exception to record check evaluation requirements.* A person with a criminal or abuse record who is or was employed by a certified program and is hired by another certified program shall be subject to the background check.

a. A reevaluation of the latest record check is not required, and the person may commence employment with the other certified program if the following requirements are met:

(1) The department of human services previously performed an evaluation concerning the person's criminal or abuse record and concluded the record did not warrant prohibition of the person's employment;

(2) The latest background check does not indicate a crime was committed or founded abuse record was entered subsequent to the prior evaluation;

(3) The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed;

(4) Any restrictions placed on the person's employment in the previous evaluation by the department of human services and still applicable shall remain applicable in the person's subsequent employment; and

(5) The person subject to the background check has maintained a copy of the previous evaluation and provided it to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a current record check evaluation shall be performed.

b. For purposes of this subrule, a position is "substantially the same or has the same job responsibilities" if the position requires the same certification, licensure, or advanced training. For example, a licensed nurse has substantially the same or the same job responsibilities as a director of nursing; a certified nurse aide does not have substantially the same or the same job responsibilities as a licensed nurse.

c. The subsequent employer must maintain the previous evaluation in the employee's personnel file for verification of the exception to the requirement for a record check evaluation.

d. The subsequent employer may request a reevaluation of the background check and may employ the person while the reevaluation is being performed, even though an exemption under paragraph 67.19(8)*"a"* may be authorized.

67.19(9) *Employee notification of criminal convictions or founded abuse after employment.* If a person employed by an employer that is subject to this rule is convicted of a crime or has a record of founded child or dependent adult abuse entered in the abuse registry after the person's employment application date, the person shall inform the employer of such information within 48 hours of the criminal conviction or entry of the record of founded child or dependent adult abuse.

a. The employer shall act to verify the information within seven calendar days of notification. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.19(3)*"c"* and *"d."*

c. The employer may continue to employ the person pending the performance of an evaluation by the department of human services.

d. A person who is required by this subrule to inform the person's employer of a conviction or entry of an abuse record and fails to do so within the required period commits a serious misdemeanor under Iowa Code section 135C.33.

e. The employer may notify the county attorney for the county where the employer is located of any violation or failure by an employee to notify the employer of a criminal conviction or entry of an abuse record within the period required under this subrule.

67.19(10) *Program receipt of credible information that an employee has been convicted of a crime or founded for abuse.* If the program receives credible information, as determined by the program, from someone other than the employee, that the employee has been convicted of a crime or a record of founded child or dependent adult abuse has been entered in the abuse registry after employment, and the employee has not informed the employer of the information within the time required by subrule 67.19(9), the program shall take the following actions:

a. The program shall act to verify credible information within seven calendar days of receipt. "Verify," for purposes of this subrule, means to access the single contact repository (SING) to perform a background check, to request a criminal background check from the department of public safety, to request an abuse record check from the department of human services, to conduct an online search through the Iowa Courts Online Web site, or to contact the county clerk of court office and obtain a copy of relevant court documents.

b. If the information is verified, the program shall follow the requirements of paragraphs 67.19(3)*"c"* and *"d."*

67.19(11) *Proof of background checks for temporary employment agencies and contractors.* Proof of background checks may be kept in the files maintained by temporary employment agencies and contractors. Facilities may require temporary employment agencies and contractors to provide a copy of the result of the background checks. Copies of such results shall be made available to the department upon request.

This rule is intended to implement Iowa Code sections 231B.2(1), 231C.3(1), 231D.2(2), and 135C.33 and 2013 Iowa Acts, Senate File 347.

[**ARC 0963C**, IAB 8/21/13, effective 9/25/13; **ARC 1547C**, IAB 7/23/14, effective 8/27/14]

481—67.20(17A,231C,231D) Emergency removal of tenants. If the department determines that the health or safety of tenants is in jeopardy and the tenants need to be removed from the program, the department shall use the following procedures to ensure a safe and orderly transfer.

67.20(1) The department shall notify the department of human services, the tenant advocate, the appropriate area agency on aging, and other agencies as necessary and appropriate:

a. To alert them to the need to transfer tenants from a program;

b. To request assistance in identifying alternative programs or other appropriate settings; and

c. To contact the tenants and their legal representatives or family members, if applicable, and others as appropriate, including health care professionals.

67.20(2) The department shall notify the program of the immediate need to transfer tenants and of any assistance available, in coordination with the appropriate parties under subrule 67.20(1).

67.20(3) The department, in conjunction with other agencies as necessary and appropriate, shall proceed with the transfer of tenants.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.21(231C) Nursing assistant work credit.

67.21(1) A person who is certified as a nursing assistant, including a medication aide, and who is supervised by a registered nurse may submit information to the department to obtain credit toward maintaining certification for working in a program. A program may add an employee to the direct care worker registry by calling (515)281-4077 or by registering through the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Documents" tab.

67.21(2) A program shall complete and submit to the department a direct care worker registry application for each certified nursing assistant who works in the program. A registered nurse employed by the program shall supervise the nursing assistant. The application may

be obtained by telephone at (515)281-4077 or via the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Documents" tab.

67.21(3) A program shall complete and submit to the department a direct care worker registry quarterly employment report whenever a change in the employment of a certified nursing assistant occurs. The report form may be obtained by telephone at (515)281-4077 or via the health facilities division Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do, under the "Documents" tab.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.22(231B,231C,231D) Public or confidential information.

67.22(1) *Public information.*

a. Public disclosure of findings. The program shall post a notice stating that copies of the final report resulting from a monitoring are available via the department's Web site at https://dia-hfd.iowa.gov/DIA_HFD/Home.do. The program shall post the notice in a prominent location on the premises of the program. Copies shall also be available upon request from the Department of Inspections and Appeals, Adult Services Bureau, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0083; telephone (515)281-6325.

b. Open records. The following records are open records available for inspection:

(1) Certification applications, certification status, and accompanying materials;

(2) Final findings of state monitorings, including a monitoring that results from a complaint or program-reported incident;

(3) Reports from the state fire marshal;

(4) Plans of correction submitted by a program;

(5) Official notices of certification sanctions, including enforcement actions;

(6) Findings of fact, conclusions of law, decisions and orders issued pursuant to rules 481—67.10(17A,231B,231C,231D), 481—67.12(17A,231B,231C,231D), and 481—67.13(17A,231B, 231C,231D);

(7) Waivers, including the department's approval and denial letter and any letter requesting the waiver.

67.22(2) *Confidential information.* Confidential information includes the following:

a. Information that does not comprise a final report resulting from a monitoring, complaint investigation, or program-reported incident investigation. Information which does not comprise a final report may be made public in a legal proceeding concerning a denial, suspension or revocation of certification;

b. Names of all complainants;

c. Names of tenants of a program, identifying medical information, copies of documentation appointing a legal representative, and the address of anyone other than an owner or operator; and

d. Social security numbers or employer identification numbers (EIN).

67.22(3) *Redaction of confidential information.* If a record normally open for inspection contains confidential information, the confidential information shall be redacted before the records are provided for inspection.

[**ARC 8174B**, IAB 9/23/09, effective 1/1/10; **ARC 1055C**, IAB 10/2/13, effective 1/1/14]

481—67.23(231B,231C,231D) Training related to Alzheimer's disease and similar forms of irreversible dementia. Rescinded **ARC 1547C**, IAB 7/23/14, effective 8/27/14.

These rules are intended to implement Iowa Code chapters 231B, 231C as amended by 2013 Iowa Acts, Senate File 394, and 231D.

[Filed ARC 8174B (Notice ARC 7877B, IAB 6/17/09), IAB 9/23/09, effective 1/1/10]
[Filed ARC 0961C (Notice ARC 0809C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]
[Filed ARC 0963C (Notice ARC 0808C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]
[Filed ARC 1050C (Notice ARC 0907C, IAB 8/7/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1055C (Notice ARC 0941C, IAB 8/7/13), IAB 10/2/13, effective 1/1/14]
[Filed ARC 1547C (Notice ARC 1472C, IAB 5/28/14), IAB 7/23/14, effective 8/27/14]
[Filed ARC 1701C (Notice ARC 1616C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]

[Filed ARC 1994C (Notice ARC 1942C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

CHAPTER 27
STANDARDS OF PRACTICE AND PRINCIPLES OF PROFESSIONAL ETHICS

650—27.1(153) General.

27.1(1) *Dental ethics.* The following principles relating to dental ethics are compatible with the Code of Professional Ethics and advisory opinions published in August 1998 by the American Dental Association. These principles are not intended to provide a limitation on the ability of the board to address problems in the area of ethics but rather to provide a basis for board review of questions concerning professional ethics. The dentist's primary professional obligation shall be service to the public with the most important aspect of that obligation being the competent delivery of appropriate care within the bounds of the clinical circumstances presented by the patient, with due consideration being given to the needs and desires of the patient. Unprofessional conduct includes, but is not limited, to any violation of these rules.

27.1(2) *Dental hygiene ethics.* The following principles relating to dental hygiene ethics are compatible with the Code of Ethics of the American Dental Hygienists' Association published in 1995. Standards of practice for dental hygienists are compatible with the Iowa dental hygienists' association dental hygiene standards of practice adopted in May 1993. These principles and standards are not intended to provide a limitation on the ability of the dental hygiene committee to address problems in the area of ethics and professional standards for dental hygienists but rather to provide a basis for committee review of questions regarding the same. The dental hygienist's primary responsibility is to provide quality care and service to the public according to the clinical circumstances presented by the patient, with due consideration of responsibilities to the patient and the supervising dentist according to the laws and rules governing the practice of dental hygiene.

27.1(3) *Dental assistant ethics.* Dental assistants shall utilize the principles of professional dental and dental hygiene ethics for guidance, and the laws and rules governing the practice of dental assisting.

650—27.2(153,272C) Patient acceptance. Dentists, in serving the public, may exercise reasonable discretion in accepting patients in their practices; however, dentists shall not refuse to accept patients into their practice or deny dental service to patients because of the patient's race, creed, sex or national origin.

650—27.3(153) Emergency service. Emergency services in dentistry are deemed to be those services necessary for the relief of pain or to thwart infection and prevent its spread.

27.3(1) Dentists shall make reasonable arrangements for the emergency care of their patients of record.

27.3(2) Dentists shall, when consulted in an emergency by patients not of record, make reasonable arrangements for emergency care.

650—27.4(153) Consultation and referral.

27.4(1) Dentists shall seek consultation, if possible, whenever the welfare of patients will be safeguarded or advanced by utilizing those practitioners who have special skills, knowledge and experience.

27.4(2) The specialist or consulting dentist upon completion of their care shall return the patient, unless the patient expressly states a different preference, to the referring dentist or, if none, to the dentist of record for future care.

27.4(3) The specialist shall be obliged, when there is no referring dentist and upon completion of the treatment, to inform the patient when there is a need for further dental care.

27.4(4) A dentist who has a patient referred for a second opinion regarding a diagnosis or treatment plan recommended by the patient's treating dentist, should render the requested second opinion in accordance with these rules. In the interest of the patient being afforded quality care, the dentist rendering the second opinion should not have a vested interest in the ensuing recommendation.

650—27.5(153) Use of personnel. Dentists shall protect the health of their patients by assigning to qualified personnel only those duties that can be legally delegated. Dentists shall supervise the work of all personnel working under their direction and control.

650—27.6(153) Evidence of incompetent treatment.

27.6(1) Licensees or registrants shall report to the board instances of gross or continually faulty treatment by other licensees or registrants.

27.6(2) Licensees or registrants may provide expert testimony when that testimony is essential to a just and fair disposition of a judicial or administrative action.

650—27.7(153) Representation of care and fees.

27.7(1) Dentists shall not represent the care being rendered to their patients or the fees being charged for providing the care in a false or misleading manner.

27.7(2) A dentist who accepts a third-party payment under a copayment plan as payment in full without disclosing to the third-party payer that the patient's payment portion will not be collected is engaging in deception and misrepresentation by this overbilling practice.

27.7(3) A dentist shall not increase a fee to a patient solely because the patient has insurance.

27.7(4) Payments accepted by a dentist under a governmentally funded program, a component or constituent dental society sponsored access program, or a participating agreement entered into under a program of a third party shall not be considered as evidence of overbilling in determining whether a charge to a patient or to another third party on behalf of a patient not covered under any of these programs, constitutes overbilling under this rule.

27.7(5) A dentist who submits a claim form to a third party reporting incorrect treatment dates is engaged in making unethical, false or misleading representations.

27.7(6) A dentist who incorrectly describes a dental procedure on a third party claim form in order to receive a greater payment or incorrectly makes a noncovered procedure appear to be a covered procedure is engaged in making an unethical, false or misleading representation to the third party.

27.7(7) A dentist who recommends or performs unnecessary dental services or procedures is engaged in unprofessional conduct.

27.7(8) A dentist shall not bill for services not rendered. A dentist shall not be prohibited from billing for those services which have been rendered, for actual costs incurred in the treatment of the patient, or for charges for missed appointments.

27.7(9) A dentist shall not bill or draw on a patient's line of credit prior to services being rendered. A dentist may bill or draw on a patient's line of credit for those services which have been rendered or for actual costs incurred in the treatment of the patient.

27.7(10) A dentist shall not be prohibited from permitting patients to prepay for services, in whole or in part, on a voluntary basis.

[**ARC 9218B**, IAB 11/3/10, effective 12/8/10]

650—27.8(153) General practitioner announcement of services. General dentists who wish to announce the services available in their practices are permitted to announce the availability of those services so long as they avoid any communications that express or imply specialization. General dentists shall also state that the services are being provided by a general dentist.

650—27.9(153) Unethical and unprofessional conduct.

27.9(1) Licensee or registrant actions determined by the board to be abusive, coercive, intimidating, harassing, untruthful or threatening in connection with the practice of dentistry shall constitute unethical or unprofessional conduct.

27.9(2) A treatment regimen shall be fully explained and patient authorization obtained before treatment is begun.

27.9(3) A licensee or registrant determined to be infected with HIV or HBV shall not perform an exposure-prone procedure except as approved by the expert review panel as specified in Iowa Code section 139A.22, established by the Iowa department of public health, or if the licensee or registrant

works in a hospital setting, the licensee or registrant may elect either the expert review panel established by the hospital or the expert review panel established by the Iowa department of public health for the purpose of making a determination of the circumstances under which the licensee or registrant may perform exposure-prone procedures. The licensee or registrant shall comply with the recommendations of the expert review panel. Failure to do so shall constitute unethical and unprofessional conduct and is grounds for disciplinary action by the board.

27.9(4) Knowingly providing false or misleading information to the board or an agent of the board is considered unethical and unprofessional conduct.

27.9(5) Prohibiting a person from filing or interfering with a person's filing a complaint with the board is considered unethical and unprofessional conduct.

27.9(6) A licensee shall not enter into any agreement with a patient that the patient will not file a complaint with the board.

[**ARC 9218B**, IAB 11/3/10, effective 12/8/10]

650—27.10(153) Retirement or discontinuance of practice.

27.10(1) A licensee, upon retirement, or upon discontinuation of the practice of dentistry, or upon leaving or moving from a community, shall notify all active patients in writing, or by publication once a week for three consecutive weeks in a newspaper of general circulation in the community, that the licensee intends to discontinue the practice of dentistry in the community, and shall encourage patients to seek the services of another licensee. The licensee shall make reasonable arrangements with active patients for the transfer of patient records, or copies thereof, to the succeeding licensee. "Active patient" means a person whom the licensee has examined, treated, cared for, or otherwise consulted with during the two-year period prior to retirement, discontinuation of the practice of dentistry, or leaving or moving from a community.

27.10(2) Nothing herein provided shall prohibit a licensee from conveying or transferring the licensee's patient records to another licensed dentist who is assuming a practice, provided that written notice is furnished to all patients as hereinbefore specified.

650—27.11(153,272C) Record keeping. Dentists shall maintain patient records in a manner consistent with the protection of the welfare of the patient. Records shall be permanent, timely, accurate, legible, and easily understandable.

27.11(1) *Dental records.* Dentists shall maintain dental records for each patient. The records shall contain all of the following:

a. *Personal data.*

(1) Name, date of birth, address and, if a minor, name of parent or guardian.

(2) Name and telephone number of person to contact in case of emergency.

b. *Dental and medical history.* Dental records shall include information from the patient or the patient's parent or guardian regarding the patient's dental and medical history. The information shall include sufficient data to support the recommended treatment plan.

c. *Patient's reason for visit.* When a patient presents with a chief complaint, dental records shall include the patient's stated oral health care reasons for visiting the dentist.

d. *Clinical examination progress notes.* Dental records shall include chronological dates and descriptions of the following:

(1) Clinical examination findings, tests conducted, and a summary of all pertinent diagnoses;

(2) Plan of intended treatment and treatment sequence;

(3) Services rendered and any treatment complications;

(4) All radiographs, study models, and periodontal charting, if applicable;

(5) Name, quantity, and strength of all drugs dispensed, administered, or prescribed; and

(6) Name of dentist, dental hygienist, or any other auxiliary, who performs any treatment or service or who may have contact with a patient regarding the patient's dental health.

e. Informed consent. Dental records shall include, at a minimum, documentation of informed consent that includes discussion of procedure(s), treatment options, potential complications and known risks, and patient's consent to proceed with treatment.

27.11(2) *Retention of records.* A dentist shall maintain a patient's dental record for a minimum of six years after the date of last examination, prescription, or treatment. Records for minors shall be maintained for a minimum of either (a) one year after the patient reaches the age of majority (18), or (b) six years, whichever is longer. Study models and casts shall be maintained for six years after the date of completion of treatment. Alternatively, one year after completion of treatment, study models and casts may be provided to the patient for retention. Proper safeguards shall be maintained to ensure safety of records from destructive elements.

27.11(3) *Electronic record keeping.* The requirements of this rule apply to electronic records as well as to records kept by any other means. When electronic records are kept, a dentist shall keep either a duplicate hard copy record or use an unalterable electronic record.

27.11(4) *Correction of records.* Notations shall be legible, written in ink, and contain no erasures or white-outs. If incorrect information is placed in the record, it must be crossed out with a single nondeleting line and be initialed by a dental health care worker.

27.11(5) *Confidentiality and transfer of records.* Dentists shall preserve the confidentiality of patient records in a manner consistent with the protection of the welfare of the patient. Upon request of the patient or patient's legal guardian, the dentist shall furnish the dental records or copies or summaries of the records, including dental radiographs or copies of the radiographs that are of diagnostic quality, as will be beneficial for the future treatment of that patient. The dentist may charge a nominal fee for duplication of records, but may not refuse to transfer records for nonpayment of any fees.

[**ARC 8369B**, IAB 12/16/09, effective 1/20/10; **ARC 1995C**, IAB 5/27/15, effective 7/1/15]

650—27.12(17A,147,153,272C) Waiver prohibited. Rules in this chapter are not subject to waiver pursuant to 650—Chapter 7 or any other provision of law.

These rules are intended to implement Iowa Code sections 153.34(7), 153.34(9), 272C.3, 272C.4(1f) and 272C.4(6).

[Filed 9/1/88, Notice 7/27/88—published 9/21/88, effective 10/26/88]
[Filed 2/1/91, Notice 12/12/90—published 2/20/91, effective 3/27/91]
[Filed 1/29/93, Notice 11/25/92—published 2/17/93, effective 3/24/93]
[Filed 7/30/93, Notice 6/9/93—published 8/18/93, effective 9/22/93]
[Filed 7/28/94, Notice 3/30/94—published 8/17/94, effective 9/21/94]
[Filed 1/27/95, Notice 12/7/94—published 2/15/95, effective 3/22/95]
[Filed 1/22/99, Notice 11/18/98—published 2/10/99, effective 3/17/99]
[Filed 7/21/00, Notice 5/17/00—published 8/9/00, effective 9/13/00]
[Filed 10/23/00, Notice 8/9/00—published 11/15/00, effective 1/1/01]
[Filed 1/19/01, Notice 11/15/00—published 2/7/01, effective 3/14/01]
[Filed 1/18/02, Notice 11/14/01—published 2/6/02, effective 3/13/02]
[Filed 4/25/03, Notice 12/11/02—published 5/14/03, effective 6/18/03]
[Filed 7/1/04, Notice 5/12/04—published 7/21/04, effective 8/25/04]
[Filed 2/5/07, Notice 11/22/06—published 2/28/07, effective 4/4/07]
[Filed ARC 8369B (Notice ARC 8044B, IAB 8/12/09), IAB 12/16/09, effective 1/20/10]
[Filed ARC 9218B (Notice ARC 8846B, IAB 6/16/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 1995C (Notice ARC 1897C, IAB 3/4/15), IAB 5/27/15, effective 7/1/15]