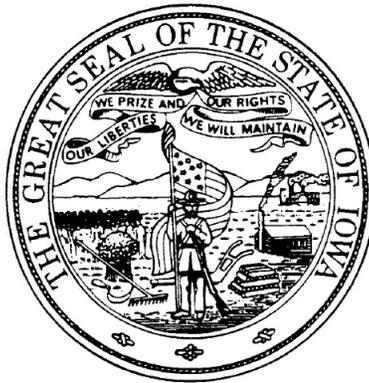


State of Iowa

Iowa
Administrative
Code
Supplement

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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code sections 2B.5A and 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 or suspension 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

Alcoholic Beverages Division[185]

Replace Chapter 4
Replace Chapter 9

Insurance Division[191]

Replace Analysis
Replace Chapter 1
Replace Chapters 3 and 4
Replace Chapter 36
Replace Chapters 39 to 41
Replace Chapter 72
Replace Chapter 76
Replace Chapter 81
Replace Chapter 100

Inspections and Appeals Department[481]

Replace Analysis
Replace Chapter 8

Homeland Security and Emergency Management Department[605]

Replace Chapter 7

Professional Licensure Division[645]

Replace Analysis
Replace Chapter 4

Nursing Board[655]

Replace Analysis
Replace Chapter 19

Revenue Department[701]

Replace Analysis
Replace Chapter 7

CHAPTER 4
LIQUOR LICENSES—BEER PERMITS—WINE PERMITS

[Ch 4, IAC 7/1/75 rescinded 3/7/79; see Chs 4,5]
[Prior to 10/8/86, Beer and Liquor Control Department[150]]

185—4.1(123) Definitions.

“*Act*” means the alcoholic beverage control Act.

“*Administrator*” means the chief administrative officer of the alcoholic beverages division or a designee.

“*Beverages*” as used in Iowa Code section 123.3(18) does not include alcoholic liquor, wine, or beer as defined in Iowa Code sections 123.3(4), 123.3(5), 123.3(7), 123.3(19), 123.3(28), 123.3(30), 123.3(43) and 123.3(47).

“*Division*” means the alcoholic beverages division of the department of commerce.

This rule is intended to implement Iowa Code sections 123.3 and 123.4.

[ARC 2382C, IAB 2/3/16, effective 3/9/16; ARC 3928C, IAB 8/1/18, effective 9/5/18]

185—4.2(123) General requirements. All applicants for liquor control licenses, wine permits, or beer permits shall comply with the following requirements, where applicable, prior to receiving a liquor license, wine permit, or beer permit.

4.2(1) Cleanliness of premises. The interior and exterior of all licensed premises shall be kept clean, free of litter or rubbish, painted and in good repair. Licensees and permittees shall at all times keep and maintain their respective premises in compliance with the laws, orders, ordinances and rules of the state, county and city health and fire departments and the Iowa department of inspections and appeals.

4.2(2) Toilet facilities. All licensees and permittees who mix, serve, or sell alcoholic liquor, wine, or beer for consumption on the licensed premises shall provide for their patrons adequate, conveniently located separate indoor or outdoor toilet facilities for men and women, which shall conform to county, city, and department of inspections and appeals’ rules and regulations. In case of outdoor facilities, they shall be approved by the department of inspections and appeals and the local approving authority where the licensed premises is located.

4.2(3) Water. All licensed establishments shall be equipped with hot and cold running water from a source approved by an authorized health department.

4.2(4) Financial standing and reputation. A local authority or the administrator may consider an applicant’s financial standing and good reputation in addition to the other requirements and conditions for obtaining a liquor control license, wine or beer permit, or certificate of compliance, and the local authority or the administrator shall disapprove or deny an application for a liquor control license, wine or beer permit, or certificate of compliance if the applicant fails to demonstrate that the applicant complies with the lawful requirements and conditions for holding the license, permit or certificate of compliance.

a. In evaluating an applicant’s “financial standing,” the local authority or the administrator may consider the following: An applicant’s “financial standing” may include, but is not limited to, verified source(s) of financial support and adequate operating capital for the applicant’s proposed establishment, a record of prompt payment of local or state taxes due, a record of prompt payment to the local authority of fees or charges made by a local authority for municipal utilities or other municipal services incurred in conjunction with the proposed establishment, and a record of prompt payment or satisfaction of administrative penalties imposed pursuant to Iowa Code chapter 123.

b. In evaluating an applicant’s “good reputation,” the local authority or the administrator may consider such factors as, but not limited to, the following: pattern or practice of sales of alcoholic beverages to 19- and 20-year-old persons for which the licensee or permittee, the licensee’s or permittee’s agents or employees, have pled or have been found guilty, pattern and practice by the licensee or permittee, or the licensee’s or permittee’s agents or employees, of violating alcoholic beverages laws and regulations for which corrective action has been taken since the previous license or permit was issued, sales to intoxicated persons, licensee or permittee convictions for violations of laws relating to operating a motor vehicle while under the influence of drugs or alcohol, the recency

of convictions under laws relating to operating a motor vehicle while under the influence of drugs or alcohol, licensee or permittee misdemeanor convictions, the recency of the misdemeanor convictions.

This rule is intended to implement Iowa Code sections 123.3(11), 123.21(11) and 123.30.

185—4.3(123) Local ordinances permitted. The foregoing rules shall in no way be construed as to prevent any county, city or town from adopting ordinances or regulations, which are more restrictive, governing licensed establishments within their jurisdiction.

This rule is intended to implement Iowa Code section 123.39.

185—4.4(123) Licensed premises. The following criteria must be met before a “place” (as used in Iowa Code section 123.3(25)) may be licensed as a “place susceptible of precise description satisfactory to the administrator.”

4.4(1) The “place” must be owned by or under the control of the prospective licensee.

4.4(2) The “place” must be solely within the jurisdiction of one local approving authority.

4.4(3) The “place” must be described by a sketch of the “premises” as defined in Iowa Code section 123.3(25) and showing the boundaries of the proposed “place”; showing the locations of selling/serving areas within the confines of the “place”; showing all entrances and exits; and indicating the measurements of the “place” and distances between selling/serving areas.

4.4(4) The “place” must satisfy the health, safety, fire and seating requirements of the division, local authorities and the Iowa department of inspections and appeals.

4.4(5) Any other criteria as required by the administrator.

This rule is intended to implement Iowa Code sections 123.3(25) and 123.4.

[ARC 3928C, IAB 8/1/18, effective 9/5/18]

185—4.5(123) Mixed drinks or cocktails not for immediate consumption. An on-premises liquor control licensee may mix, store, and allow the consumption of mixed drinks or cocktails which are not for immediate consumption for up to 72 hours, subject to the requirements and restrictions provided in 2012 Iowa Acts, House File 2465, section 22, and this rule.

4.5(1) Definitions.

“Immediate consumption.” For purposes of Iowa Code section 123.49(2) “d” as amended by 2012 Iowa Acts, House File 2465, section 22, and this rule, “immediate consumption” is defined as the compounding and fulfillment of a mixed drink or cocktail order upon receipt of the order for the mixed drink or cocktail.

“Mixed drink or cocktail.” A mixed drink or cocktail is a beverage composed in whole or in part of alcoholic liquors, combined with other alcoholic beverages or nonalcoholic beverages or ingredients including but not limited to ice, water, soft drinks, or flavorings.

4.5(2) Location. Mixed drinks or cocktails which are not for immediate consumption shall be mixed, stored, and consumed on the liquor control licensed premises. Mixed drinks or cocktails shall not be removed from the licensed premises.

4.5(3) Quantity. A mixed drink or cocktail which is not for immediate consumption shall be mixed and stored in, and dispensed from, a labeled container in a quantity not to exceed three gallons.

4.5(4) Container. A mixed drink or cocktail which is not for immediate consumption shall at all times be in a container compliant with applicable state and federal food safety statutes and regulations.

a. The mixed drink or cocktail shall be mixed and remain stored in the same container.

b. The mixed drink or cocktail shall be removed from the stored container for one of the following dispensing purposes:

(1) To compound and fulfill a mixed drink or cocktail order upon receipt of the order for the mixed drink or cocktail.

(2) For transfer into a pourable container. The pourable container shall have affixed a label compliant with subrule 4.5(5) displaying label information identical to that on the container from which the contents were poured. The expiration date and time shall not be extended by the transfer of product to a pourable container.

c. The mixed drink or cocktail may be strained into another container when each of the following conditions is met:

(1) The mixed drink or cocktail is returned without delay to the labeled container from which it was strained.

(2) The container and process are compliant with applicable state and federal food safety statutes and regulations.

d. An original package of alcoholic liquor as purchased from the division or an original package of wine shall not be used to mix, store, or dispense a mixed drink or cocktail, pursuant to Iowa Code section 123.49(2) "d" as amended by 2012 Iowa Acts, House File 2465, section 22, and section 123.49(2) "e."

e. The mixed drink or cocktail shall not be mixed, stored, or dispensed from a container bearing an alcoholic beverage name brand.

4.5(5) Label. A label shall be placed on a container when the contents of the mixed drink or cocktail are placed into the empty container.

a. Contents are defined in subrule 4.5(6).

b. The label shall be subject to the following requirements and restrictions:

(1) The label shall be affixed to the container in a conspicuous place.

(2) The label shall legibly identify the month, day, and year the contents are placed into the empty container.

(3) The label shall legibly identify the time the contents were placed into the empty container. The time shall be reported to the minute utilizing the 12-hour clock, and include either the ante meridian (AM) or post meridian (PM) part of time.

(4) The label shall legibly identify the month, day, and year the contents expire.

(5) The label shall legibly identify the time the contents expire. The time shall be reported in the same manner as reported in subparagraph 4.5(5) "b"(4).

(6) The label shall legibly specify the title of the recipe used for the contents of the container.

(7) The label shall legibly identify the person who prepared the contents of the container.

(8) The label shall legibly identify the size of the batch within the container and be conspicuously marked with the words "CONTAINS ALCOHOL."

(9) The label shall be removed from the container once the entire contents have been consumed, transferred to a pourable container pursuant to subparagraph 4.5(4) "b"(2), or destroyed and disposed of in accordance with applicable law.

(10) A label shall not be reused, nor shall a removed label be reapplied to a container.

(11) A new label, subject to the requirements and restrictions of paragraph 4.5(5) "b," shall be placed on the container for each prepared batch of mixed drinks or cocktails which is not for immediate consumption.

c. A licensee may access a label template on the website of the division located at www.IowaABD.com.

4.5(6) Contents. Contents include alcoholic beverages, nonalcoholic ingredients, or combination thereof, which are not for immediate consumption.

a. A licensee is limited to utilizing alcoholic beverages in the mixed drink or cocktail which are authorized by the license.

b. A licensee shall utilize alcoholic beverages in the mixed drink or cocktail which are obtained as prescribed by Iowa Code chapter 123.

c. The added flavors and other nonbeverage ingredients of the mixed drink or cocktail shall not include hallucinogenic substances, added caffeine or added stimulants including but not limited to guarana, ginseng, and taurine, or a controlled substance as defined in Iowa Code section 124.401.

4.5(7) Disposal.

a. Any mixed drink or cocktail, or portion thereof, not consumed within 72 hours of the contents' being placed into the empty container is expired and shall be destroyed and disposed of in accordance with applicable law.

b. An expired mixed drink or cocktail which is not for immediate consumption shall not be:

(1) Added to an empty container and relabeled; or

(2) Added to another mixed drink or cocktail which is not for immediate consumption.

4.5(8) Records. A licensee shall maintain accurate and legible records for each prepared batch of mixed drinks or cocktails which is not for immediate consumption.

a. Records shall contain:

(1) The month, day, and year the contents are placed into the empty container.

(2) The time the contents are placed into the empty container. The time shall be reported in the same manner as reported in subparagraph 4.5(5) “b”(4).

(3) Each alcoholic beverage, including the brand and the amount, placed in the container. The amount of each alcoholic beverage shall be reported utilizing the metric system.

(4) Each nonalcoholic ingredient placed in the container.

(5) The recipe title and directions for preparing the contents of the container.

(6) The size of the batch.

(7) The identity of the person who prepared the contents of the container.

(8) The month, day, and year the contents of the container are destroyed and disposed of or entirely consumed.

(9) The time the contents of the container are destroyed and disposed of or entirely consumed. The time shall be reported in the same manner as reported in subparagraph 4.5(5) “b”(4).

(10) The method of destruction and disposal or shall specify that the entire contents were consumed.

(11) The identity of the person who destroyed and disposed of the contents, if the contents were not consumed.

b. A licensee may access record-keeping forms on the website of the division located at www.IowaABD.com, by sending a request by fax to (515)281-7375, or by sending a request by mail to Alcoholic Beverages Division, 1918 SE Hulsizer Road, Ankeny, Iowa 50021.

c. Records shall be maintained on the licensed premises for a period of three years and shall be open to inspection pursuant to Iowa Code section 123.30(1).

4.5(9) Dispensing machines. A dispensing machine which contains a mixed drink or cocktail with alcoholic beverages is subject to the requirements and restrictions of this rule.

4.5(10) Food safety compliance. A licensee who mixes, stores, and allows the consumption of mixed drinks or cocktails which are not for immediate consumption shall comply with all applicable state and federal food safety statutes and regulations.

4.5(11) Federal alcohol compliance. A licensee who mixes, stores, and allows the consumption of mixed drinks or cocktails which are not for immediate consumption shall comply with all applicable federal statutes and regulations. Prohibitions include but are not limited to processing with non-tax-paid alcoholic liquor, aging alcoholic liquor in barrels, heating alcoholic liquor, bottling alcoholic liquor, and refilling alcoholic liquor or wine bottles.

4.5(12) Violations. Failure to comply with the requirements and restrictions of this rule shall subject the licensee to the penalty provisions of Iowa Code section 123.39.

This rule is intended to implement Iowa Code subsection 123.49(2) as amended by 2012 Iowa Acts, House File 2465, section 22.

[ARC 0204C, IAB 7/11/12, effective 7/1/12; ARC 0406C, IAB 10/17/12, effective 11/21/12]

185—4.6(123) Filling and selling of beer in a container other than the original container. Class “B,” class “C,” and special class “C” liquor control licensees, class “B” and class “C” beer permittees, and the licensee’s or permittee’s employees may fill, refill, and sell beer in a container other than the original container, otherwise known as a growler, subject to the requirements and restrictions provided in Iowa Code section 123.131 as amended by 2020 Iowa Acts, House File 2540, section 14; Iowa Code section 123.132; and this rule.

4.6(1) Definitions.

“*Beer*,” for the purposes of this rule, means “beer” as defined in Iowa Code section 123.3(7) and “high alcoholic content beer” as defined in Iowa Code section 123.3(22).

“*Growler*,” for the purposes of this rule, means any fillable and sealable glass, ceramic, plastic, aluminum, or stainless steel container designed to hold beer or high alcoholic content beer.

“*Original container*,” for the purposes of this rule, means a vessel containing beer that has been lawfully obtained and has been securely capped, sealed, or corked at the location of manufacture. For special class “A” beer permit holders, an “original container” includes a tank used for storing and serving beer.

4.6(2) *Filling and refilling requirements.*

- a. A growler shall have the capacity to hold no more than 72 ounces.
- b. A growler shall be filled or refilled only by the licensee or permittee or the licensee’s or permittee’s employees who are 18 years of age or older.
- c. A growler shall be filled or refilled only on demand by a consumer at the time of the sale.
- d. A growler shall be filled or refilled only with beer from the original container procured from a class “A” beer permittee unless the beer being used to fill or refill a growler on the premises of a special class “A” beer permit holder was manufactured by that special class “A” beer permit holder on the permitted premises.
- e. A retailer may exchange a growler to be filled or refilled.
- f. The filling or refilling of a growler shall at all times be conducted in compliance with applicable state and federal food safety statutes and regulations.

4.6(3) *Sealing requirements.* A filled or refilled growler shall be securely sealed at the time of the sale by the licensee or permittee or the licensee’s or permittee’s employees in the following manner:

- a. A growler shall bear a cap, lid, stopper, or plug.
- b. A plastic heat shrink wrap band, strip, or sleeve shall extend around the cap or lid or over the stopper or plug to form a seal that must be broken upon the opening of the growler. A lid permanently affixed with a can seamer shall not require a plastic heat shrink wrap band, strip, or sleeve.
- c. The heat shrink wrap seal shall be so secure that it is visibly apparent when the seal on a growler has been tampered with or a sealed growler has otherwise been reopened.
- d. A growler shall not be deemed an open container, subject to the requirements of Iowa Code sections 321.284 and 321.284A, provided the sealed growler is unopened and the seal has not been tampered with and the contents of the growler have not been partially removed.

4.6(4) *Restrictions.*

- a. A growler shall not be filled in advance of a sale.
- b. A growler filled pursuant to this rule shall not be delivered or direct-shipped to a consumer.
- c. A growler filled pursuant to this rule shall not be sold or otherwise distributed to a retailer.
- d. A licensee or permittee or a licensee’s or permittee’s employees shall not allow a consumer to fill or refill a growler.
- e. The filling, refilling and selling of a growler shall be limited to the hours in which alcoholic beverages may be legally sold.
- f. A filled or refilled growler shall not be sold to any consumer who is under legal age, intoxicated, or simulating intoxication.
- g. An original container shall only be opened on the premises of a class “C” beer permittee for the limited purposes of filling or refilling a growler as provided in this rule, or for a tasting in accordance with rule 185—16.7(123).
- h. A class “C” beer permittee shall only fill a growler at the time of an in-person sale.

4.6(5) *Violations.* Failure to comply with the requirements and restrictions of this rule shall subject the licensee or permittee to the penalty provisions provided in Iowa Code chapter 123.

This rule is intended to implement Iowa Code sections 123.123, 123.131, and 123.132.

[ARC 2382C, IAB 2/3/16, effective 3/9/16; ARC 2777C, IAB 10/12/16, effective 11/16/16; ARC 3928C, IAB 8/1/18, effective 9/5/18; ARC 5191C, IAB 9/23/20, effective 10/28/20]

185—4.7(123) Improper conduct.

4.7(1) *Illegality on premises.* No licensee, permittee, their agent or employee, shall engage in any illegal occupation or illegal act on the licensed premise.

4.7(2) Cooperation with law enforcement officers. No licensee, permittee, their agent or employee, shall refuse, fail or neglect to cooperate with any law enforcement officer in the performance of such officer's duties to enforce the provisions of the Act.

4.7(3) Illegal activities. No licensee, permittee, their agent or employee, shall knowingly allow in or upon the licensed premises any conduct as defined in Iowa Code sections 725.1, 725.2, 725.3, 728.2, 728.3 and 728.5.

4.7(4) Frequenting premises. No licensee, permittee, their agent or employee, shall knowingly permit the licensed premises to be frequented by, or become the meeting place, hangout or rendezvous for known pimps, panhandlers or prostitutes, or those who are known to engage in the use, sale or distribution of narcotics, or in any other illegal occupation or business.

4.7(5) Prohibited interest in business of licensee. Rescinded IAB 5/15/91, effective 6/19/91.

4.7(6) No licensee, permittee, its agents or employees, shall allow any filled, partially filled, or empty liquor glasses or liquor bottles, including miniature liquor bottles during the holiday season, to be taken off the licensed premises. However, unopened and opened containers and glasses of beer may be allowed to be taken off the licensed premises. A class "E" liquor control licensee, its agents or employees, shall not permit other liquor control licensees or consumers to remove partially filled, empty, open or unsealed containers of alcoholic liquor from the class "E" licensed premises.

4.7(7) Identifying markers. A licensee shall not keep on the licensed premises nor use for resale alcoholic liquor which does not bear identifying markers as prescribed by the administrator of this division. Identifying markers shall demonstrate that the alcoholic liquor was lawfully purchased from this division.

4.7(8) A licensee or permittee, or an agent or employee of a licensee or permittee, who sells, gives or otherwise supplies alcoholic liquor, wine or beer to a person 19 or 20 years old does not subject the license or permit to suspension or revocation. The division or the local authority shall not impose any administrative sanction, including license suspension or revocation, upon a licensee or permittee who is convicted of a violation of Iowa Code section 123.47A, nor shall administrative proceedings pursuant to Iowa Code chapter 17A and Iowa Code section 123.39 be commenced against a licensee or permittee for a violation of Iowa Code section 123.47A.

4.7(9) The holder of a class "E" liquor control license shall sell alcoholic liquor in original, sealed and unopened containers only for off-premises consumption.

This rule is intended to implement Iowa Code subsection 123.49(2).

185—4.8(123) Violation by agent, servant or employee. Any violation of the Act or the rules of the division by any employee, agent or servant of a licensee or permittee shall be deemed to be the act of the licensee or permittee and shall subject the license or permit of said licensee or permittee to suspension or revocation.

This rule is intended to implement Iowa Code sections 123.4 and 123.49(2).

185—4.9(123) Gambling evidence. The intentional possession or willful keeping of any gambling device, machine or apparatus as defined in Iowa Code section 99A.1 upon the premises of any establishment licensed by the division shall be prima facie evidence of a violation of Iowa Code section 123.49(2) "a" and subject the license of said licensee or permittee to suspension or revocation.

This rule is intended to implement Iowa Code sections 123.4 and 123.49.

185—4.10(123) Suppliers interest. Rescinded IAB 5/15/91, effective 6/19/91.

185—4.11(123) Filling and selling of wine and native wine in a container other than the original container. Class "C" liquor control licensees; class "B," class "B" native, and class "C" native wine permittees; and the licensee's or permittee's employees may fill, refill, and sell wine or native wine in a container other than the original container, otherwise known as a growler, subject to the requirements and restrictions provided in Iowa Code sections 123.178, 123.178A, and 123.178B as amended by 2020 Iowa Acts, House File 2540, sections 4, 5, 6, 7, 8, and 9, and in this rule.

4.11(1) Definitions.

“Growler,” for the purposes of this rule, means any fillable and sealable glass, ceramic, plastic, aluminum, or stainless steel container designed to hold wine or native wine.

“Native wine,” for the purposes of this rule, means wine manufactured in Iowa by fermentation of fruit, vegetables, dandelions, clover, honey, or any combination of these ingredients by a class “A” wine permittee.

“Original container,” for the purposes of this rule, means a vessel containing wine or native wine that has been lawfully obtained and has been securely capped, sealed, or corked at the location of manufacture.

“Wine,” for the purposes of this rule, means “wine” as defined in Iowa Code section 123.3(54).

4.11(2) Filling and refilling requirements.

- a. A growler shall have the capacity to hold no more than 72 ounces.
- b. A growler shall be filled or refilled only by the licensee or permittee or the licensee’s or permittee’s employees who are 18 years of age or older.
- c. A growler shall be filled or refilled only on demand by a consumer at the time of the sale.
- d. A growler shall be filled or refilled only with wine or native wine from the original container procured from a class “A” wine permittee.
- e. Class “B” native and class “C” native wine permittees shall fill a growler with only native wine.
- f. A retailer may exchange a growler to be filled or refilled.
- g. The filling or refilling of a growler shall at all times be conducted in compliance with applicable state and federal food safety statutes and regulations.

4.11(3) Sealing requirements. A filled or refilled growler shall be securely sealed at the time of the sale by the licensee or permittee or the licensee’s or permittee’s employees in the following manner:

- a. A growler shall bear a cap, lid, stopper, or plug.
- b. A plastic heat shrink wrap band, strip, or sleeve shall extend around the cap or lid or over the stopper or plug to form a seal that must be broken upon the opening of the growler. A lid permanently affixed with a can seamer shall not require a plastic heat shrink wrap band, strip, or sleeve.
- c. The heat shrink wrap seal shall be so secure that it is visibly apparent when the seal on a growler has been tampered with or a sealed growler has otherwise been reopened.
- d. A growler shall not be deemed an open container, subject to the requirements of Iowa Code sections 321.284 and 321.284A, provided the sealed growler is unopened and the seal has not been tampered with and the contents of the growler have not been partially removed.

4.11(4) Restrictions.

- a. A growler shall not be filled in advance of a sale.
- b. A growler filled pursuant to this rule shall not be delivered or direct-shipped to a consumer.
- c. A growler filled pursuant to this rule shall not be sold or otherwise distributed to a retailer.
- d. A licensee or permittee or a licensee’s or permittee’s employees shall not allow a consumer to fill or refill a growler.
- e. The filling, refilling, and selling of a growler shall be limited to the hours in which alcoholic beverages may be legally sold.
- f. A filled or refilled growler shall not be sold to any consumer who is under legal age, intoxicated, or simulating intoxication.
- g. An original container shall only be opened on the premises of a class “B” or class “B” native wine permittee for the limited purposes of filling or refilling a growler as provided in this rule, or for a tasting in accordance with rule 185—16.7(123).

4.11(5) Violations. Failure to comply with the requirements and restrictions of this rule shall subject the licensee or permittee to the penalty provisions provided in Iowa Code chapter 123.

This rule is intended to implement Iowa Code sections 123.172, 123.178, 123.178A, and 123.178B. [ARC 5191C, IAB 9/23/20, effective 10/28/20]

185—4.12(123) Display of license, permit, or signs. All licenses, permits or signs issued by the division shall be prominently displayed in full view on the licensed premises.

This rule is intended to implement Iowa Code sections 123.4 and 123.30.

185—4.13(123) Outdoor service. Any licensee or permittee having an outdoor, contiguous, discernible area on the same property on which their licensed establishment is located may serve the type of alcoholic liquor or beer permitted by the license or permit in the outdoor area. After a licensee or permittee satisfies the requirements of this rule, they may serve and sell beer or liquor in both their indoor licensed establishment and in their outdoor area at the same time because an outdoor area is merely an extension of their licensed premise and is not a transfer of their license. A licensee or permittee, prior to serving in the outdoor area, must file with this division:

1. A new diagram showing the discernible outdoor area.
2. A letter from licensee or permittee telling what dates the outdoor area will be used.
3. A letter from local authority approving the outdoor area.
4. A letter from the insurance and bonding companies acknowledging that the outdoor area is covered by the dramshop insurance policy and the bond.

This rule is intended to implement Iowa Code sections 123.3(20), 123.4 and 123.38.

185—4.14(123) Revocation or suspension by local authority. When the local authority revokes or suspends a beer permit, wine permit, or liquor control license, they shall notify the division in written form stating the reasons for the revocation or suspension and in the case of a suspension, the length of time of the suspension.

This rule is intended to implement Iowa Code sections 123.4 and 123.39.

185—4.15(123) Suspension of liquor control license, wine permit, or beer permit. At the time of the suspension of any license, wine permit, or beer permit by the division, there shall be placed, in a conspicuous place in the front door or window of the licensed establishment, a placard furnished by the division showing that the license or permit of that establishment has been suspended by the division and such placard shall also show the number of days and reason for the suspension. No licensee or permittee shall remove, alter, obscure or destroy said placard without the express written approval of the division.

This rule is intended to implement Iowa Code sections 123.4 and 123.39.

185—4.16(123) Cancellation of beer permits—refunds. A beer permittee, or the executor or administrator, may voluntarily surrender such permit to the division or to the local authority. When so surrendered to the division, the division will notify the local authority; state whether there is a complaint on file in the division office; and inquire if there are any complaints filed locally charging such permittee with violation of the laws that would make the permittee ineligible for a refund. When the permit is surrendered to the local authority, the local authority shall notify the division and inquire if there is a complaint on file with the division that would make the permittee ineligible for a refund. The local authority by itself, in the case of retail beer permits, shall make the refund on a quarterly use basis starting from the effective date of the permit. The local authority will complete, and send to the division, a cancellation certificate. The certificate is to be furnished by the division. The permit is to be attached to the cancellation certificate, if at all possible. The division must have all cancellations reported to them.

This rule is intended to implement Iowa Code sections 123.4 and 123.38.

185—4.17(123) Prohibited storage of alcoholic beverages and wine. No licensee shall permit alcoholic beverages and wine, purchased under authority of a retail license or retail permit, to be kept or stored upon any premises other than those licensed. However, under special circumstances, the administrator may authorize the storage of alcoholic beverages and wine on premises other than those covered by the license or permit. The administrator may allow class “D” liquor control licensees to

store alcoholic liquor and wine in a bonded warehouse to be used for consumption in Iowa, under the authority of a class “D” liquor control license.

This rule is intended to implement Iowa Code sections 123.4 and 123.21(11).

185—4.18(123) Transfer of license or permit to another location. A licensee or permittee cannot transfer to anyone else the right to use the liquor license, wine permit, or beer permit of the licensee or permittee; the right of transfer is merely an opportunity for a licensee or permittee to use the licensee’s or permittee’s liquor license, wine permit, or beer permit at a different location. A liquor license, wine permit, or a beer permit may only be transferred within the boundaries of the local authority which approved the license or permit.

4.18(1) *Permanent transfers.* A person may obtain an application for a permanent transfer from the local authority or the division. The application must be approved by the local authority and sent to the division prior to the transfer. An endorsement from the insurance company holding the dramshop policy listing the new address must be sent to the division prior to the transfer. When the above requirements are met, the division shall issue an amended license or permit showing the new permanent address.

4.18(2) *Temporary transfers.* If the transfer of a license or permit is for the purpose of accommodating a special event or circumstance temporary in nature, the minimum time of transfer is hereby set at 24 hours and transfer time shall not exceed seven days. A letter from the local authority granting the temporary transfer must be sent to the division. The insurance company holding the dramshop policy must be notified of any change of address.

This rule is intended to implement Iowa Code sections 123.4 and 123.38.

185—4.19(123) Execution and levy on alcoholic liquor, wine, and beer. Judgments or orders requiring the payment of money or the delivery of the possession of property may be enforced against liquor control licensees and beer and wine permittees by execution pursuant to the provisions of Iowa Code chapter 626, entitled “Executions.”

4.19(1) A secured party as defined in Iowa Code section 554.9105(1) “*m*” may take possession of and dispose of a liquor control licensee’s or permittee’s alcoholic liquor, wine, and beer in which the secured party has a security interest in such collateral pursuant to the provisions of Iowa Code chapter 554. The secured party may operate under the liquor control license or permit of its debtor as defined in Iowa Code section 554.9105(1) “*d*” for the purpose of disposing of the alcoholic liquor, wine, and beer. However, if the debtor is a class “E” liquor control licensee, the secured party may not purchase alcoholic liquor from the division to continue to operate its debtor’s business. A secured party operating under the liquor control license or permit of its debtor shall dispose of the alcoholic liquor, wine, and beer by sale only to persons authorized under Iowa Code chapter 123 to purchase alcoholic liquor, wine, and beer from the debtor. When a secured party takes possession of a liquor control licensee’s or permittee’s alcoholic liquor, wine, and beer, the secured party shall notify the division in writing of such action. A secured party shall further inform the division of the manner in which it intends to dispose of the alcoholic liquor, wine, and beer and shall state the reasonable length of time in which it intends to operate under the liquor control license or permit of its debtor. The secured party shall notify the division in writing when the disposition of its collateral has been completed, and the secured party shall cease operating under the liquor control license or permit of its debtor.

4.19(2) A sheriff or other officer acting pursuant to Iowa Code chapter 626 may take possession of a liquor control licensee’s or permittee’s alcoholic liquor, wine, and beer and may dispose of such inventory according to the provisions of Iowa Code chapter 626; however, the sheriff or other officer must sell the alcoholic liquor, wine and beer only to those persons authorized by Iowa Code chapter 123 to purchase alcoholic liquor, wine, and beer from the liquor control licensee whose inventory is subject to the execution and levy. The sheriff or other officer shall notify the division in writing at the time the sheriff or officer takes possession of a liquor control licensee’s or permittee’s alcoholic liquor, wine, and beer and shall further notify the division of the time and place of the sale of such property.

This rule is intended to implement Iowa Code sections 123.4, 123.21(3), and 123.38.

185—4.20(123) Liquor store checks accepted. The Iowa state liquor stores and the division may accept checks from holders of a retail liquor control license, including a class “E” licensee, under the following conditions:

1. The check must be either the personal check of the licensee or the business check of the licensee. The business check must be the named establishment on the license and cannot be a check on another business owned or operated by the licensee.

2. The check must be signed by the licensee. (For all holders of liquor control licenses this is interpreted as those persons whose authorized signatures are on file with the bank for the licensee’s account). However, this does not preclude an agent of the licensee from presenting a check signed by the licensee in the normal transaction of buying liquor.

3. Traveler’s checks and bank drafts, signed by the licensee, will be accepted.

4. Personal checks or traveler’s checks may be accepted as payment for purchases in state liquor stores. Second party checks shall not be accepted as payment for purchases in state liquor stores. Vendors shall follow the policy established by the administrator of the division for accepting personal checks and traveler’s checks for the purchase of alcoholic beverages.

4.20(1) If a licensee presents this division with a check which is subsequently dishonored by the licensee’s bank, the administrator of this division shall cause a written notice of nonpayment and penalty to be served upon the licensee. If the licensee fails to satisfy the obligation within ten days after service of the notice, the administrator or designee shall hold a hearing as in other contested cases pursuant to Iowa Code chapter 17A to determine whether or not the licensee failed to satisfy the obligation within ten days after service of the notice of nonpayment and penalty. If the administrator determines that the licensee has failed to satisfy the obligation, after notice and an opportunity to be heard, the administrator shall suspend the licensee’s liquor control license for a period of not less than 3 and not more than 30 days.

4.20(2) A retail liquor establishment which tenders the division one insufficient funds check for the purchase of alcoholic liquor will lose its check-writing privilege for 90 days from the date the establishment pays the division even though the division does not suspend the liquor license because the establishment paid the division within the 10-day demand period. A retail liquor establishment which tenders the division more than one insufficient funds check for the purchase of alcoholic liquor will lose its check-writing privilege for 180 days from the date the establishment pays the division even though the division does not suspend the liquor license because the establishment paid the division within the 10-day demand period.

During the period that a licensee may not tender checks to the state liquor stores or this division in payment for alcoholic liquor, state liquor stores and this division may accept from the licensee: cash, money order payable to the division for the amount of the purchase, bank cashier’s check signed by a bank official and made payable to the division for the amount of the purchase, or the licensee’s personal or business check made payable to the division for the amount of the purchase which has been certified by the bank on which the check is drawn.

4.20(3) The division may collect from the licensee a \$10 fee for each dishonored check tendered to the division by a licensee for the purchase of alcoholic beverages.

4.20(4) The division may accept from the general public for alcoholic beverages traveler’s checks issued in a foreign country if payment is in U.S. dollars.

4.20(5) The division may require, at the discretion of the administrator, that a licensee submit a letter of credit in a reasonable amount to be determined by the administrator for future purchases of alcoholic liquor from the division, when a licensee tenders to the division a check which is subsequently dishonored by the bank on which the check is drawn if the licensee fails to satisfy the obligation within ten days after service of notice of nonpayment and penalty.

This rule is intended to implement Iowa Code sections 123.4 and 123.24.

185—4.21(123) Where retailers must purchase wine. Retail licensees and retail permittees must purchase their wine from either a wine wholesaler or a wine and beer wholesaler. Retail licensees and retail permittees cannot buy wine from other retailers.

This rule is intended to implement Iowa Code subsections 123.30(3) and 123.178(3).

185—4.22(123) Liquor on licensed premises. Holders of liquor control licenses must purchase their liquor supplies from state liquor stores.

4.22(1) Exception to the above requirement. “Bona fide conventions or meetings” may bring their own legal liquor onto licensed premises under the following conditions:

a. “Bona fide conventions or meetings” shall be construed to mean an identifiable body of persons gathered together in furtherance of a specific common purpose or cause, whether political, fraternal, or business, including but not limited to structured club meetings and conventions, professional association functions, employer-employee gatherings and political dinners. Neither the mere purchase nor consumption of liquor nor the purchase of an admission ticket shall be deemed to create a specific common purpose or cause.

b. Liquor may be brought onto the licensed premises at a bona fide convention or meeting by either the sponsoring entity or the individuals comprising that entity.

c. Consumption or dispensation of liquor brought onto the licensed premises by a bona fide convention or meeting must be confined to the meeting place or convention rooms within the licensed premises.

d. The liquor must be served to the delegates or guests without cost.

e. At the completion of the convention or meeting, all liquor brought onto the licensed premises by the members of the convention or meeting must be removed from the licensed premises by those members.

f. All other laws and rules governing the license shall apply to dispensing and consumption of liquor at bona fide conventions or meetings, including hours for consumption and Sunday sales.

4.22(2) Reserved.

This rule is intended to implement Iowa Code sections 123.30, 123.46, and 123.95.

185—4.23(123) Liquor on unlicensed places. Liquor may be kept and consumed but not sold on unlicensed places under the following conditions:

4.23(1) Liquor may be kept and consumed in a private home at any time.

4.23(2) Liquor may be kept and consumed, by the guests or residents, in the residential or sleeping quarters of a hotel or motel at any time. This is considered as an extension of the private home.

4.23(3) Liquor may be consumed at a private social gathering in a private place at any time.

4.23(4) A private place is a location which meets all of the following criteria:

a. One to which the general public does not have access at the time the liquor is kept, dispensed or consumed; one at which the attendees are limited to the bona fide social hosts and invited guests.

b. One which is not of a commercial nature at the time the liquor is consumed or dispensed at the location.

c. One where goods or services are neither sold nor purchased at the time the liquor is consumed or dispensed at the location.

d. One where the use of the location was obtained without charges or rent or any other thing of value was exchanged for its use.

e. One which is not a licensed premises.

f. One where no admission fees or other kinds of entrance fees, fare, ticket, donation or charges are made or are required of the invited guests to enter the location.

This rule is intended to implement Iowa Code section 123.95.

185—4.24(123) Alcoholic liquor and wine on beer permit premises. Rescinded ARC 3928C, IAB 8/1/18, effective 9/5/18.

185—4.25(123) Age requirements. Persons 21 years of age or older may hold a liquor license, wine permit, or beer permit; however, persons who are between the ages of 18 and 21 and hold a liquor license, wine permit, or beer permit before September 1, 1986, are not affected by or subject to this rule, and may hold such license or permit even though the licensee or permittee has not attained the age of 21. Persons 18 years of age and older may be bartenders, waiters, waitresses, and may handle alcoholic beverages, wine, and beer during the course of the person's employment for a licensee or permittee in establishments in which alcoholic beverages, wine, and beer are consumed. Persons 16 years of age and older may sell beer and wine in off-premises beer and wine establishments. Persons must be 18 years of age or older to work in a state liquor store.

This rule is intended to implement Iowa Code sections 123.30, 123.47A and 123.49.

185—4.26(123) Timely filed status.

4.26(1) In addition to the requirements which may be imposed by a local authority upon the holder of an alcoholic beverages license or permit to obtain timely filed status of a renewal application, the division may grant timely filed status if the applicant complies with the following conditions:

a. The applicant files a completed application with the local authority or the division as required by applicable law.

b. The applicant files a current dram shop liability certificate with the local authority or the division if proof of dram shop liability is required as a condition precedent to the issuance of the license or permit.

c. The applicant pays the appropriate license or permit fee in full to the local authority or the division as required by applicable law.

d. The applicant files a bond with the local authority or the division if a bond is required as a condition precedent to the issuance of the license or permit under applicable law.

4.26(2) Timely filed status allows the holder of the license or permit to continue to operate under a license or permit after its expiration and until the local authority and the division have finally determined whether the license or permit should be issued. If the application for the license or permit is denied, timely filed status continues until the last day for seeking judicial review of the division's action.

4.26(3) An applicant for a new alcoholic beverages license or permit may not sell alcoholic liquor, wine or beer in the proposed establishment until a license or permit has been granted by the division.

This rule is intended to implement Iowa Code sections 123.32, 123.35 and 17A.18.

185—4.27(123) Effect of suspension. Subject to the right to convey a suspended establishment under Iowa Code section 123.39, no beer, wine, or liquor can be sold or consumed in an establishment during a suspension period. An establishment may be open during a suspension period to conduct lawful business other than the sale of liquor, wine, and beer as long as no liquor, wine, or beer is sold or consumed during the suspension period.

This rule is intended to implement Iowa Code section 123.39.

185—4.28(123) Use of establishment during hours alcoholic liquor, wine, and beer cannot be consumed. No one, including licensee, permittee, and employees can consume beer, wine, or alcoholic beverages in their licensed establishment during hours which beer, wine, and alcoholic beverages cannot be sold. An establishment covered by a liquor license, wine permit, or beer permit can be used as a restaurant or any other lawful purpose during hours which beer, wine, or alcoholic liquor cannot be sold as long as beer, wine, or alcoholic beverages are not consumed during these hours.

This rule is intended to implement Iowa Code section 123.49.

185—4.29 Rescinded, effective 7/1/85.

185—4.30(123) Persons producing fuel alcohol. Persons producing fuel alcohol for their own use or to be sold commercially do not have to obtain a license or permit from the division.

This rule is intended to implement Iowa Code sections 123.4 and 123.41.

185—4.31(123) Storage of beer. No retail liquor licensee or retail beer permittee shall store beer except on premises licensed for retail sale and then only to the extent that the beer is intended for sale to consumers from the individually licensed premises where stored. The adoption of this rule shall not preclude a retail liquor licensee or a retail beer permittee from picking up beer from class “A” and “F” beer permittees and directly transporting the beer to the retail establishment where the beer is intended to be sold at retail.

This rule is intended to implement Iowa Code section 123.21.

185—4.32(123) Delivery of alcoholic liquor. Individuals who do not work for this division may operate a delivery service in which they will charge licensees a fee for picking up their alcoholic liquor orders at this division’s liquor stores and delivering it to their establishments.

This rule is intended to implement Iowa Code sections 123.4 and 123.21(10).

185—4.33(123) Delivery of beer and wine. Licensees and permittees who hold a license or permit which allows them to sell bottled wine and bottled beer may deliver beer and wine to residences if the customers telephoned and requested that the beer and wine be delivered.

This rule is intended to implement Iowa Code subsection 123.21(10).

185—4.34(123) Determination of population. Decennial Censuses and Special Censuses done by the U.S. Census Bureau are recognized as being the official population of a town for the purpose of deciding the price of licenses and permits in that town, but estimates done by the U.S. Census Bureau cannot be viewed as being the official population when deciding the price of licenses and permits.

This rule is intended to implement Iowa Code subsection 123.21(11).

185—4.35(123) Minors in licensed establishments. Because Iowa law does not prohibit minors from being in licensed establishments, a minor can be in a licensed establishment if local authority does not have a local ordinance prohibiting minors from being in licensed establishments in its jurisdiction.

This rule is intended to implement Iowa Code subsection 123.21(5).

185—4.36(123) Sale of alcoholic liquor and wine stock when licensee or permittee sells business. When a licensee or permittee goes out of business, the licensee or permittee may sell the licensee’s or permittee’s stock of alcoholic liquor and wine to the person who is going to operate a licensed establishment in the same location.

This rule is intended to implement Iowa Code subsection 123.21(5).

185—4.37(123) Business as usual on election days. Licensees and permittees may sell alcoholic liquor, wine, or beer during regular hours on days local and national elections are held because present Iowa law does not restrict the sale of liquor, wine, and beer on election days.

This rule is intended to implement Iowa Code subsection 123.21(3).

185—4.38(123) Sunday sale of wine. A holder of a class “B” wine permit or combination retail wine license, excluding any liquor control licensee or beer permittee which does not qualify for Sunday sales under Iowa Code sections 123.36(6) and 123.134(5), respectively, may sell wine for consumption off the premises between the hours of 10 a.m. and 12 midnight on Sundays. No fee shall be imposed for that privilege.

This rule is intended to implement Iowa Code subsection 123.49(2).

185—4.39(123) Intoxication notice. Rescinded IAB 8/18/93, effective 7/29/93.

185—4.40(123) Warehousing of beer and wine. A person holding a class “A” wine permit or a class “A” or “F” beer permit shall warehouse their wine or beer inventory within the state of Iowa. Persons issued a class “A” wine permit or class “A” or “F” beer permit prior to June 10, 1987, shall comply upon

renewal or November 1, 1987, whichever date occurs first. A warehouse of a person holding a class “A” wine permit or a class “A” or “F” beer permit shall be considered a licensed premises.

This rule is intended to implement Iowa Code section 123.127.

185—4.41(123) Vending machines to dispense alcoholic beverages prohibited. A liquor control licensee or beer or wine permittee shall not install or permit the installation of vending machines on the licensed premises for the purpose of selling, dispensing or serving alcoholic beverages. A vending machine is defined as a slug, coin, currency or credit card operated mechanical device used for dispensing merchandise, including single cans of beer or other alcoholic beverages, and includes a mechanical device operated by remote control and used for dispensing single cans of beer or other alcoholic beverages. A vending machine is not a unit installed in individual hotel or motel rooms used for the storage of alcoholic beverages and intended for the personal use of hotel or motel guests within the privacy of the guests’ rooms.

This rule is intended to implement Iowa Code sections 123.47, 123.47A, 123.49(1), 123.49(2) “b,” 123.49(2) “h,” and 123.49(2) “k.”

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¹ Effective date of 4.32 delayed seventy days by the Administrative Rules Review Committee on 8/2/83.

² Two ARCs. See Alcoholic Beverages Division in IAB.

CHAPTER 9
PERSONAL IMPORTATION OF ALCOHOLIC LIQUOR, WINE, AND BEER

185—9.1(123) Tax liability. The division makes no judgment or decision regarding any tax liability resulting from the personal importation of alcoholic liquor, wine, or beer as provided in Iowa Code section 123.10, 123.22, 123.171, or 123.122, as applicable.

[ARC 3994C, IAB 9/12/18, effective 10/17/18; ARC 5192C, IAB 9/23/20, effective 10/28/20]

185—9.2(123) Personal importation in excess of the amounts provided—waiver. The administrator may provide for the issuance of a waiver for an individual of legal age desiring to import alcoholic liquor, wine, or beer in excess of the amounts provided in Iowa Code section 123.22, 123.171, or 123.122. The decision on whether the circumstances justify the issuance of a waiver shall be made at the discretion of the administrator upon consideration of all the relevant factors.

9.2(1) Criteria. The division may, in response to a completed request, issue a waiver, as applied to the circumstances of a specific situation if the division finds each of the following:

- a. The requester is an individual of legal age;
- b. The requester is an individual who was domiciled outside the state within one year of the request;
- c. The alcoholic liquor, wine, or beer imported pursuant to the waiver shall be only for personal consumption in a private home or other private accommodation and only if it is not sold, exchanged, bartered, dispensed, or given in consideration of purchase for any property or services or in evasion of the requirements of Iowa Code chapter 123; and
- d. The alcoholic liquor, wine, or beer imported pursuant to the waiver shall be in unopened original containers.

9.2(2) Domicile. Domicile, for the purposes of establishing when an individual is “domiciled outside the state,” shall be determined in accordance with rule 701—38.17(422).

9.2(3) Request. All requests for a waiver to import alcoholic liquor, wine, or beer in excess of the amount provided in Iowa Code section 123.22, 123.171, or 123.122 shall be submitted in writing by completing a request for import authorization form and returning it to the division, as instructed.

9.2(4) Content of form. A request for import authorization form shall be prescribed by the division and shall include the following information: the name, date of birth, and personal contact information of the requester; full residential history of the requester for the past three years without gaps; a statement of reasons that the requester believes will justify import authorization; the destination address for the imported alcoholic beverages; the name, date of birth, and personal contact information of the recipient of the alcoholic beverages, if different from that of the requester; a detailed inventory of the alcoholic beverages for which the requester seeks import authorization; and any other information the administrator may require.

9.2(5) Burden of persuasion. When a request is filed for a waiver pursuant to this rule, the burden of persuasion shall be on the requester to demonstrate by clear and convincing evidence that the division should exercise its discretion in the granting of the waiver.

9.2(6) Notice. The division shall acknowledge a request for a waiver upon receipt of a completed request for import authorization form.

9.2(7) Additional information. Prior to granting or denying a request for a waiver, the division may request additional information from the requester relative to the request and surrounding circumstances.

9.2(8) Investigation. The division may conduct an investigation as the administrator deems necessary to determine that the requester meets the criteria in subrule 9.2(1) or to verify the accuracy of the information provided by the requester.

9.2(9) Ruling. A letter granting or denying a request for a waiver to import alcoholic liquor, wine, or beer in excess of the amount provided in Iowa Code section 123.22, 123.171, or 123.122 shall be in writing and shall contain a description of the precise scope and duration of the waiver if one is issued.

9.2(10) *Duration of waiver.* A waiver issued pursuant to this rule shall allow only for the importation of the inventory of alcoholic beverages detailed on the request for import authorization form. If a waiver is granted, there is no automatic right to renewal.

9.2(11) *Public availability.* The division shall maintain a record of all waivers granted or denied under this rule. All rulings in response to requests for waivers shall be indexed and available to members of the public at the Alcoholic Beverages Division, 1918 S.E. Hulsizer Road, Ankeny, Iowa 50021. Waivers containing information that the division is authorized or required to keep confidential shall be edited prior to public inspection.

9.2(12) *Cancellation.* A waiver issued by the division pursuant to this rule may be withdrawn, canceled, or modified if, after appropriate notice, the division finds any of the following:

a. The requester of the waiver withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or

b. The recipient of the waiver has failed to comply with any of the conditions contained in the waiver.

9.2(13) *Violations.* Violation of a condition in a waiver is equivalent to a violation of Iowa Code section 123.10, 123.22, 123.171, or 123.122, as applicable. The recipient of a waiver under this rule who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the applicable Iowa Code section.

9.2(14) *Defense.* After the division grants a waiver under this rule, the waiver is a defense within its terms and the specific facts indicated therein for the recipient of the waiver in any proceedings in which the waiver in question is sought to be invoked.

9.2(15) *Appeals.* Granting or denying a request for a waiver is final agency action under Iowa Code chapter 17A.

[ARC 3994C, IAB 9/12/18, effective 10/17/18; ARC 5192C, IAB 9/23/20, effective 10/28/20]

These rules are intended to implement Iowa Code sections 123.10, 123.22, 123.59, 123.22, and 123.171.

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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 ADMINISTRATION

1.1(502,505)	Definitions
1.2(502,505)	Mission
1.3(502,505)	General course and method of operations
1.4(502,505)	Contact information and business hours
1.5(502,505)	Information, forms, and requests
1.6(502,505)	Organization
1.7(505)	Service of process

CHAPTER 2 PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

2.1(17A,22)	Statement of policy
2.2(17A,22)	Definitions
2.3(17A,22)	General provisions
2.4(17A,22)	Requests for access to records
2.5(17A,22)	Access to confidential records
2.6(17A,22)	Requests for confidential treatment
2.7(17A,22)	Procedure by which additions, dissents, or objections may be entered into certain records
2.8(17A,22)	Disclosures without the consent of the subject
2.9(17A,22)	Consent to disclosure by the subject of a confidential record
2.10(17A,22)	Notice to suppliers of information
2.11(17A,22)	Personally identifiable information collected by the division
2.12(17A,22)	Confidential records

CHAPTER 3 CONTESTED CASES

3.1(17A)	Scope and applicability
3.2(17A)	Definitions
3.3(17A)	Time requirements
3.4(17A)	Requests for contested case proceeding
3.5(17A,507B)	Commencement of hearing; service; delivery; notice of hearing; answer
3.6(17A)	Presiding officer
3.7(17A)	Waiver of procedures
3.8(17A)	Telephone, video, or electronic proceedings
3.9(17A)	Disqualification
3.10(17A)	Consolidation—severance
3.11	Reserved
3.12(17A)	Service and filing of pleadings and other papers
3.13(17A)	Discovery
3.14(17A,505)	Subpoenas
3.15(17A)	Motions
3.16(17A)	Prehearing conference
3.17(17A)	Continuances
3.18(17A)	Withdrawals
3.19(17A,507B)	Intervention
3.20(17A)	Hearing procedures

3.21(17A,507B)	Evidence
3.22(17A)	Default
3.23(17A)	Ex parte communication
3.24(17A)	Recording costs
3.25(17A)	Interlocutory appeals
3.26(17A)	Final decision
3.27(17A)	Appeals and review by the commissioner of proposed decisions
3.28(17A)	Applications for rehearing
3.29(17A)	Stay of division action
3.30(17A)	No factual dispute contested cases
3.31(17A)	Emergency adjudicative proceedings
3.32(502,505,507B)	Summary cease and desist orders
3.33(17A,502,505)	Informal settlement

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING, WAIVER OF RULES,
AND DECLARATORY ORDERS

DIVISION I
AGENCY PROCEDURE FOR RULE MAKING

4.1(17A)	Applicability
4.2(17A)	Definitions
4.3(17A)	Severability
4.4(17A)	Public rule-making docket
4.5(17A)	Rule making
4.6(17A)	Differences between adopted rule and rule proposed in Notice of Intended Action
4.7(17A)	Petition for rule making
4.8 to 4.20	Reserved

DIVISION II
WAIVER OF RULES

4.21(17A)	Waivers
4.22(17A)	Petition for waiver
4.23(17A)	Waiver hearing procedures and ruling
4.24 to 4.36	Reserved

DIVISION III
DECLARATORY ORDERS

4.37(17A)	Petition for declaratory order
4.38(17A)	Notice of petition
4.39(17A)	Intervention
4.40(17A)	Briefs
4.41(17A)	Inquiries
4.42(17A)	Service and filing of petitions and other papers
4.43(17A)	Consideration
4.44(17A)	Action on petition
4.45(17A)	Refusal to issue order
4.46(17A)	Contents of declaratory order—effective date
4.47(17A)	Copies of orders
4.48(17A)	Effect of a declaratory order

REGULATION OF INSURERS

CHAPTER 5

REGULATION OF INSURERS—GENERAL PROVISIONS

- 5.1(507) Examination reports
- 5.2(505,507) Examination for admission
- 5.3(507,508,515) Submission of quarterly financial information
- 5.4(505,508,515,520) Surplus notes
- 5.5(505,515,520) Maximum allowable premium volume
- 5.6(505,515,520) Treatment of various items on the financial statement
- 5.7(505) Ordering withdrawal of domestic insurers from states
- 5.8(505) Monitoring
- 5.9(505) Rate and form filings
- 5.10(511) Life companies—permissible investments
- 5.11(511) Investment of funds
- 5.12(515) Collateral loans
- 5.13(508,515) Loans to officers, directors, employees, etc.
- 5.14 Reserved
- 5.15(508,512B,514,514B,515,520) Accounting practices and procedures manual and annual statement instructions
- 5.16 to 5.19 Reserved
- 5.20(508) Computation of reserves

UNEARNED PREMIUM RESERVES ON MORTGAGE GUARANTY INSURANCE POLICIES

- 5.21(515C) Unearned premium reserve factors
- 5.22(515C) Contingency reserve
- 5.23(507C) Standards
- 5.24(507C) Commissioner's authority
- 5.25 Reserved
- 5.26(508,515) Participation in the NAIC Insurance Regulatory Information System
- 5.27(508,515,520) Asset valuation
- 5.28(508,515,520) Risk-based capital and surplus
- 5.29(508,515) Actuarial certification of reserves
- 5.30(515) Single maximum risk—fidelity and surety risks
- 5.31(515) Reinsurance contracts
- 5.32(511,515) Investments in medium grade and lower grade obligations
- 5.33(510) Credit for reinsurance
- 5.34(508) Actuarial opinion and memorandum
- 5.35 to 5.39 Reserved
- 5.40(515) Premium tax
- 5.41(508) Tax on gross premiums—life companies
- 5.42(432) Cash refund of premium tax
- 5.43(510) Managing general agents

DISCLOSURE OF MORTGAGE LOAN APPLICATIONS

- 5.44 to 5.49 Reserved
- 5.50(535A) Purpose
- 5.51(535A) Definitions
- 5.52(535A) Filing of reports
- 5.53(535A) Form and content of reports
- 5.54(535A) Additional information required
- 5.55(535A) Written complaints

CHAPTER 6
ORGANIZATION OF DOMESTIC INSURANCE COMPANIES

6.1(506)	Definitions
6.2(506)	Promoters contributions
6.3(506)	Escrow
6.4(506)	Alienation
6.5(506)	Sales to promoters
6.6(506)	Options
6.7(506)	Qualifications of management
6.8(506)	Chief executive
6.9(506)	Directors

CHAPTER 7
DOMESTIC STOCK INSURERS PROXIES

PROXY REGULATIONS

7.1(523)	Application of regulation
7.2(523)	Proxies, consents and authorizations
7.3(523)	Disclosure of equivalent information
7.4(523)	Definitions
7.5(523)	Information to be furnished to stockholders
7.6(523)	Requirements as to proxy
7.7(523)	Material required to be filed
7.8(523)	False or misleading statements
7.9(523)	Prohibition of certain solicitations
7.10(523)	Special provisions applicable to election contests

SCHEDULE A
INFORMATION REQUIRED IN PROXY STATEMENT

SCHEDULE B
INFORMATION TO BE INCLUDED IN STATEMENTS FILED BY OR ON BEHALF
OF A PARTICIPANT (OTHER THAN THE INSURER) IN A PROXY SOLICITATION
IN AN ELECTION CONTEST

POLICYHOLDER PROXY SOLICITATION

7.11(523)	Application
7.12(523)	Conditions—revocation
7.13(523)	Filing proxy
7.14(523)	Solicitation by agents—use of funds
7.15 to 7.19	Reserved

STOCK TRANSACTION REPORTING

7.20(523)	Statement of changes of beneficial ownership of securities
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CHAPTER 8
BENEVOLENT ASSOCIATIONS

8.1 and 8.2	Reserved
8.3(512A)	Organization
8.4(512A)	Membership
8.5(512A)	Fees, dues and assessments
8.6(512A)	Reserve fund
8.7(512A)	Certificates
8.8(512A)	Beneficiaries
8.9(512A)	Mergers
8.10(512A)	Directors and officers

- 8.11(512A) Stockholders
- 8.12(512A) Bookkeeping and accounts

CHAPTER 9

Reserved

INSURANCE PRODUCERS

CHAPTER 10

INSURANCE PRODUCER LICENSES AND LIMITED LICENSES

- 10.1(522B) Purpose and authority
- 10.2(522B) Definitions
- 10.3(522B) Requirement to hold a license
- 10.4(522B) Licensing of resident producers
- 10.5(522B) Licensing of nonresident producers
- 10.6(522B) Issuance of license
- 10.7(522B) License lines of authority
- 10.8(522B) License renewal
- 10.9(522B) License reinstatement
- 10.10(522B) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance
- 10.11(522B) Temporary licenses
- 10.12(522B) Change in name, address or state of residence
- 10.13(522B) Reporting of actions
- 10.14(522B) Commissions and referral fees
- 10.15(522B) Appointments
- 10.16(522B) Appointment renewal
- 10.17(522B) Appointment terminations
- 10.18(522B) Licensing of a business entity
- 10.19(522B) Use of senior-specific certifications and professional designations in the sale of life insurance and annuities
- 10.20(522B) Violations and penalties
- 10.21(252J,272D) Suspension for failure to pay child support or state debt
- 10.22 and 10.23 Reserved
- 10.24(522B) Administration of examinations
- 10.25(522B) Forms
- 10.26(522B) Fees
- 10.27 to 10.50 Reserved
- 10.51(522A,522E) Limited licenses

CHAPTER 11

CONTINUING EDUCATION FOR
INSURANCE PRODUCERS

- 11.1(505,522B) Statutory authority—purpose—applicability
- 11.2(505,522B) Definitions
- 11.3(505,522B) Continuing education requirements for producers
- 11.4(505,522B) Proof of completion of continuing education requirements
- 11.5(505,522B) Course approval
- 11.6(505,522B) Topic guidelines
- 11.7(505,522B) CE course renewal
- 11.8(505,522B) Appeals
- 11.9(505,522B) CE provider approval
- 11.10(505,522B) CE provider's responsibilities

- 11.11(505,522B) Prohibited conduct—CE providers
- 11.12(505,522B) Outside vendor
- 11.13(505,522B) CE course audits
- 11.14(505,522B) Fees and costs

CHAPTER 12
PORT OF ENTRY REQUIREMENTS

- 12.1(508,515) Purpose
- 12.2(508,515) Trust and other admission requirements
- 12.3(508,515) Examination and preferred supervision
- 12.4(508,515) Surplus required
- 12.5(508,515) Investments

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

- 13.1(505,522B) Purpose and authority
- 13.2(505,522B) Definitions
- 13.3(505,522B) Requirement for prohibited persons to obtain consent
- 13.4(505,522B) Applications for consent
- 13.5(505,522B) Consideration of applications for consent
- 13.6(505,522B) Review of application by the division
- 13.7(505,522B) Consent effective for specified positions and responsibilities only
- 13.8(505,522B) Change in circumstances
- 13.9(505,522B) Burden of proof
- 13.10(505,522B) Violations and penalties

UNFAIR TRADE PRACTICES

CHAPTER 14
LIFE INSURANCE ILLUSTRATIONS MODEL REGULATION

- 14.1(507B) Purpose
- 14.2(507B) Authority
- 14.3(507B) Applicability and scope
- 14.4(507B) Definitions
- 14.5(507B) Policies to be illustrated
- 14.6(507B) General rules and prohibitions
- 14.7(507B) Standards for basic illustrations
- 14.8(507B) Standards for supplemental illustrations
- 14.9(507B) Delivery of illustration and record retention
- 14.10(507B) Annual report; notice to policyowners
- 14.11(507B) Annual certifications
- 14.12(507B) Penalties
- 14.13(507B) Separability
- 14.14(507B) Effective date

CHAPTER 15
UNFAIR TRADE PRACTICES

DIVISION I
SALES PRACTICES

- 15.1(507B) Purpose
- 15.2(507B) Definitions
- 15.3(507B) Advertising
- 15.4(507B) Life insurance cost and benefit disclosure requirements

15.5(507B)	Health insurance sales to individuals 65 years of age or older
15.6	Reserved
15.7(507B)	Twisting prohibited
15.8(507B)	Producer responsibilities
15.9(507B)	Right to return a life insurance policy or annuity (free look)
15.10(507B)	Uninsured/underinsured automobile coverage—notice required
15.11(507B)	Unfair discrimination
15.12(507B)	Testing restrictions of insurance applications for the human immunodeficiency virus
15.13(507B)	Records maintenance
15.14(505,507B)	Enforcement section—cease and desist and penalty orders
15.15 to 15.30	Reserved

DIVISION II
CLAIMS

15.31(507B)	General claims settlement guidelines
15.32(507B)	Prompt payment of certain health claims
15.33(507B)	Audit procedures for medical claims
15.34 to 15.40	Reserved
15.41(507B)	Claims settlement guidelines for property and casualty insurance
15.42(507B)	Acknowledgment of communications by property and casualty insurers
15.43(507B)	Standards for settlement of automobile insurance claims
15.44(507B)	Standards for determining replacement cost and actual cost values
15.45(507B)	Guidelines for use of aftermarket crash parts in motor vehicles
15.46 to 15.50	Reserved

DIVISION III

DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

15.51(507B)	Purpose
15.52(507B)	Definition
15.53(507B)	Exemptions
15.54(507B)	Disclosure requirements
15.55(507B)	Insurer duties
15.56 to 15.60	Reserved

DIVISION IV

ANNUITY DISCLOSURE REQUIREMENTS

15.61(507B)	Purpose
15.62(507B)	Applicability and scope
15.63(507B)	Definitions
15.64(507B)	Standards for the disclosure document and Buyer's Guide
15.65(507B)	Content of disclosure documents
15.66(507B)	Standards for annuity illustrations
15.67(507B)	Report to contract owners
15.68(507B)	Penalties
15.69(507B)	Severability
15.70 and 15.71	Reserved

DIVISION V

SUITABILITY IN ANNUITY TRANSACTIONS

15.72(507B)	Purpose
15.73(507B)	Applicability and scope
15.74(507B)	Definitions
15.75(507B)	Duties of insurers and producers
15.76(507B)	Producer training

- 15.77(507B) Compliance; mitigation; penalties; enforcement
- 15.78(507B) Record keeping
- 15.79 Reserved

DIVISION VI
INDEXED PRODUCTS TRAINING REQUIREMENT

- 15.80(507B,522B) Purpose
- 15.81(507B,522B) Definitions
- 15.82(507B,522B) Special training required
- 15.83(507B,522B) Conduct of training course
- 15.84(507B,522B) Insurer duties
- 15.85(507B,522B) Verification of training
- 15.86(507B,522B) Penalties
- 15.87(507B,522B) Compliance date

CHAPTER 16
REPLACEMENT OF LIFE INSURANCE AND ANNUITIES

DIVISION I

- 16.1 to 16.20 Reserved

DIVISION II

- 16.21(507B) Purpose
- 16.22(507B) Definitions
- 16.23(507B) Exemptions
- 16.24(507B) Duties of producers
- 16.25(507B) Duties of all insurers that use producers on or after January 1, 2001
- 16.26(507B) Duties of replacing insurers that use producers
- 16.27(507B) Duties of the existing insurer
- 16.28(507B) Duties of insurers with respect to direct-response solicitations
- 16.29(507B) Violations and penalties
- 16.30(507B) Severability

CHAPTER 17
LIFE AND HEALTH REINSURANCE AGREEMENTS

- 17.1(508) Authority and purpose
- 17.2(508) Scope
- 17.3(508) Accounting requirements
- 17.4(508) Written agreements
- 17.5(508) Existing agreements

CHAPTERS 18 and 19
Reserved

PROPERTY AND CASUALTY INSURANCE

CHAPTER 20
PROPERTY AND CASUALTY INSURANCE

DIVISION I
FORM AND RATE REQUIREMENTS

- 20.1(505,509,514A,515,515A,515F) General filing requirements
- 20.2(505) Objection to filing
- 20.3 Reserved
- 20.4(505,509,514A,515,515A,515F) Policy form filing
- 20.5(515A) Rate or manual rule filing
- 20.6(515A) Exemption from filing requirement

20.7	Reserved
20.8(515F)	Rate filings for crop-hail insurance
20.9 and 20.10	Reserved
20.11(515)	Exemption from form and rate filing requirements
20.12 to 20.40	Reserved

DIVISION II
IOWA FAIR PLAN ACT

20.41(515,515F)	Purpose
20.42(515,515F)	Scope
20.43(515,515F)	Definitions
20.44(515,515F)	Eligible risks
20.45(515,515F)	Membership
20.46(515,515F)	Administration
20.47(515,515F)	Duties of the governing committee
20.48(515,515F)	Annual and special meetings
20.49(515,515F)	Application for insurance
20.50(515,515F)	Inspection procedure
20.51(515,515F)	Procedure after inspection and receipt of application
20.52(515,515F)	Reasonable underwriting standards for property coverage
20.53(515,515F)	Reasonable underwriting standards for liability coverage
20.54(515,515F)	Cancellation; nonrenewal and limitations; review of eligibility
20.55(515,515F)	Assessments
20.56(515,515F)	Commission
20.57(515,515F)	Public education
20.58(515,515F)	Cooperation and authority of producers
20.59(515,515F)	Review by commissioner
20.60(515,515F)	Indemnification
20.61 to 20.69	Reserved

DIVISION III
CERTIFICATES OF INSURANCE FOR COMMERCIAL LENDING TRANSACTIONS

20.70(515)	Purpose
20.71(515)	Definitions
20.72(515)	Evidence of insurance
20.73 to 20.79	Reserved

DIVISION IV
CANCELLATIONS, NONRENEWALS AND TERMINATIONS

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

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

21.1(515E,515I)	Definitions
21.2(515I)	Eligible surplus lines insurer's duties
21.3(515I)	Surplus lines insurance producer's duties
21.4(515I)	Surplus lines insurance producer's duty to insured
21.5(515I)	Procedures for qualification and renewal as an eligible surplus lines insurer
21.6(515E)	Procedures for qualification as a risk retention group
21.7(515E)	Risk retention groups
21.8(515E)	Procedures for registration as a purchasing group
21.9(515E,515I)	Failure to comply; penalties

CHAPTER 22
FINANCIAL GUARANTY INSURANCE

- 22.1(515C) Definitions
22.2(515) Financial requirements and reserves

CHAPTERS 23 and 24
Reserved

CHAPTER 25
MILITARY SALES PRACTICES

- 25.1(505) Purpose and authority
25.2(505) Scope
25.3(505) Exemptions
25.4(505) Definitions
25.5(505) Practices declared false, misleading, deceptive or unfair on a military installation
25.6(505) Practices declared false, misleading, deceptive or unfair regardless of location
25.7(505) Reporting requirements
25.8(505) Violation and penalties
25.9(505) Severability

CHAPTER 26
Reserved

CHAPTER 27
PREFERRED PROVIDER ARRANGEMENTS

- 27.1(514F) Purpose
27.2(514F) Definitions
27.3(514F) Preferred provider arrangements
27.4(514F) Health benefit plans
27.5(514F) Preferred provider participation requirements
27.6(514F) General requirements
27.7(514F) Civil penalties
27.8(514F) Health care insurer requirements

CHAPTER 28
CREDIT LIFE AND CREDIT
ACCIDENT AND HEALTH INSURANCE

- 28.1(509) Purpose
28.2(509) Definitions
28.3(509) Rights and treatment of debtors
28.4(509) Policy forms and related material
28.5(509) Determination of reasonableness of benefits in relation to premium charge
28.6 Reserved
28.7(509) Credit life insurance rates
28.8(509) Credit accident and health insurance
28.9(509) Refund formulas
28.10(509) Experience reports and adjustment of prima facie rates
28.11(509) Use of rates—direct business only
28.12(509) Supervision of credit insurance operations
28.13(509) Prohibited transactions
28.14(509) Disclosure and readability
28.15(509) Severability

- 28.16(509) Effective date
- 28.17(509) Fifteen-day free examination

CHAPTER 29

CONTINUATION RIGHTS UNDER GROUP ACCIDENT
AND HEALTH INSURANCE POLICIES

- 29.1(509B) Definitions
- 29.2(509B) Notice regarding continuation rights
- 29.3(509B) Qualifying events for continuation rights
- 29.4(509B) Interplay between chapter 509B and COBRA
- 29.5(509B) Effective date for compliance

LIFE AND HEALTH INSURANCE

CHAPTER 30

LIFE INSURANCE POLICIES

- 30.1(508) Purpose
- 30.2(508) Scope
- 30.3(508) Definitions
- 30.4(508) Prohibitions, regulations and disclosure requirements
- 30.5(508) General filing requirements
- 30.6(508) Back dating of life policies
- 30.7(508,515) Expiration date of policy vs. charter expiration date
- 30.8(509) Electronic delivery of group life insurance certificates
- 30.9(505,508) Notice of cancellation, nonrenewal or termination of life insurance and annuities

CHAPTER 31

LIFE INSURANCE COMPANIES—VARIABLE ANNUITIES CONTRACTS

- 31.1(508) Definitions
- 31.2(508) Insurance company qualifications
- 31.3(508) Filing, policy forms and provision
- 31.4(508) Separate account or accounts and investments
- 31.5(508) Required reports
- 31.6(508) Producers
- 31.7(508) Foreign companies

CHAPTER 32

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

- 32.1(508) Purpose
- 32.2(508) Definitions
- 32.3(508) Requirements upon custodial account and custodial agreement
- 32.4(508) Requirements upon custodians
- 32.5(508,511) Deposit of securities

CHAPTER 33

VARIABLE LIFE INSURANCE MODEL REGULATION

- 33.1(508A) Authority
- 33.2(508A) Definitions
- 33.3(508A) Qualification of insurer to issue variable life insurance
- 33.4(508A) Insurance policy requirements
- 33.5(508A) Reserve liabilities for variable life insurance
- 33.6(508A) Separate accounts
- 33.7(508A) Information furnished to applicants

33.8(508A)	Applications
33.9(508A)	Reports to policyholders
33.10(508A)	Foreign companies
33.11	Reserved
33.12(508A)	Separability article

CHAPTER 34

NONPROFIT HEALTH SERVICE CORPORATIONS

34.1(514)	Purpose
34.2(514)	Definitions
34.3(514)	Annual report requirements
34.4(514)	Arbitration
34.5(514)	Filing requirements
34.6(514)	Participating hospital contracts
34.7(514)	Composition, nomination, and election of board of directors

CHAPTER 35

ACCIDENT AND HEALTH INSURANCE

BLANKET ACCIDENT AND SICKNESS INSURANCE

35.1(509)	Purpose
35.2(509)	Scope
35.3(509)	Definitions
35.4(509)	Required provisions
35.5(509)	Application and certificates not required
35.6(509)	Facility of payment
35.7(509)	General filing requirements
35.8(509)	Electronic delivery of accident and health group insurance certificates

GENERAL ACCIDENT AND HEALTH INSURANCE REQUIREMENTS

35.9(509B,513B,514D)	Notice of cancellation, nonrenewal or termination of accident and health insurance
35.10 to 35.19	Reserved
35.20(509A)	Life and health self-funded plans
35.21(509)	Review of certificates issued under group policies

LARGE GROUP HEALTH INSURANCE COVERAGE

35.22(509)	Purpose
35.23(509)	Definitions
35.24(509)	Eligibility to enroll
35.25(509)	Special enrollments
35.26(509)	Group health insurance coverage policy requirements
35.27(509)	Methods of counting creditable coverage
35.28(509)	Certificates of creditable coverage
35.29(509)	Notification requirements
35.30	Reserved
35.31(509)	Disclosure requirements
35.32(514C)	Treatment options
35.33(514C)	Emergency services
35.34(514C)	Provider access
35.35(509)	Reconstructive surgery

CONSUMER GUIDE

35.36(514K)	Purpose
35.37(514K)	Information filing requirements

- 35.38(514K) Limitation of information published
- 35.39(514C) Contraceptive coverage
- 35.40(514C) Autism spectrum disorders coverage

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

DIVISION I
MINIMUM STANDARDS

- 36.1(514D) Purpose
- 36.2(514D) Applicability and scope
- 36.3(514D) Effective date
- 36.4(514D) Policy definitions
- 36.5(514D) Prohibited policy provisions
- 36.6(514D) Accident and sickness minimum standards for benefits
- 36.7(514D) Required disclosure provisions
- 36.8(507B) Requirements for replacement
- 36.9(514D) Filing requirements
- 36.10(514D) Loss ratios
- 36.11(514D) Certification
- 36.12(514D) Severability
- 36.13(513C,514D) Individual health insurance coverage for children under the age of 19
- 36.14 to 36.19 Reserved

DIVISION II
RATE HEARINGS

- 36.20(514D,83GA,SF2201) Rate hearings

CHAPTER 37
MEDICARE SUPPLEMENT INSURANCE

- 37.1(514D) Purpose and authority
- 37.2(514D) Applicability, scope, and appendices
- 37.3(514D) Definitions
- 37.4(514D) Policy definitions and terms
- 37.5(514D) Policy provisions
- 37.6(514D) Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992 (prestandardized plans)
- 37.7(514D) Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010 (1990 plans)
- 37.8(514D) Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010 (2010 plans)
- 37.9(514D) Standard Medicare supplement benefit plans for 2020 standardized Medicare supplement benefit plan policies or certificates issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020
- 37.10 to 37.19 Reserved
- 37.20(514D) Medicare Select policies and certificates
- 37.21(514D) Open enrollment
- 37.22(514D) Standards for claims payment
- 37.23(514D) Loss ratio standards and refund or credit of premium
- 37.24(514D) Filing and approval of policies and certificates and premium rates

37.25(514D)	Permitted compensation arrangements
37.26(514D)	Required notice regarding policies or certificates which are not Medicare supplement policies or certificates
37.27(514D)	Requirements for application forms and replacement coverage
37.28(514D)	Required disclosure provisions
37.29	Reserved
37.30(514D)	Standards for marketing
37.31(514D)	Appropriateness of recommended purchase and excessive insurance
37.32(514D)	Reporting of multiple policies
37.33(514D)	Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates
37.34(514D)	Prohibitions against use of genetic information and against requests for genetic testing
37.35(514D)	Prohibition against using materials prepared by SHIIP
37.36(514D)	Guaranteed issue for eligible persons
37.37 to 37.49	Reserved
37.50(507B,514D)	Medicare supplement advertising
37.51(514D)	Severability

CHAPTER 38 COORDINATION OF BENEFITS

DIVISION I

38.1 to 38.11	Reserved
---------------	----------

DIVISION II

38.12(509,514)	Purpose and applicability
38.13(509,514)	Definitions
38.14(509,514)	Use of model COB contract provision
38.15(509,514)	Rules for coordination of benefits
38.16(509,514)	Procedure to be followed by secondary plan to calculate benefits and pay a claim
38.17(509,514)	Notice to covered persons
38.18(509,514)	Miscellaneous provisions

CHAPTER 39 LONG-TERM CARE INSURANCE

DIVISION I GENERAL PROVISIONS

39.1(514G)	Purpose
39.2(514G)	Authority
39.3(514G)	Applicability and scope
39.4(514G)	Definitions
39.5(514G)	Policy definitions
39.6(514G)	Policy practices and provisions
39.7(514G)	Required disclosure provisions
39.8(514G)	Prohibition against postclaims underwriting
39.9(514D,514G)	Minimum standards for home health care benefits in long-term care insurance policies
39.10(514D,514G)	Requirement to offer inflation protection
39.11(514D,514G)	Requirements for application forms and replacement coverage
39.12(514G)	Reserve standards
39.13(514D)	Loss ratio
39.14(514G)	Filing requirement
39.15(514D,514G)	Standards for marketing

- 39.16(514D,514G) Suitability
- 39.17(514G) Prohibition against preexisting conditions and probationary periods in replacement policies or certificates
- 39.18(514G) Standard format outline of coverage
- 39.19(514G) Requirement to deliver shopper's guide
- 39.20(514G) Policy summary and delivery of life insurance policies with long-term care riders
- 39.21(514G) Reporting requirement for long-term care benefits funded through life insurance by acceleration of the death benefit
- 39.22(514G) Unintentional lapse
- 39.23(514G) Denial of claims
- 39.24(514G) Incontestability period
- 39.25(514G) Required disclosure of rating practices to consumers
- 39.26(514G) Initial filing requirements
- 39.27(514G) Reporting requirements
- 39.28(514G) Premium rate schedule increases
- 39.29(514G) Nonforfeiture
- 39.30(514G) Standards for benefit triggers
- 39.31(514G) Additional standards for benefit triggers for qualified long-term care insurance contracts
- 39.32(514G) Penalties
- 39.33(514G) Notice of cancellation, nonrenewal or termination of long-term care insurance
- 39.34 to 39.40 Reserved

DIVISION II

INDEPENDENT REVIEW OF BENEFIT TRIGGER DETERMINATIONS

- 39.41(514G) Purpose
- 39.42(514G) Effective date
- 39.43(514G) Definitions
- 39.44(514G) Notice of benefit trigger determination and content
- 39.45(514G) Notice of internal appeal decision and right to independent review
- 39.46(514G) Independent review request
- 39.47(514G) Certification process
- 39.48(514G) Selection of independent review entity
- 39.49(514G) Independent review process
- 39.50(514G) Decision notification
- 39.51(514G) Insurer information
- 39.52(514G) Certification of independent review entity
- 39.53(514G) Additional requirements
- 39.54(514G) Toll-free telephone number
- 39.55(514G) Division application and reports
- 39.56 to 39.74 Reserved

DIVISION III

LONG-TERM CARE PARTNERSHIP PROGRAM

- 39.75(514H,83GA,HF723) Purpose
- 39.76(514H,83GA,HF723) Effective date
- 39.77(514H,83GA,HF723) Definitions
- 39.78(514H,83GA,HF723) Eligibility
- 39.79(514H,83GA,HF723) Discontinuance of partnership program
- 39.80(514H,83GA,HF723) Required disclosures
- 39.81(514H,83GA,HF723) Form filings
- 39.82(514H,83GA,HF723) Exchanges
- 39.83(514H,83GA,HF723) Required policy terms and disclosures

- 39.84(514H,83GA,HF723) Standards for marketing and suitability
 39.85(514H,83GA,HF723) Required reports

CHAPTER 40 HEALTH MAINTENANCE ORGANIZATIONS

(Health and Insurance—Joint Rules)

- | | |
|-------------|---|
| 40.1(514B) | Definitions |
| 40.2(514B) | Application |
| 40.3(514B) | Inspection of evidence of coverage |
| 40.4(514B) | Governing body and enrollee representation |
| 40.5(514B) | Quality of care |
| 40.6(514B) | Change of name |
| 40.7(514B) | Change of ownership |
| 40.8(514B) | Termination of services |
| 40.9(514B) | Complaints |
| 40.10(514B) | Cancellation of enrollees |
| 40.11(514B) | Application for certificate of authority |
| 40.12(514B) | Net worth |
| 40.13(514B) | Fidelity bond |
| 40.14(514B) | Annual report |
| 40.15(514B) | Cash or asset management agreements |
| 40.16 | Reserved |
| 40.17(514B) | Reinsurance |
| 40.18(514B) | Provider contracts |
| 40.19(514B) | Producers' duties |
| 40.20(514B) | Emergency services |
| 40.21(514B) | Reimbursement |
| 40.22(514B) | Health maintenance organization requirements |
| 40.23(514B) | Disclosure requirements |
| 40.24(514B) | Provider access |
| 40.25(514B) | Electronic delivery of accident and health group insurance certificates |
| 40.26(514B) | Notice of cancellation, nonrenewal or termination of enrollment |

CHAPTER 41 LIMITED SERVICE ORGANIZATIONS

- | | |
|-------------|--|
| 41.1(514B) | Definitions |
| 41.2(514B) | Application |
| 41.3(514B) | Inspection of evidence of coverage |
| 41.4(514B) | Governing body and enrollee representation |
| 41.5(514B) | Quality of care |
| 41.6(514B) | Change of name |
| 41.7(514B) | Change of ownership |
| 41.8(514B) | Complaints |
| 41.9(514B) | Cancellation of enrollees |
| 41.10(514B) | Application for certificate of authority |
| 41.11(514B) | Net equity and deposit requirements |
| 41.12(514B) | Fidelity bond |
| 41.13(514B) | Annual report |
| 41.14(514B) | Cash or asset management agreements |
| 41.15(514B) | Reinsurance |
| 41.16(514B) | Provider contracts |
| 41.17(514B) | Producers' duties |

- 41.18(514B) Emergency services
- 41.19(514B) Reimbursement
- 41.20(514B) Limited service organization requirements
- 41.21(514B) Disclosure requirements

CHAPTER 42

GENDER-BLENDED MINIMUM NONFORFEITURE
STANDARDS FOR LIFE INSURANCE

- 42.1(508) Purpose
- 42.2(508) Definitions
- 42.3(508) Use of gender-blended mortality tables
- 42.4(508) Unfair discrimination
- 42.5(508) Separability
- 42.6(508) 2001 CSO Mortality Table

CHAPTER 43

ANNUITY MORTALITY TABLES FOR USE IN
DETERMINING RESERVE LIABILITIES FOR ANNUITIES

- 43.1(508) Purpose
- 43.2(508) Definitions
- 43.3(508) Individual annuity or pure endowment contracts
- 43.4(508) Group annuity or pure endowment contracts
- 43.5(508) Application of the 1994 GAR Table
- 43.6(508) Application of the 2012 IAR Mortality Table
- 43.7(508) Separability

CHAPTER 44

SMOKER/NONSMOKER MORTALITY TABLES
FOR USE IN DETERMINING MINIMUM RESERVE LIABILITIES
AND NONFORFEITURE BENEFITS

- 44.1(508) Purpose
- 44.2(508) Definitions
- 44.3(508) Alternate tables
- 44.4(508) Conditions
- 44.5(508) Separability
- 44.6(508) 2001 CSO Mortality Table

INSURANCE HOLDING COMPANY SYSTEMS

CHAPTER 45

INSURANCE HOLDING COMPANY SYSTEMS

- 45.1(521A) Purpose
- 45.2(521A) Definitions
- 45.3(521A) Subsidiaries of domestic insurers
- 45.4(521A) Control acquisition of domestic insurer
- 45.5(521A) Registration of insurers
- 45.6(521A) Alternative and consolidated registrations
- 45.7(521A) Exemptions
- 45.8(521A) Disclaimers and termination of registration
- 45.9(521A) Transactions subject to prior notice—notice filing
- 45.10(521A) Extraordinary dividends and other distributions
- 45.11(521A) Enterprise risk report
- 45.12(521A) Forms—additional information and exhibits

CHAPTER 46
MUTUAL HOLDING COMPANIES

46.1(521A)	Purpose
46.2(521A)	Definitions
46.3(521A)	Application—contents—process
46.4(521A)	Plan of reorganization
46.5(521A)	Duties of the commissioner
46.6(521A)	Regulation—compliance
46.7(521A)	Reorganization of domestic mutual insurer with mutual insurance holding company
46.8(521A)	Reorganization of foreign mutual insurer with mutual insurance holding company
46.9(521A)	Mergers of mutual insurance holding companies
46.10(521A)	Stock offerings
46.11(521A)	Regulation of holding company system
46.12(521A)	Reporting of stock ownership and transactions

CHAPTER 47
VALUATION OF LIFE INSURANCE POLICIES

(Including New Select Mortality Factors)

47.1(508)	Purpose
47.2(508)	Application
47.3(508)	Definitions
47.4(508)	General calculation requirements for basic reserves and premium deficiency reserves
47.5(508)	Calculation of minimum valuation standard for policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits (other than universal life policies)
47.6(508)	Calculation of minimum valuation standard for flexible premium and fixed premium universal life insurance policies that contain provisions resulting in the ability of a policyowner to keep a policy in force over a secondary guarantee period
47.7(508)	2001 CSO Mortality Table

VIATICAL AND LIFE SETTLEMENTS

CHAPTER 48
VIATICAL AND LIFE SETTLEMENTS

48.1(508E)	Purpose and authority
48.2(508E)	Definitions
48.3(508E)	License requirements
48.4(508E)	Disclosure statements
48.5(508E)	Contract requirements
48.6(508E)	Filing of forms
48.7(508E)	Reporting requirements
48.8(508E)	Examination or investigations
48.9(508E)	Requirements and prohibitions
48.10(508E)	Penalties; injunctions; civil remedies; cease and desist
48.11(252J,272D)	Suspension for failure to pay child support or state debt
48.12 and 48.13	Reserved
48.14(508E)	Severability

CHAPTER 49
FINANCIAL INSTRUMENTS USED IN HEDGING TRANSACTIONS

49.1(511)	Purpose
49.2(511)	Definitions

- 49.3(511) Guidelines and internal control procedures
- 49.4(511) Documentation requirements
- 49.5(511) Trading requirements

SECURITIES

CHAPTER 50
REGULATION OF SECURITIES OFFERINGS AND THOSE WHO ENGAGE
IN THE SECURITIES BUSINESS

DIVISION I
DEFINITIONS AND ADMINISTRATION

- 50.1(502) Definitions
- 50.2(502) Cost of audit or inspection
- 50.3(502) Interpretative opinions or no-action letters
- 50.4 to 50.9 Reserved

DIVISION II
REGISTRATION OF BROKER-DEALERS AND AGENTS

- 50.10(502) Broker-dealer registrations, renewals, amendments, succession, and withdrawals
- 50.11(502) Principals
- 50.12(502) Agent and issuer registrations, renewals and amendments
- 50.13(502) Agent continuing education requirements
- 50.14(502) Broker-dealer record-keeping requirements
- 50.15(502) Broker-dealer minimum financial requirements and financial reporting requirements
- 50.16(502) Dishonest or unethical practices in the securities business
- 50.17(502) Rules of conduct
- 50.18(502) Limited registration of Canadian broker-dealers and agents
- 50.19(502) Brokerage services by national and state banks
- 50.20(502) Broker-dealers having contracts with national and state banks
- 50.21(502) Brokerage services by credit unions, savings banks, and savings and loan institutions
- 50.22(502) Broker-dealers having contracts with credit unions, savings banks, and savings and loan institutions
- 50.23 to 50.29 Reserved

DIVISION III
REGISTRATION OF INVESTMENT ADVISERS,
INVESTMENT ADVISER REPRESENTATIVES,
AND FEDERAL COVERED INVESTMENT ADVISERS

- 50.30(502) Electronic filing with designated entity
- 50.31(502) Investment adviser applications and renewals
- 50.32(502) Application for investment adviser representative registration
- 50.33(502) Examination requirements
- 50.34(502) Notice filing requirements for federal covered investment advisers
- 50.35(502) Withdrawal of investment adviser registration
- 50.36(502) Investment adviser brochure
- 50.37(502) Cash solicitation
- 50.38(502) Prohibited conduct in providing investment advice
- 50.39(502) Custody of client funds or securities by investment advisers
- 50.40(502) Minimum financial requirements for investment advisers
- 50.41(502) Bonding requirements for investment advisers
- 50.42(502) Record-keeping requirements for investment advisers
- 50.43(502) Financial reporting requirements for investment advisers
- 50.44(502) Solely incidental services by certain professionals

50.45(502)	Registration exemption for investment advisers to private funds
50.46(502)	Contents of investment advisory contract
50.47(502)	Business continuity and succession planning for investment advisers
50.48 and 50.49	Reserved

DIVISION IV
RULES COVERING ALL REGISTERED PERSONS

50.50(502)	Internet advertising by broker-dealers, investment advisers, broker-dealer agents, investment adviser representatives, and federal covered investment advisers
50.51(502)	Consent to service
50.52(252J)	Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay child support
50.53	Reserved
50.54(272D)	Denial, suspension or revocation of agent or investment adviser representative registration for failure to pay state debt
50.55(502)	Use of senior-specific certifications and professional designations
50.56 to 50.59	Reserved

DIVISION V
REGISTRATION OF SECURITIES

50.60(502)	Notice filings for investment company securities offerings
50.61(502)	Registration of small corporate offerings
50.62(502)	Streamlined registration for certain equity securities
50.63(502)	Registration of multijurisdictional offerings
50.64(502)	Form of financial statements
50.65(502)	Reports contingent to registration by qualification
50.66(502)	NASAA guidelines and statements of policy
50.67(502)	Amendments to registration by qualification
50.68(502)	Delivery of prospectus
50.69(502)	Advertisements
50.70(502)	Fee for securities registration filings under Iowa Code section 502.305
50.71 to 50.79	Reserved

DIVISION VI
EXEMPTIONS

50.80	Reserved
50.81(502)	Notice filings for Rule 506 offerings
50.82(502)	Notice filings for agricultural cooperative associations
50.83(502)	Unsolicited order exemption
50.84(502)	Solicitation of interest exemption
50.85(502)	Internet offers exemption
50.86(502)	Denial, suspension, revocation, condition, or limitation of limited offering transaction exemption
50.87(502)	Nonprofit securities exemption
50.88(502)	Transactions with specified investors
50.89(502)	Designated securities manuals
50.90(502)	Intrastate crowdfunding exemption
50.91(502)	Notice filing requirement for federal crowdfunding offerings
50.92(502)	Notice filing requirement for Regulation A – Tier 2 offerings
50.93 to 50.99	Reserved

DIVISION VII
FRAUD AND OTHER PROHIBITED CONDUCT

50.100(502)	Fraudulent practices
50.101(502)	Rescission offers

- 50.102(502) Fraudulent, deceptive or manipulative act, practice, or course of business in providing investment advice
- 50.103(502) Investment advisory contracts
- 50.104 to 50.109 Reserved

DIVISION VIII
VIATICAL SETTLEMENT INVESTMENT CONTRACTS

- 50.110(502) Application by viatical settlement investment contract issuers and registration of agents to sell viatical settlement investment contracts
- 50.111(502) Risk disclosure
- 50.112(502) Advertising of viatical settlement investment contracts
- 50.113(502) Duty to disclose

CHAPTERS 51 to 54
Reserved

CHAPTER 55
LICENSING OF PUBLIC ADJUSTERS

- 55.1(82GA,HF499) Purpose
- 55.2(82GA,HF499) Definitions
- 55.3(82GA,HF499) License required to operate as public adjuster
- 55.4(82GA,HF499) Application for license
- 55.5(82GA,HF499) Issuance of resident license
- 55.6(82GA,HF499) Public adjuster examination
- 55.7(82GA,HF499) Exemptions from examination
- 55.8(82GA,HF499) Nonresident license reciprocity
- 55.9(82GA,HF499) Terms of licensure
- 55.10(82GA,HF499) Evidence of financial responsibility
- 55.11(82GA,HF499) Continuing education
- 55.12(82GA,HF499) License denial, nonrenewal or revocation
- 55.13(82GA,HF499) Reinstatement or reissuance of a license after suspension, revocation or forfeiture in connection with disciplinary matters; and forfeiture in lieu of compliance
- 55.14(82GA,HF499) Contract between public adjuster and insured
- 55.15(82GA,HF499) Escrow accounts
- 55.16(82GA,HF499) Record retention
- 55.17(82GA,HF499) Standards of conduct of public adjuster
- 55.18(82GA,HF499) Public adjuster fees
- 55.19(82GA,HF499) Penalties
- 55.20(82GA,HF499) Fees
- 55.21(82GA,HF499) Severability

CHAPTER 56
WORKERS' COMPENSATION GROUP SELF-INSURANCE

- 56.1(87,505) General provisions
- 56.2(87,505) Definitions
- 56.3(87,505) Requirements for self-insurance
- 56.4 Reserved
- 56.5(87,505) Excess insurance
- 56.6(87,505) Rates and reporting of rates
- 56.7(87,505) Special provisions
- 56.8(87,505) Certificate of approval; termination
- 56.9(87,505) Examinations
- 56.10(87,505) Board of trustees—membership, powers, duties, and prohibitions

56.11(87,505)	Association membership; termination; liability
56.12(87,505)	Requirements of sales agents
56.13(87,505)	Requirements for continued approval
56.14(87,505)	Misrepresentation prohibited
56.15(87,505)	Investments
56.16(87,505)	Refunds
56.17(87,505)	Premium payment; reserves
56.18(87,505)	Deficits and insolvencies
56.19(87,505)	Grounds for nonrenewal or revocation of a certificate of relief from insurance
56.20(87,505)	Hearing and appeal
56.21(87,505)	Existing approved self-insurers
56.22(87,505)	Severability clause

CHAPTER 57

WORKERS' COMPENSATION SELF-INSURANCE FOR INDIVIDUAL EMPLOYERS

57.1(87,505)	General provisions
57.2(87,505)	Definitions
57.3(87,505)	Requirements for self-insurance
57.4(87,505)	Additional security requirements
57.5(87,505)	Application for an individual self-insurer
57.6	Reserved
57.7(87,505)	Excess insurance
57.8(87,505)	Insolvency
57.9(87,505)	Renewals
57.10(87,505)	Periodic examination
57.11(87,505)	Grounds for nonrenewal or revocation of a certificate of relief from insurance
57.12(87,505)	Hearing and appeal
57.13(87,505)	Existing approved self-insurers
57.14(87,505)	Severability clause

CHAPTER 58

THIRD-PARTY ADMINISTRATORS

58.1(510)	Purpose
58.2(510)	Definitions
58.3(505,510)	Registration required
58.4(510)	Third-party administrator duties
58.5(510)	Renewal procedure
58.6(505,510)	Responsibilities of the insurer
58.7(505,510)	Written agreement
58.8(510)	Compensation to the third-party administrator
58.9(510)	Disclosure of charges and fees
58.10(510)	Delivery of materials to covered individuals
58.11(510)	Annual report and fee
58.12(510)	Change of information
58.13(510)	Inquiry by commissioner
58.14(510)	Complaints
58.15(510)	Periodic examination
58.16(510)	Grounds for denial, nonrenewal, suspension or revocation of certificate of registration
58.17(510)	Confidential information
58.18(510)	Fees

- 58.19(510) Severability clause
 58.20(510) Compliance date

CHAPTER 59
 PHARMACY BENEFITS MANAGERS

- 59.1(510B,510C) Purpose
 59.2(510B) Definitions
 59.3(510B) Timely payment of pharmacy claims
 59.4(510B) Audits of pharmacies by pharmacy benefits managers
 59.5(510B) Disclosure of national compendia used
 59.6(510B) Termination or suspension of contracts with pharmacies by pharmacy benefits managers
 59.7(510B) Price change
 59.8(510B) Complaints
 59.9(510,510B) Duty to notify commissioner of fraud
 59.10(507,510,510B) Commissioner examinations of pharmacy benefits managers
 59.11(510B,510C) Pharmacy benefits manager annual report
 59.12(505,507,507B,510,510B,510C,514L) Failure to comply

CHAPTER 60
 WORKERS' COMPENSATION INSURANCE RATE FILING PROCEDURES

- 60.1(515A) Purpose
 60.2(515A) Definitions, scope, authority
 60.3(515A) General filing requirements
 60.4(515A) Rate or manual rule filing
 60.5(515A) Violation and penalties
 60.6(515A) Severability
 60.7(515A) Effective date

CHAPTERS 61 to 69
 Reserved

MANAGED HEALTH CARE

CHAPTER 70
 UTILIZATION REVIEW

- 70.1(505,514F) Purpose
 70.2(505,514F) Definitions
 70.3(505,514F) Application
 70.4(505,514F) Standards
 70.5(505,514F) Retroactive application
 70.6(505,514F) Variances allowed
 70.7(505,514F) Confidentiality
 70.8(76GA,ch1202) Utilization review of postdelivery benefits and care
 70.9(505,507B,514F) Enforcement
 70.10(514F) Credentialing—retrospective payment

HEALTH BENEFIT PLANS

CHAPTER 71
 SMALL GROUP HEALTH BENEFIT PLANS

- 71.1(513B) Purpose
 71.2(513B) Definitions
 71.3(513B) Applicability and scope
 71.4(513B) Establishment of classes of business

71.5(513B)	Transition for assumptions of business from another carrier
71.6(513B)	Restrictions relating to premium rates
71.7(513B)	Requirement to insure entire groups
71.8(513B)	Case characteristics
71.9(513B)	Application to reenter state
71.10(513B)	Creditable coverage
71.11(513B)	Rules related to fair marketing
71.12(513B)	Status of carriers as small employer carriers
71.13(513B)	Restoration of coverage
71.14(513B)	Basic health benefit plan and standard health plan policy forms
71.15(513B)	Methods of counting creditable coverage
71.16(513B)	Certificates of creditable coverage
71.17(513B)	Notification requirements
71.18(513B)	Special enrollments
71.19(513B)	Disclosure requirements
71.20(514C)	Treatment options
71.21(514C)	Emergency services
71.22(514C)	Provider access
71.23(513B)	Reconstructive surgery
71.24(514C)	Contraceptive coverage
71.25(513B)	Suspension of the small employer health reinsurance program
71.26(513B)	Uniform health insurance application form

CHAPTER 72

LONG-TERM CARE ASSET PRESERVATION PROGRAM

72.1(249G)	Purpose
72.2(249G)	Applicability and scope
72.3(249G)	Definitions
72.4(249G)	Qualification of long-term care insurance policies and certificates
72.5(249G)	Standards for marketing
72.6(249G)	Minimum benefit standards for qualifying policies and certificates
72.7(249G)	Required policy and certificate provisions
72.8(249G)	Prohibited provisions in certified policies or certificates
72.9(249G)	Reporting requirements
72.10(249G)	Maintaining auditing information
72.11(249G)	Reporting on asset protection
72.12(249G)	Preparing a service summary
72.13(249G)	Plan of action
72.14(249G)	Auditing and correcting deficiencies in issuer record keeping
72.15(249G)	Separability

CHAPTER 73

HEALTH INSURANCE PURCHASING COOPERATIVES

73.1(75GA,ch158)	Purpose
73.2(75GA,ch158)	Applicability and scope
73.3(75GA,ch158)	Definitions
73.4(75GA,ch158)	Division duties—application—filing requirements—license—audits and examinations
73.5(75GA,ch158)	Fidelity bond—letter of credit
73.6(75GA,ch158)	Annual report
73.7(75GA,ch158)	Business plan
73.8(75GA,ch158)	Participants

73.9(75GA,ch158)	Health insurance purchasing cooperative—product offerings—exemptions
73.10(75GA,ch158)	Insurance risk
73.11(75GA,ch158)	Rates
73.12(75GA,ch158)	Election—disclosure and confidentiality
73.13(75GA,ch158)	Structure—merger and consolidation
73.14(75GA,ch158)	Conflict of interest
73.15(75GA,ch158)	Nondiscrimination and retaliatory protections
73.16(75GA,ch158)	Annual health insurance or health care benefits plan selection
73.17(75GA,ch158)	License subject to conditions—waivers
73.18(75GA,ch158)	Procedures
73.19(75GA,ch158)	Data collection—quality evaluation
73.20(75GA,ch158)	Examination—costs
73.21(75GA,ch158)	Trade practices
73.22(75GA,ch158)	Grounds for denial, nonrenewal, suspension or revocation of certificate
73.23(75GA,ch158)	Hearing and appeal
73.24(75GA,ch158)	Solvency

CHAPTER 74 HEALTH CARE ACCESS

74.1(505)	Purpose
74.2(505)	Applicability and scope
74.3(505)	Definitions
74.4(505)	Access to health care or health insurance for an employee
74.5(505)	Employer participation
74.6(505)	Violation of chapter

CHAPTER 75 IOWA INDIVIDUAL HEALTH BENEFIT PLANS

75.1(513C)	Purpose
75.2(513C)	Definitions
75.3(513C)	Applicability and scope
75.4(513C)	Establishment of blocks of business
75.5(513C)	Transition for assumptions of business from another carrier
75.6(513C)	Restrictions relating to premium rates
75.7(513C)	Availability of coverage
75.8(513C)	Disclosure of information
75.9(513C)	Standards to ensure fair marketing
75.10(513C)	Basic health benefit plan and standard health benefit plan policy forms
75.11(513C)	Maternity benefit rider
75.12(513C)	Disclosure requirements
75.13(514C)	Treatment options
75.14(514C)	Emergency services
75.15(514C)	Provider access
75.16(514C)	Diabetic coverage
75.17(513C)	Reconstructive surgery
75.18(514C)	Contraceptive coverage

CHAPTER 76 EXTERNAL REVIEW

76.1(514J)	Purpose
76.2(514J)	Applicable law and definitions
76.3(514J)	Disclosure requirements
76.4(514J)	External review request

- 76.5(514J) Communication between covered person, health carrier, independent review organization and the commissioner
- 76.6(514J) Assignment of independent review organization by the commissioner
- 76.7(514J) Decision notification
- 76.8(514J) Health carrier information
- 76.9(514J) Certification of independent review organization
- 76.10(514J) Fees charged by independent review organizations
- 76.11(514J) Penalties

CHAPTER 77

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

- 77.1(507A) Purpose
- 77.2(507A) Definitions
- 77.3(507A) Self-insured multiple employer welfare arrangements
- 77.4(507A) Fully insured multiple employer welfare arrangements
- 77.5(507A,513D) Self-insured association health plans
- 77.6(507A) Fully insured association health plans

CHAPTER 78

UNIFORM PRESCRIPTION DRUG INFORMATION CARD

- 78.1(514L) Purpose
- 78.2(514L) Definitions
- 78.3(514L) Implementation

CHAPTER 79

PRIOR AUTHORIZATION—PRESCRIPTION DRUG BENEFITS

- 79.1(505) Purpose
- 79.2(505) Definitions
- 79.3(505) Prior authorization protocols
- 79.4(505) Filing with the division
- 79.5(505) Violations
- 79.6(505) Applicability

*INSURANCE COVERAGE FOR
PEDIATRIC PREVENTIVE SERVICES*

CHAPTER 80

WELL-CHILD CARE

- 80.1(505,514H) Purpose
- 80.2(505,514H) Applicability and scope
- 80.3(505,514H) Effective date
- 80.4(505,514H) Policy definitions
- 80.5(505,514H) Benefit plan

CHAPTER 81

POSTDELIVERY BENEFITS AND CARE

- 81.1(514C) Purpose
- 81.2(514C) Applicability and scope
- 81.3(514C) Postdelivery benefits

CHAPTERS 82 to 84

Reserved

CHAPTER 85
REGULATION OF NAVIGATORS

- 85.1(505,522D) Purpose and authority
- 85.2(505,522D) Definitions
- 85.3(505,522D) Requirement to hold a license
- 85.4(505,522D) Issuance of license
- 85.5(505,522D) License renewal
- 85.6(505,522D) License reinstatement
- 85.7(505,522D) Reinstatement or reissuance of a license after suspension, revocation or forfeiture
in connection with disciplinary matters; and forfeiture in lieu of compliance
- 85.8(505,522D) Change in name, address or state of residence
- 85.9(505,522D) Licensing of a business entity
- 85.10(505,522D) Initial training of navigators
- 85.11(505,522D) Continuing education requirements for navigators
- 85.12(505,522D) Administration of examinations
- 85.13(505,522D) Fees
- 85.14(505,522D) Evidence of financial responsibility
- 85.15(505,522D) Practices
- 85.16(505,522D) Severability

CHAPTERS 86 to 89
Reserved

CHAPTER 90
FINANCIAL AND HEALTH INFORMATION REGULATION

- 90.1(505) Purpose and scope
- 90.2(505) Definitions

DIVISION I
RULES FOR FINANCIAL INFORMATION

- 90.3(505) Initial privacy notice to consumers required
- 90.4(505) Annual privacy notice to customers required
- 90.5(505) Information to be included in privacy notices
- 90.6(505) Form of opt-out notice to consumers and opt-out methods
- 90.7(505) Revised privacy notices
- 90.8(505) Delivery of notice
- 90.9(505) Limits on disclosure of nonpublic personal financial information to nonaffiliated
third parties
- 90.10(505) Limits on redisclosure and reuse of nonpublic personal financial information
- 90.11(505) Limits on sharing account number information for marketing purposes
- 90.12(505) Exception to opt-out requirements for disclosure of nonpublic personal financial
information for service providers and joint marketing
- 90.13(505) Exceptions to notice and opt-out requirements for disclosure of nonpublic personal
financial information for processing and servicing transactions
- 90.14(505) Other exceptions to notice and opt-out requirements for disclosure of nonpublic
personal financial information
- 90.15(505) Notice through a Web site
- 90.16(505) Licensee exception to notice requirement

DIVISION II
RULES FOR HEALTH INFORMATION

- 90.17(505) Disclosure of nonpublic personal health information
- 90.18(505) Authorizations
- 90.19(505) Delivery of authorization request

90.20(505)	Relationship to federal rules
90.21(505)	Relationship to state laws
90.22(505)	Protection of Fair Credit Reporting Act
90.23(505)	Nondiscrimination
90.24(505)	Severability
90.25(505)	Penalties
90.26(505)	Effective dates
90.27 to 90.36	Reserved

DIVISION III
SAFEGUARDING CUSTOMER INFORMATION

90.37(505)	Information security program
90.38(505)	Examples of methods of development and implementation
90.39(505)	Penalties
90.40(505)	Effective date

CHAPTER 91
2001 CSO MORTALITY TABLE

91.1(508)	Purpose
91.2(508)	Definitions
91.3(508)	2001 CSO Mortality Table
91.4(508)	Conditions
91.5(508)	Applicability of the 2001 CSO Mortality Table to 191—Chapter 47, Valuation of Life Insurance Policies
91.6(508)	Gender-blended table
91.7(508)	Separability

CHAPTER 92
UNIVERSAL LIFE INSURANCE

92.1(508)	Purpose and authority
92.2(508)	Definitions
92.3(508)	Scope
92.4(508)	Valuation
92.5(508)	Nonforfeiture
92.6(508)	Mandatory policy provisions
92.7(508)	Disclosure requirements
92.8(508)	Periodic disclosure to policyowner
92.9(508)	Interest-indexed universal life insurance policies
92.10(508)	Applicability

CHAPTER 93
CONDUIT DERIVATIVE TRANSACTIONS

93.1(511,521A)	Purposes
93.2(511,521A)	Definitions
93.3(511,521A)	Provisions not applicable
93.4(511,521A)	Standards for conduit derivative transactions
93.5(511,521A)	Internal controls
93.6(511,521A)	Reporting requirements for conduit derivative transactions
93.7(511,521A)	Conduit ownership
93.8(511,521A)	Exemption from applicability

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

94.1(508)	Purpose
94.2(508)	Definitions
94.3(508)	2001 CSO Preferred Class Structure Mortality Table
94.4(508)	Conditions
94.5(508)	Separability

CHAPTER 95
DETERMINING RESERVE LIABILITIES FOR PRENEED LIFE INSURANCE

95.1(508)	Authority
95.2(508)	Scope
95.3(508)	Purpose
95.4(508)	Definitions
95.5(508)	Minimum valuation mortality standards
95.6(508)	Minimum valuation interest rate standards
95.7(508)	Minimum valuation method standards
95.8(508)	Transition rules
95.9(508)	Effective date

CHAPTER 96
SYNTHETIC GUARANTEED INVESTMENT CONTRACTS

96.1(505,508)	Authority
96.2(505,508)	Purpose
96.3(505,508)	Scope and application
96.4(505,508)	Definitions
96.5(505,508)	Financial requirements and plan of operation
96.6(505,508)	Required contract provisions and filing requirements
96.7(505,508)	Investment management of the segregated portfolio
96.8(505,508)	Purchase of annuities
96.9(505,508)	Unilateral contract terminations
96.10(505,508)	Reserves
96.11(505,508)	Severability
96.12(505,508)	Effective date

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

97.1(508)	Authority
97.2(508)	Purpose
97.3(508)	Definitions
97.4(508)	Asset accounting
97.5(508)	Indexed annuity product reserve calculation methodology
97.6(508)	Indexed life product reserve calculation methodology
97.7(508)	Other requirements

CHAPTER 98
ANNUAL FINANCIAL REPORTING REQUIREMENTS

98.1(505)	Authority
98.2(505)	Purpose
98.3(505)	Definitions

98.4(505)	General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment
98.5(505)	Contents of annual audited financial report
98.6(505)	Designation of independent certified public accountant
98.7(505)	Qualifications of independent certified public accountant
98.8(505)	Consolidated or combined audits
98.9(505)	Scope of audit and report of independent certified public accountant
98.10(505)	Notification of adverse financial condition
98.11(505)	Communication of Internal Control Related Matters Noted in an Audit
98.12(505)	Definition, availability and maintenance of independent certified public accountants' work papers
98.13(505)	Requirements for audit committees
98.14(505)	Internal audit function requirements
98.15(505)	Conduct of insurer in connection with the preparation of required reports and documents
98.16(505)	Management's Report of Internal Control Over Financial Reporting
98.17(505)	Exemptions
98.18(505)	Letter to insurer with accountant's qualifications
98.19(505)	Canadian and British companies
98.20(505)	Severability provision
98.21(505)	Effective date

CHAPTER 99

LIMITED PURPOSE SUBSIDIARY LIFE INSURANCE COMPANIES

99.1(505,508)	Authority
99.2(505,508)	Purpose
99.3(505,508)	Definitions
99.4(505,508)	Formation of LPS
99.5(505,508)	Certificate of authority
99.6(505,508)	Capital and surplus
99.7(505,508)	Plan of operation
99.8(505,508)	Dividends and distributions
99.9(505,508)	Reports and notifications
99.10(505,508)	Material transactions
99.11(505,508)	Investments
99.12(508)	Securities
99.13(505,508)	Permitted reinsurance
99.14(505,508)	Certification of actuarial officer
99.15(505,508)	Effective date

REGULATED INDUSTRIES

CHAPTER 100

SALES OF CEMETERY MERCHANDISE, FUNERAL MERCHANDISE AND FUNERAL SERVICES

100.1(523A)	Purpose
100.2(523A)	Definitions
100.3(523A)	Contact and correspondence
100.4 to 100.9	Reserved
100.10(523A)	License status
100.11(523A)	Application for license
100.12(523A)	Processing of application for a license
100.13(523A)	Approval and denial of license applications; issuance of license

100.14(523A)	Continuing education requirements
100.15(523A)	License renewal
100.16(523A)	Prohibited activities related to licensing
100.17(523A)	Reinstatement of a restricted license
100.18(523A)	Payment of fees
100.19(523A)	Master trusts
100.20(523A)	Trust interest or income
100.21(523A)	Cancellation refunds
100.22(523A)	Consumer price index adjustment
100.23(523A)	Preneed seller's use of surety bond in lieu of trust
100.24	Reserved
100.25(523A)	Funeral and cemetery merchandise warehoused by preneed sellers
100.26 to 100.29	Reserved
100.30(523A)	Standards of conduct for preneed sellers and sales agents
100.31(523A)	Advertisements, sales practices and disclosures
100.32	Reserved
100.33(523A)	Records maintenance and retention
100.34(523A)	Changes in funding methods for or terms of purchase agreements
100.35(523A)	Preneed seller's change of ownership and cessation of business operations
100.36 to 100.39	Reserved
100.40(523A)	Prohibited practices for preneed sellers and sales agents
100.41(523A)	Disciplinary procedures

CHAPTER 101
BURIAL SITES AND CEMETERIES

101.1(523I)	Purpose
101.2(523I)	Definitions
101.3(523I)	Examination expenses assessment
101.4(523I)	Sale of insurance
101.5(523I)	Notice of disinterment
101.6(523I)	Cemeteries owned or operated by a governmental subdivision
101.7(523I)	Commingling of care fund accounts
101.8(523I)	Distribution of care fund amounts using a total return distribution method
101.9(523I)	Filing annual reports
101.10(523I)	Independent review

CHAPTER 102
IOWA RETIREMENT FACILITIES

102.1(523D)	Purpose and applicability
102.2(523D)	Definitions
102.3(523D)	Forms and filings
102.4(523D)	Standards for the disclosure statement
102.5(523D)	Certified financial statements, studies, and forecasts
102.6(523D)	Amendments to the disclosure statement
102.7(523D)	Records
102.8(523D)	Misrepresentations
102.9(523D)	Violations

CHAPTER 103
RESIDENTIAL AND MOTOR VEHICLE SERVICE CONTRACTS

103.1(523C)	Purpose
103.2(523C)	Definitions
103.3(523C)	Filings of forms, contracts and other items

103.4(523C)	Forms and instructions
103.5(523C)	Financial security deposits
103.6(523C)	Prohibited acts or practices
103.7(523C)	Service company licenses
103.8	Reserved
103.9(523C)	Financial statements and calculation of net worth
103.10(523C)	Records
103.11 to 103.14	Reserved
103.15(523C)	Violations

CHAPTERS 104 to 109

Reserved

CHAPTER 110

STANDARDS AND COMMISSIONER'S AUTHORITY FOR COMPANIES
DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

110.1(505)	Authority
110.2(505)	Purpose
110.3(505)	Definition
110.4(505)	Standards
110.5(505)	Commissioner's authority
110.6(505)	Judicial review
110.7(505)	Separability
110.8(505)	Effective date

CHAPTER 111

CORPORATE GOVERNANCE ANNUAL DISCLOSURE

111.1(521H)	Purpose
111.2(521H)	Authority
111.3(521H)	Definitions
111.4(521H)	Filing procedures
111.5(521H)	Contents of corporate governance annual disclosure

CHAPTER 112

TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING

112.1(521B)	Authority
112.2(521B)	Purpose and intent
112.3(521B)	Applicability
112.4(521B)	Exemptions
112.5(521B)	Definitions
112.6(521B)	The actuarial method
112.7(521B)	Requirements applicable to covered policies to obtain credit for reinsurance; opportunity for remediation
112.8(521B)	Severability
112.9(521B)	Prohibition against avoidance

ORGANIZATION AND PROCEDURES

CHAPTER 1
ADMINISTRATION

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

191—1.1(502,505) Definitions. For rules of the insurance division, the following definitions apply:

“*Commissioner*” means the commissioner of insurance or the commissioner’s designee.

“*Division*” means the Iowa insurance division.

“*Division’s website*” means the information and related content found at iid.iowa.gov.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—1.2(502,505) Mission. The division protects consumers through consumer education and enforcement while effectively and efficiently providing a fair, flexible, and positive regulatory environment.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—1.3(502,505) General course and method of operations. The division is the state regulator which supervises all insurance business transacted in the state of Iowa as well as securities and other regulated industries.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—1.4(502,505) Contact information and business hours. The division’s office and mailing address is 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315. The general telephone number for the division is 515-654-6600 or 1-877-955-1212. The division’s facsimile number is 515-654-6500. The division’s website address is iid.iowa.gov. The division’s hours are 8 a.m. to 4:30 p.m. Monday through Friday, excluding legal holidays.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

191—1.5(502,505) Information, forms, and requests. Information, applications, and forms may be obtained from the division’s website, in person at the division’s offices, or by telephone using the division’s general telephone number. Specific instructions, forms and guidance may be provided in administrative rules or on the division’s website. Submissions and requests can be submitted through the division’s website, in person, or by telephone.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—1.6(502,505) Organization. The division is headed by the commissioner, who is assisted by a first deputy commissioner, a second deputy commissioner, a deputy commissioner for supervision, and other deputy commissioners and assistant commissioners. The functions of the division are divided into eight bureaus.

1.6(1) Administrative bureau. The administrative bureau provides staff support to the commissioner and the division and is responsible for budget, personnel, procurement, communication, legislative, and other services.

1.6(2) Company regulation bureau. The company regulation bureau is responsible for the following:

a. Regulating domestic and foreign insurance companies licensed in Iowa, through licensure, analysis and financial and market examinations.

b. Examining the financial condition of domestic insurance companies not less than once every five years. Foreign companies are examined as deemed appropriate. The bureau ensures compliance with National Association of Insurance Commissioners accreditation mandates and with financial examination and analysis standards.

c. Serving as a general insurance information repository and resource for both insurers and consumers regarding, for example, insurance companies’ statuses, addresses, telephone numbers, certifications, and financial statements; statutory construction; life and health insurance guaranty association fund calculations; compilation of statistics; and publication of the division’s annual report to the governor required by Iowa Code section 505.12.

d. Reviewing and approving filed company transactions, including but not limited to approval of acquisitions and mergers of domestic insurers, intercompany contractual agreements and assumption reinsurance agreements.

e. Authorizing and overseeing individual and group workers' compensation self-insurance.

f. Authorizing, examining and analyzing benevolent associations and fraternal benefit societies.

g. Authorizing and reviewing multiple employer welfare arrangements.

h. Registering and verifying compliance for risk retention groups.

i. Supervising the rehabilitation and liquidation of insurance companies.

j. Auditing and monitoring premium tax remittances for admitted companies and supervising statutory deposits.

k. Reviewing and approving admission applications for foreign surplus lines insurers as well as conducting premium tax audits associated with the nonadmitted insurance industry.

l. Implementing and maintaining the division's information technology resources.

1.6(3) *Securities and regulated industries bureau.* The securities and regulated industries bureau is responsible for administering and enforcing the Iowa uniform securities Act through enforcement, licensing, and securities registration to ensure investor protection and a positive climate for capital formation. The bureau is also responsible for protecting the public by administering and enforcing rules related to motor vehicle service contracts, residential service contracts, retirement facilities, cemeteries, and preneed purchase agreements for cemetery merchandise, funeral merchandise and funeral services.

1.6(4) *Consumer advocate bureau.* The consumer advocate bureau consists of the consumer advocate and, in addition to being responsible for the duties described in Iowa Code section 505.8(6) "b," is responsible for providing outreach to consumers, assisting in creation of consumer protection laws and regulations, and reviewing complaints. In order to fulfill the prescribed duties, the commissioner has delegated investigation and enforcement duties to the market regulation, enforcement, and fraud bureaus.

1.6(5) *Market regulation bureau.* The market regulation bureau is responsible for the following:

a. Ensuring fair treatment of consumers.

b. Investigating unfair or deceptive trade practices in the business of insurance.

c. Reviewing, investigating and responding to inquiries and complaints from the public regarding insurance producers and insurers.

d. When requested by consumers, coordinating external reviews of health insurance claim decisions if insurance companies deny benefits either on the basis that the services were not medically necessary or on the basis that the services were investigational or experimental.

e. When requested by consumers, coordinating independent reviews of long-term care insurance claim decisions if insurance companies deny benefits on the basis that insureds did not meet benefit trigger requirements.

1.6(6) *Enforcement bureau.* The enforcement bureau takes administrative action against individuals and entities regulated by the division for violations of insurance, securities, and other laws under the authority of the division and provides legal counsel to the division.

1.6(7) *Fraud bureau.* The fraud bureau confronts the problem of insurance and securities fraud by prevention, investigation, and prosecution of fraudulent insurance acts in an effort to reduce the amount of premium dollars used to pay fraudulent insurance claims, as set forth in Iowa Code chapter 507E. Matters investigated by the fraud bureau may be referred to the attorney general's office or to local prosecutors for potential action or prosecution.

1.6(8) *Product and producer regulation bureau.* The product and producer regulation bureau is responsible for the following:

a. Reviewing, approving or disapproving property, casualty, life and health forms and, where provided by law, premium rates of certain types of insurance.

b. Performing actuarial analysis of life and health insurance plans funded by certain public bodies.

c. Licensing, registering, and monitoring entities and individuals under the authority of the commissioner.

d. Overseeing the senior health insurance information program (SHIIP) and senior Medicare patrol (SMP). SHIIP's mission is to advocate for, inform, educate and assist consumers on Medicare and related health insurance information issues so Iowans can make informed decisions and access resources to address their needs. SMP seeks to increase public awareness on how to prevent, detect, and report health care fraud, errors and abuse through grassroots education and community engagement. Iowa SHIIP-SMP services are local, carried out by a statewide network of certified, trained volunteer counselors located at sponsor site offices across Iowa. Iowa SHIIP-SMP volunteers provide one-to-one Medicare counseling and conduct community education on Medicare and fraud prevention. The Administration for Community Living (ACL), Office of Healthcare Information and Counseling, manages the competitively obtained Iowa SHIIP and SMP grants. ACL is a part of the U.S. Department of Health and Human Services.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—1.7(505) Service of process. Certain individuals and entities under the jurisdiction of the commissioner are required by law to consent to having the commissioner serve as agent for the individual or entity for the purpose of receiving service of process.

1.7(1) Request for service. A party to a proceeding who requests that the commissioner accept service of process as allowed by law must submit to the division, at the address stated in rule 191—1.4(502,505), all of the following:

- a.* For each individual or entity to be served, one original and one copy of the documents to be served by the division.
- b.* A cover letter indicating the name of each individual or entity to be served by the division.
- c.* A check for service fees, made payable to Iowa Insurance Division, for \$50 for each individual or entity to be served, unless another amount is required by law.

1.7(2) Division actions. After the division receives the items listed in paragraph 1.7(1)“*a.*,” the division must do the following:

- a.* Accept the service of process on behalf of the individual or entity.
- b.* Forward, by certified mail, the original documents to the individual or entity to be served.
- c.* File a notice of acceptance electronically through the Iowa court electronic filing system.

1.7(3) Types of documents the division will serve.

a. The division will serve documents related to the initiation of a case, such as original notices, petitions, and jury demands. The division will not serve documents related to later processes in a case, including but not limited to subpoenas and garnishments, unless required to do so by law.

b. The division will serve documents related to matters in the Iowa court system. The division will not serve documents related to matters in other courts, including but not limited to the federal court system, or matters in other administrative systems, except for workers' compensation cases filed with the Iowa division of workers' compensation.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

These rules are intended to implement Iowa Code sections 17A.3, 502.601, 502.605, 505.1 and 505.30.

[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]

[Editorial change: IAC Supplement 9/23/20]

CHAPTER 3
CONTESTED CASES

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

191—3.1(17A) Scope and applicability. This chapter applies to contested case proceedings conducted by the insurance division.

191—3.2(17A) Definitions. In addition to the definitions in rule 191—1.1(502,505), and except where otherwise specifically defined by law or the context otherwise requires, the following definitions apply:

“*Contested case*” means a proceeding defined by Iowa Code section 17A.2(5), and includes any matter defined as a no factual dispute contested case under Iowa Code section 17A.10A.

“*File,*” “*filed,*” or “*filing,*” when used as a verb, means the actions set forth in subrules 3.12(3) and 3.12(4), except otherwise specifically defined by law. “*Filing,*” when used as a noun, means the documents filed.

“*Issuance*” means the date of mailing of a decision or order or the date of delivery if service is by other means, unless another date is specified in the order.

“*License*” means the whole or a part of any permit, certificate, approval, registration, charter or similar form of permission required by statute.

“*Licensee*” means a person or entity to whom the division has issued a license.

“*Party*” means the same as defined in Iowa Code section 17A.2.

“*Person*” means the same as defined in Iowa Code section 17A.2.

“*Presiding officer*” means the commissioner, the commissioner’s designee or an administrative law judge from the department of inspections and appeals.

“*Proposed decision*” means the administrative law judge’s or the commissioner’s designee’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the commissioner did not preside.

“*Provision of law*” means the same as defined in Iowa Code section 17A.2.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.3(17A) Time requirements.

3.3(1) Time shall be computed as provided in Iowa Code section 4.1(34).

3.3(2) For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer may afford all parties an opportunity to be heard or to file written arguments.

191—3.4(17A) Requests for contested case proceeding. Any person claiming an entitlement to a contested case proceeding shall file a written request for such a proceeding within the time specified by the particular rules or statutes governing the subject matter or, in the absence of such law, the time specified in the division action in question. The request shall be filed with the division, at the address disclosed in rule 191—1.4(502,505).

The request for a contested case proceeding shall state the name and address of the requester; identify the specific division action which is disputed if applicable; include a short and plain statement of the issues of material fact in dispute; and, where the requester is represented by a lawyer, identify the provisions of law or precedent requiring or authorizing a contested case proceeding in the particular circumstances involved.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.5(17A,507B) Commencement of hearing; service; delivery; notice of hearing; answer.

3.5(1) *Service and delivery of the notice of hearing.*

a. Commencement of hearing. Delivery of the notice of hearing referred to in this rule constitutes commencement of the contested case proceeding.

b. Delivery of the notice of hearing. Delivery shall be accomplished by personal service as provided in the Iowa Rules of Civil Procedure or by certified mail, return receipt requested, at least 15 days before the hearing date unless the parties agree to a shorter time period, or unless otherwise provided by statute. Proof of delivery by mail is the same as proof of mailing specified in subrule 3.12(5).

c. Consent to service upon the commissioner. Certain persons regulated by the division have an obligation to keep their contact information, including their mailing address, current. For such persons who have consented in writing to have the commissioner accept service of process on their behalf, delivery of the notice of hearing referred to in this rule is accomplished at the time the notice of hearing is signed by the commissioner, unless otherwise provided by law.

3.5(2) Notice of hearing. The notice of hearing shall be prepared in the form of an order and contain the following information in the notice of hearing or accompanying charging document:

- 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 particular sections of the statutes and rules involved;
- d.* A short and plain statement of the matters asserted. If the division or other party is unable to state the matters in detail at the time the notice is served, the initial notice may be limited to a statement of the issues involved. Thereafter, upon written application, a more definite and detailed statement shall be furnished;
- e.* Identification of all parties including the name, address and telephone number of the person who will act as advocate for the division and of parties' counsel where known;
- f.* Reference to the procedural rules governing conduct of the contested case proceeding;
- g.* Reference to the procedural rules governing informal settlement;
- h.* Identification of the presiding officer and address, if known. If not known, a general description of the type of person who will serve as presiding officer;
- i.* Notification of the time period in which a party may request, under rule 191—3.6(17A), that the presiding officer be an administrative law judge;
- j.* Notification that failure to file an answer within 20 days of service may result in default pursuant to rule 191—3.22(17A); and
- k.* Reference to the procedural rules governing discovery.

3.5(3) Answer. An answer shall be filed within 20 days of service of the notice of hearing unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement of the matters asserted or charging document when appropriate.

a. An answer shall show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the notice of hearing or accompanying charging document. The answer shall state any facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

b. An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

c. Any allegation in the notice of hearing or accompanying charging document not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

d. The answer shall be filed with the division pursuant to rule 191—3.12(17A).

3.5(4) Amendments. Any notice of hearing or other charging document may be amended before a responsive pleading has been filed. Amendments to a notice of hearing or charging document after a responsive pleading has been filed and amendments to an answer may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

3.5(5) Timing of hearing. The hearing in a contested case proceeding shall be held within 90 days after the commencement of the contested case unless a continuance is granted by the presiding officer.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.6(17A) Presiding officer.

3.6(1) If the presiding officer is not an administrative law judge, any party wishing to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must file a written request with the division within 20 days after service of a notice of hearing identifying or describing the presiding officer as the commissioner or commissioner's designee.

3.6(2) The commissioner may deny the request only upon a finding that one or more of the following apply:

a. Neither the commissioner nor any designee under whose authority the contested case is to take place is a named party to the proceeding or a real party in interest to that proceeding.

b. There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.

c. An administrative law judge with the qualifications identified in subrule 3.6(4) is unavailable to hear the case within a reasonable time.

d. The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.

e. The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.

f. Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.

g. The request was not timely filed.

h. The request is not consistent with a specified statute.

i. A statute requires the commissioner or designee to serve as presiding officer.

j. The contested case arises from matters asserted pursuant to Iowa Code chapter 507A, 507B, 508B, 515G or 521A.

3.6(3) The commissioner or designee shall issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge with the qualifications identified in subrule 3.6(4), the parties shall be notified at least ten days prior to hearing if a qualified administrative law judge will not be available.

3.6(4) An administrative law judge assigned to act as presiding officer in insurance and securities matters shall be admitted to practice law before the courts of the state of Iowa.

3.6(5) Except as otherwise provided by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the commissioner. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.7(17A) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the division may exercise discretion to refuse to give effect to such a waiver when the waiver is inconsistent with the public interest.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.8(17A) Telephone, video, or electronic proceedings.

3.8(1) The presiding officer may resolve preliminary procedural motions by telephone conference, videoconference or other electronic means in which all parties have been afforded notice and an opportunity to participate.

3.8(2) The presiding officer may, on the officer's own motion or as requested by a party, order hearings or argument to be held by telephone conference, videoconference or other electronic means in which all parties have an opportunity to participate. Any party may call witnesses by telephone conference, videoconference or other electronic means, with 14 days' advance notice to all parties and the presiding officer. Failure of a party to make timely disclosure may result in the disallowance of testimony by telephone conference, videoconference or other electronic means.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.9(17A) Disqualification.

3.9(1) 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:

- a.* Has a personal bias or prejudice concerning a party or a representative of a party;
- b.* Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another factually related contested case with common disputed facts, or a pending controversy with common disputed facts that may culminate in a contested case involving the same parties;
- c.* 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 factually related contested case with common disputed facts or controversy involving the same parties;
- d.* Has acted as counsel to any person who is a private party to that proceeding within the past two years;
- e.* 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;
- f.* Has a spouse or relative within the third degree of relationship that is (1) a party to the case, or an officer, director or trustee of a party; (2) a lawyer in the case; (3) known to have an interest that could be substantially affected by the outcome of the case; or (4) likely to be a material witness in the case; or
- g.* Has any other legally sufficient cause to withdraw from participation in the decision making in the case.

3.9(2) The term “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. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and subrules 3.9(3) and 3.23(9).

3.9(3) In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

3.9(4) To request disqualification of a presiding officer, a party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion shall be filed as soon as practical after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but shall establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party requesting disqualification may seek an interlocutory appeal under rule 191—3.25(17A) and seek a stay under rule 191—3.29(17A).

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.10(17A) Consolidation—severance.

3.10(1) The presiding officer may consolidate contested case proceedings where (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

3.10(2) The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

191—3.11(17A) Pleadings. Rescinded **ARC 5197C**, IAB 9/23/20, effective 10/28/20.**191—3.12(17A) Service and filing of pleadings and other papers.**

3.12(1) Required service. Every pleading, motion, document, or other paper that is filed in a contested case proceeding and every discovery request or response in such a proceeding shall be served upon each of the parties of record to the proceeding, including the person designated as advocate or prosecutor for the division, no later than the time of filing, if filing is required. Except for an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

3.12(2) Methods of service. Service upon a party represented by an attorney shall be made upon the attorney of record unless otherwise ordered. Service is made by delivering or mailing a copy to the attorney at the attorney's last-known mailing address. Service upon an unrepresented party shall be made by delivering or mailing a copy to the party's last-known mailing address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order. Service may also be made upon a party or attorney by email if the party or attorney consents in writing to be served in that manner in that case. The party or attorney may consent by providing an email address for service to the other party or by filing a document with the division by email as specified in subrule 3.12(4). The consent may be withdrawn by written notice served on all other parties or attorneys. Service by electronic means is complete upon transmission to the provided email address unless the party making service received an electronic rejection or delivery failure.

3.12(3) Required filing. After the notice of hearing, all pleadings, motions, and notices of discovery in a contested case proceeding shall be filed with the division's designated filing clerk. If a contested case is assigned to an administrative law judge with the department of inspections and appeals, filing shall be conducted in accordance with the rules of the department of inspections and appeals, unless ordered otherwise.

3.12(4) Methods of filing. Except where otherwise provided by law, a document is deemed filed at the time it is hand-delivered to the division at the address disclosed in rule 191—1.4(502,505) during normal business hours, delivered to an established courier service for immediate delivery to that office during normal business hours, mailed by first-class mail or state interoffice mail to that office so long as there is proof of mailing, or emailed to the designated filing clerk at enforcement.filings@iid.iowa.gov.

3.12(5) Proof of mailing. Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or 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 Insurance Division at the address disclosed in 191—1.4(502,505) 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)

3.12(6) Proof of emailing. Proof of emailing includes a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of emailing), I emailed copies of (describe document) addressed to the Insurance Division at the email address disclosed in 191—subrule 3.12(4) and to the names and email addresses of the parties listed below by transmitting the same from (sending email address).

(Date)

(Signature)

[**ARC 4780C**, IAB 11/20/19, effective 12/25/19; **ARC 5197C**, IAB 9/23/20, effective 10/28/20]

191—3.13(17A) Discovery.

3.13(1) *Discovery permitted.* Where statutory time limitations permit, discovery may be conducted as permitted by the Iowa Rules of Civil Procedure and these rules. Discovery shall be conducted in an expedited manner to prevent unnecessary delays to the hearing.

3.13(2) *Scope of discovery.* Parties may obtain discovery regarding any matter, not privileged or confidential, which is relevant to the claim or defense of the party in the pending action seeking discovery or to the claim or defense of any other party. Discovery responses are subject to the confidentiality provisions of Iowa Code section 22.7, chapters under the jurisdiction of the commissioner, and rule 191—3.12(17A), in accordance with applicable law, including, but not limited to, Iowa Code sections 17A.13(2) and 522B.11(6), unless otherwise permitted by the presiding officer for good cause shown.

3.13(3) *Notice of discovery.* Discovery is only permitted after a party has filed, pursuant to rule 191—3.12(17A), a notice of discovery no later than 15 days after the filing of an answer unless extended by the presiding officer for good cause shown or by agreement of the parties. The notice of discovery shall be a general notice that the party is serving discovery. The notice should include a statement regarding the type of discovery being conducted and the due date but the actual discovery requests do not need to be filed.

3.13(4) *Discovery responses.* Parties must respond to discovery within 15 days of receipt unless the parties mutually agree there is good cause to lengthen the response period or by order of the presiding officer. Time periods for compliance with discovery may be lengthened or shortened by order of the presiding officer.

3.13(5) *Discovery completion.* All discovery must be completed no later than 30 days before the prehearing conference.

3.13(6) *Discovery motions.* Any motion relating to discovery must allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party in a timely manner. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of any such motion unless the time is shortened as provided in subrule 3.13(4). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.14(17A,505) Subpoenas.

3.14(1) A subpoena shall be issued by the presiding officer at a party's request.

a. A request for a subpoena must be in writing and submitted to the presiding officer or designated filing clerk by mail, email, or in-person delivery in accordance with the filing requirements of rule 191—3.12(17A).

b. 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. The request shall also note the nature of the proceeding at which the witness is requested to testify (e.g., deposition, telephone hearing, or in-person hearing), the date and time of the proceeding, whether the witness is requested to appear in person or by telephone, the location of the proceeding, and the method of recording any deposition.

c. In the absence of good cause for permitting later action, a request for a subpoena must be received at least ten days before the scheduled proceeding.

3.14(2) The requesting party is responsible for arranging service of a subpoena prior to the proceeding at which the testimony is commanded or the time at which the requested documents must be produced. The requesting party is responsible for any cost associated with serving a subpoena and for the payment of witness fees and mileage expenses. Subpoenaed witnesses shall be entitled to receive witness fees for attendance, paid pursuant to Iowa Code section 622.69, and mileage shall be paid for each mile actually traveled for a subpoenaed witness to participate in an in-person hearing or deposition pursuant to Iowa Code section 622.69. Witnesses called to testify only to an opinion founded on special study or experience in any branch of science, or to make scientific or professional examinations and state the result thereof, may receive additional compensation, to be fixed by the presiding officer,

with reference to the value of the time employed and the degree of learning or skill required, but such additional compensation shall not exceed the sum set forth in Iowa Code section 622.72.

3.14(3) The presiding officer may quash or modify a subpoena upon motion as provided in the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be promptly set for hearing.
[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.15(17A) Motions.

3.15(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief and relief sought.

3.15(2) Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by the presiding officer. In ruling on a motion, the presiding officer may consider the motion unresisted, if no response is timely filed.

3.15(3) The presiding officer may schedule oral argument on any motion.

3.15(4) Motions pertaining to the hearing, except motions for summary judgment and requests for continuances, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by an order of the presiding officer.

3.15(5) Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases.

Motions for summary judgment may be filed and served within a reasonable time prior to the hearing, as determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 15 days, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or nonoral submission shall be not less than 20 days after the filing of the motion, unless a shorter time is ordered by the presiding officer. A summary judgment order rendered on all issues in a contested case is subject to rehearing pursuant to rule 3.28(17A) and appeal pursuant to rule 3.27(17A).

[Editorial change: IAC Supplement 11/17/10; ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.16(17A) Prehearing conference.

3.16(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than 14 days prior to the hearing date. A prehearing conference shall be scheduled not less than seven business days prior to the hearing date.

The presiding officer shall give written notice of the prehearing conference to all parties.

3.16(2) Prehearing conferences may be conducted by telephone conference or videoconference or in person as stated in the notice of hearing, unless otherwise ordered by the presiding officer.

3.16(3) Each party shall exchange and receive prior to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for failure to include their names; and

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for failure to include them.

3.16(4) Witness or exhibit lists may be amended subsequent to the prehearing conference within time limits established by the presiding officer at the prehearing conference. If no time limits are established at the prehearing conference, subsequent amendments to a witness or exhibit list may be allowed with the consent of the other parties or in the discretion of the presiding officer who may impose terms and time limits. Any such amendments must be served on all parties.

3.16(5) In addition to the requirements of subrule 3.16(3), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

- c. Identify matters which the parties intend to request be officially noticed;
- d. Enter into stipulations for waiver of any provision of law; and
- e. Consider any additional matters which will expedite the hearing.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.17(17A) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

3.17(1) An application for a continuance shall:

a. Be made at the earliest possible time and no less than 14 days before the hearing except in case of unanticipated emergencies or consent of all parties, and

b. State the specific reasons for the request.

3.17(2) In determining whether to grant a continuance, the presiding officer may consider:

a. Prior continuances;

b. The interests of all parties;

c. The likelihood of informal settlement;

d. The existence of an emergency;

e. Any objection;

f. Any applicable time requirements;

g. The existence of a conflict in the schedules of counsel, parties, or witnesses;

h. The timeliness of the request;

i. Failure to timely provide discovery responses; and

j. Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.

191—3.18(17A) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing.

191—3.19(17A,507B) Intervention.

3.19(1) A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, including any statutory grounds, and the position and interest of the proposed intervenor. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

3.19(2) Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for failure to file in a timely manner. Unless inequitable or unjust, an 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 proceeding will ordinarily be denied.

3.19(3) The movant shall demonstrate that (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties; or (d) there exists a statutory right to intervene.

3.19(4) If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.20(17A) Hearing procedures.

3.20(1) The presiding officer presides at the hearing, and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure orderly conduct of the proceedings.

3.20(2) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

b. Parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer, the court reporter, or a person otherwise authorized by law, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law; and

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

3.20(3) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel a person whose conduct is disorderly.

3.20(4) Parties 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 another person authorized by law, subject to Iowa Court Rule 113.

3.20(5) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

3.20(6) All objections shall be timely made and stated on the record.

3.20(7) Witnesses may be sequestered during the hearing. This rule does not authorize exclusion of (1) a party who is a natural person, or (2) an officer or employee of a party which is not a natural person designated as its representative by its attorney, or (3) a person whose presence is shown by a party to be essential to presentation of the cause.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.21(17A,507B) Evidence.

3.21(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with applicable requirements of law.

3.21(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

3.21(3) Evidence in the proceeding shall be confined to the issues as to which the parties received notice prior to the hearing unless the parties waive their right to such notice or the presiding officer determines that good cause justifies expansion of the issues. If the presiding officer decides to admit evidence on issues outside the scope of the notice over the objection of a party who did not have actual notice of those issues, that party, upon timely request, may receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

3.21(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 no later than the time they are proffered to the presiding officer. All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

3.21(5) A party may object to specific evidence. A party may request limits on the scope of any examination or cross-examination. Objections shall be accompanied by a brief statement of the grounds upon which the objections are based. The objection and the ruling on the objection shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision, if appropriate.

3.21(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 or, with permission of the presiding officer, present the testimony. If

the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.22(17A) Default.

3.22(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice as provided in subrule 3.5(1), the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

3.22(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and failed to file a required pleading or has failed to appear after proper service.

3.22(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate constitute final division action unless one of the following occurs: (1) the presiding officer otherwise orders, (2) a motion to vacate the default decision is filed within 15 days after the date of notification or mailing of the decision in accordance with rule 191—3.12(17A), or (3) an appeal to the commissioner of a proposed default decision is filed in accordance with rule 191—3.27(17A). A motion to vacate must be filed and served on all parties and state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

3.22(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

3.22(5) A motion to vacate shall be granted only when it is timely filed, is properly substantiated, and demonstrates good cause for the party's failure to appear or participate. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

3.22(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

3.22(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 3.25(17A).

3.22(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall schedule another hearing on the merits and the contested case shall proceed accordingly.

3.22(9) A default decision may award any relief consistent with the request for relief made in the petition, notice of hearing, or charging document and embraced in its issues.

3.22(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 3.29(17A).

[Editorial change: IAC Supplement 11/17/10; ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.23(17A) Ex parte communication.

3.23(1) Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the division or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule

3.9(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

3.23(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

3.23(3) Written, oral or other forms of communication are “ex parte” if made without notice and opportunity for all parties to participate.

3.23(4) To avoid prohibited ex parte communications notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 3.12(17A) and may be supplemented by telephone, facsimile, electronic mail or other means of notification.

3.23(5) Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

3.23(6) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 3.16(17A).

3.23(7) A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record, either under seal by protective order or in the public file, at the discretion of the presiding officer. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

3.23(8) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

3.23(9) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the division. Violation of ex parte communication prohibitions by division personnel shall be reported to the first deputy commissioner or designee for possible sanctions including censure, suspension, dismissal or other disciplinary action.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.24(17A) Recording costs. Upon request, the presiding officer with notice to all parties shall provide a copy of the whole or any portion of the record at a reasonable cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party. Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

191—3.25(17A) Interlocutory appeals. Upon written request of a party or on its own motion, the commissioner or designee may review an interlocutory order of the presiding officer. In determining

whether to do so, the commissioner or designee shall weigh the extent to which granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order at the time the proposed decision of the presiding officer is reviewed would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

191—3.26(17A) Final decision.

3.26(1) When the commissioner presides over the reception of evidence at the hearing, the commissioner's decision is a final decision.

3.26(2) When the commissioner does not preside over the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the division when adopted by the commissioner or without further proceedings after the time provided in rule 191—3.27(17A) unless there is a timely appeal to the commissioner or motion by the division to review the proposed decision.

3.26(3) The presiding officer's decision shall specify in bold print either that the decision is final or that the decision shall become final without further proceedings after the time provided in rule 191—3.27(17A) unless there is an appeal to, or review on motion of, the commissioner within the time provided in rule 191—3.27(17A).

3.26(4) Any administrative law judge serving as a presiding officer in a contested case shall report to the commissioner on a monthly basis all matters taken under advisement for longer than 60 days, together with an explanation of the reasons for the delay and an expected date of a proposed decision. A matter shall be reported when all hearings have been completed and the matter awaits decision without further appearance of the parties or their attorneys, even though briefs or transcripts have been ordered but have not yet been filed. The report shall be due on the tenth day of each calendar month for the period ending with the last day of the preceding calendar month. The report shall be signed by the administrative law judge. All reports received will be filed with the Iowa insurance division as records available for public inspection.

3.26(5) Parties shall be promptly notified of each proposed or final decision or order by delivery to them of a copy of such decision or order in the manner provided by Iowa Code section 17A.12(1) unless the party has consented to an alternative form of delivery.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.27(17A) Appeals and review by the commissioner of proposed decisions.

3.27(1) Any adversely affected party may appeal a proposed decision to the commissioner within 30 days after issuance of the proposed decision.

3.27(2) The division may initiate review of a proposed decision on its own motion at any time within 30 days following issuance of such a decision.

3.27(3) An appeal of a proposed decision is initiated by filing a timely notice of appeal with the commissioner. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

- a. The proposed decision or order appealed from;
- b. The parties initiating the appeal;
- c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;
- d. The grounds for relief; and
- e. The relief sought.

3.27(4) On appeal from a proposed decision of a presiding officer, the issues shall be limited to those raised before the presiding officer. No new issues will be considered for the first time on appeal.

3.27(5) On appeal, a party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within ten days of service

of the notice of appeal. The commissioner may remand a case to the presiding officer for further hearing or the commissioner may preside at the taking of additional evidence.

3.27(6) The commissioner shall issue a schedule for consideration of the appeal.

3.27(7) Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Any written requests to present oral argument shall be filed with the briefs. The commissioner may resolve the appeal on the briefs or provide an opportunity for oral argument. The commissioner may shorten or extend the briefing period as appropriate.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.28(17A) Applications for rehearing.

3.28(1) Any party to a contested case proceeding may file an application for rehearing from a final order.

3.28(2) The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the division decision on the existing record and whether, on the basis of the grounds enumerated in subrule 3.27(5), the applicant requests an opportunity to submit additional evidence.

3.28(3) The application shall be filed with the commissioner within 20 days after issuance of the final decision.

3.28(4) A copy of the application shall be timely mailed by the division to all parties of record not joining therein if the application does not contain a certificate of service demonstrating service on all parties.

3.28(5) Any application for a rehearing shall be deemed denied unless the commissioner grants the application within 20 days after its filing.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.29(17A) Stay of division action.

3.29(1) Petition requirements for stay of division action:

a. Any party to a contested case proceeding may petition the commissioner for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the division. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The commissioner may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the commissioner for a stay or other temporary remedy pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

3.29(2) In determining whether to grant a stay, the presiding officer or commissioner shall consider the factors listed in Iowa Code section 17A.19(5).

3.29(3) Any petition for stay of division action shall be deemed denied unless the commissioner grants the application within 20 days after its filing.

3.29(4) A stay may be vacated by the issuing authority upon application of the commissioner or any other party.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.30(17A) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as is practicable.

191—3.31(17A) Emergency adjudicative proceedings.

3.31(1) To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the division may issue a written order in compliance with Iowa Code section 17A.18A to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the division by emergency adjudicative order. Before issuing an emergency adjudicative order the division shall consider factors including, but not limited to, the following:

- a.* Whether there has been a sufficient factual investigation to ensure that the division is proceeding on the basis of reliable information;
- b.* Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;
- c.* Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;
- d.* Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare;
- e.* Whether the specific action contemplated by the insurance division is necessary to avoid the immediate danger; and
- f.* Whether the proposed emergency adjudicative order is sufficiently limited in scope and narrowly tailored to protect the public health, safety or welfare.

3.31(2) An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the division's decision to take immediate action.

- a.* The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing the procedures specified in subrule 3.5(1).
- b.* If practical, the division shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

3.31(3) Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the division shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

3.31(4) After issuance of an emergency adjudicative order, the division shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

3.31(5) A written emergency adjudicative order shall include notification of the date on which division proceedings are scheduled for completion. After an emergency adjudicative order is issued, continuance of further division proceedings to a later date will be granted only in compelling circumstances, and upon written application.

3.31(6) This rule does not preclude issuance of summary cease and desist orders as authorized by Iowa Code sections 502.604, 502A.12, 523A.17, 523B.8(1), 523D.13, and 523E.17; chapters 505, 507B, 507C, 508, and 515; and rule 191—3.32(502,505).

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.32(502,505,507B) Summary cease and desist orders. When a statute authorizes action to be taken without a prior hearing, the commissioner's order shall be sent to the last-known address of the party by certified mail, return receipt requested, unless the party is a licensee, in which case the order shall be sent by restricted certified mail. The order shall include a brief statement of findings of fact, conclusions of law and policy reasons for the decision; direct the person or insurer to cease and desist from engaging in the act or practice or to take other affirmative action as is necessary, in the judgment of the commissioner, to comply with the statute; and state that the party will be afforded a contested case proceeding and a hearing if a request is filed with the commissioner at least 30 days from the date that the order is issued, unless a different time is specified by statute. The commissioner shall issue a notice of hearing no later than 30 days from the date of receipt of a timely request for a contested case proceeding and hearing. If a statute requires a hearing to be held following issuance of a summary order, the date

and time of that hearing shall be set forth in the order. Summary orders shall remain effective during the pendency of proceedings.

191—3.33(17A,502,505) Informal settlement.

3.33(1) A party to a controversy that may culminate or has culminated in contested case proceedings may attempt informal settlement by complying with the procedures set forth in this subrule. No party shall be required to settle the controversy or contested case by submitting to informal settlement procedures.

3.33(2) Parties desiring informal settlement shall set forth in writing the various points of a proposed settlement, including findings of facts.

3.33(3) When signed by the parties and approved by the commissioner, a settlement shall represent final disposition of the matter.

3.33(4) When there is more than one party adverse to the division, a separate settlement between one party and the division is permissible.

3.33(5) A proposed settlement which is not accepted or signed by the parties and the commissioner shall not be admitted as evidence in the record of a contested case proceeding. Evidence of conduct or statements made in settlement negotiations likewise are not admissible. This rule does not require exclusion when the evidence is offered for another purpose, such as proving bias or prejudice of a witness, negating a contention of undue delay, or proving an effort to obstruct a criminal investigation or prosecution.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—3.34(17A,502,505) Witness fees. Rescinded ARC 5197C, IAB 9/23/20, effective 10/28/20.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

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CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING, WAIVER OF RULES,
AND DECLARATORY ORDERS

DIVISION I
AGENCY PROCEDURE FOR RULE MAKING

191—4.1(17A) Applicability. Except to the extent otherwise expressly provided by statute, all rules proposed or adopted by the division are subject to the provisions of Iowa Code chapter 17A and the provisions of this chapter.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.2(17A) Definitions. The definitions in Iowa Code section 17A.2 are incorporated into this chapter by this reference. In addition to those definitions and the definitions in rule 191—1.1(502,505), the following definitions apply:

“*Commissioner*” means the commissioner of insurance or the commissioner’s designee. For the purposes of this chapter, “commissioner” includes both the commissioner of insurance and the administrator as defined in Iowa Code chapter 502.

“*Waiver*” means action by the division that suspends in whole or in part the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—4.3(17A) Severability. If any provision of any rule adopted by the division, or if the application of any such rule to any person or circumstance, is for any reason held to be invalid, illegal or unenforceable by any court of law, the validity, legality and enforceability of the remainder of the rule and its application to other persons or circumstances shall not be affected or impaired thereby.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.4(17A) Public rule-making docket. The division shall maintain on the division’s website a current public rule-making docket listing each pending rule-making proceeding and relevant rule-making information, including the information required by Iowa Code sections 17A.3(1) “d” and 17A.6A(2). If a rule-making docket for all agencies is maintained on the Iowa legislature’s website, the division may utilize the legislature’s docket, in whole or in part, instead of creating a duplicative separate docket.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.5(17A) Rule making.

4.5(1) Notice of proposed rule making. The division must publish a Notice of Intended Action in the Iowa Administrative Bulletin prior to the adoption of a rule unless otherwise authorized by Iowa Code section 17A.4(3). The Notice of Intended Action must include:

- a. A brief explanation of the purpose of the proposed rule;
- b. The specific legal authority for the proposed rule;
- c. Except to the extent impracticable, the text of the proposed rule;
- d. The methods that persons and agencies may use to present their views on the proposed rule; and
- e. Any other information required by statute or rule.

4.5(2) Public participation.

a. With regard to proposed rules published under Notice of Intended Action, the division must receive and consider, from any person or agency, written comments and written requests to make an oral presentation when the comments and requests are prepared and submitted in conformance with the following:

(1) Comments and requests must clearly state the name, address and telephone number of the person or agency authoring the comment or request and the number and title of the proposed rule as given in the Notice of Intended Action.

(2) If an oral presentation is requested, the requester is encouraged to set forth the general subject of the presentation.

(3) Comments and requests must be submitted as specified in the Notice of Intended Action and received no later than the date specified in the Notice. The specified date must be no less than 20 days after publication of the Notice.

b. The receipt and acceptance for consideration of written comments and written requests must be promptly acknowledged by the division.

(1) Written comments received after the deadline may be accepted by the division although their consideration is not assured.

(2) Written requests to make an oral presentation received after the deadline will not be accepted.

c. In addition to the formal procedures contained in this rule, the division may solicit viewpoints or advice concerning proposed rules through informal conferences or consultations as the division may deem desirable.

4.5(3) *Regulatory analysis.* A request for the issuance of regulatory analysis pursuant to Iowa Code section 17A.4A must be submitted to the division at the address in rule 191—1.4(502,505) or as instructed on the division's website.

4.5(4) *Concise statement.* The division must issue a concise statement of the principal reasons for and against a rule that has been adopted if the statement is requested in accordance with this subrule.

a. The request for a concise statement must:

(1) Clearly state the name, address and telephone number of the person or agency authoring the request and the number and title of the rule which is the subject of the request.

(2) Be submitted in writing to the division at the address set forth in rule 191—1.4(502,505) or as instructed on the division's website and be postmarked no later than 30 days after publication in the Iowa Administrative Bulletin of the rule that is the subject of the request for a concise statement.

b. The concise statement issued by the division in response to the request must include the following:

(1) The principal reasons for adopting the rule;

(2) An indication of any change between the text of the proposed rule contained in the published Notice of Intended Action and the text of the rule as finally adopted, with the reasons for any such change; and

(3) The principal reasons urged in the rule-making proceeding for and against the rule, and the division's reasons for overruling the arguments made against the rule.

c. A requested concise statement must be issued either at the time of rule adoption or within 35 days after the division receives the request.

4.5(5) *Registration for copies of Notices of Intended Action.* Any person, entity, small business, or trade or occupational association may register its name and address with the agency to receive copies of Notices of Intended Action.

a. The request must be in writing, specify whether the requester wants to receive insurance rules, securities rules, or both, and specify the number of copies of the Notice of Intended Action the requester wishes to receive.

b. The requester must reimburse the division for the actual costs incurred in providing copies.

c. The division must promptly acknowledge the receipt of the request.

4.5(6) *Records.* The division must maintain public rule-making documents and other public records related to rule making in an accessible format for public inspection.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.6(17A) Differences between adopted rule and rule proposed in Notice of Intended Action. The division shall not adopt a rule that differs from the rule proposed in the Notice of Intended Action upon which the adopted rule is based unless the differences are within the scope of the subject matter announced in the Notice of Intended Action, are in character with the issues raised in that

Notice, and are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.7(17A) Petition for rule making.

4.7(1) Any person or agency may file a petition for rule making with the division at the address disclosed in rule 191—1.4(502,505) or as instructed on the division’s website. A petition is deemed filed when it is received. The division must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the division an extra copy for this purpose.

4.7(2) The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE IOWA INSURANCE COMMISSIONER	
Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (State subject matter).	}
	PETITION FOR RULE MAKING

4.7(3) The petition shall provide the following information in separate numbered paragraphs:

1. The petitioner’s name, address, and telephone number.
2. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation to the particular portion or portions of the rule proposed to be amended or repealed.
3. A citation to any law deemed relevant to the division’s authority to take the action urged or to the desirability of that action.
4. A brief summary of the petitioner’s arguments in support of the action urged in the petition.
5. A brief summary of any data supporting the action urged in the petition.
6. The names and addresses of other persons, or a description of any class of persons, known by the petitioner to be affected by, or interested in, the proposed action which is the subject of the petition.
7. If desired, a request to meet informally with the division to discuss the petition.

4.7(4) The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, email address if available, and telephone number of the petitioner and the petitioner’s representative, and a statement indicating the person to whom communications concerning the petition should be directed.

4.7(5) The division may deny a petition because it does not substantially conform to the required form.

4.7(6) The petitioner may submit a brief in support of the action urged in the petition. The division may request a brief from the petitioner or from any other person concerning the substance of the petition.

4.7(7) Upon request by the petitioner in the petition, the division must schedule a brief and informal meeting between the petitioner and the division or a member of the division’s staff to discuss the petition. The division may request the petitioner to submit additional information or argument concerning the petition.

4.7(8) Within 60 days after the filing of the petition, or within any longer period agreed to by the petitioner, the division must, in writing, deny the petition, and notify the petitioner of its action and the specific grounds for the denial, or grant the petition and notify the petitioner that it has instituted rule-making proceedings on the subject of the petition. The petitioner shall be deemed notified of the denial or grant of the petition on the date when the division mails or delivers the required notification to the petitioner.

4.7(9) Petitions for rule making and the disposition of the petition shall be submitted to the administrative rules review committee pursuant to Iowa Code chapter 17A.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 5197C, IAB 9/23/20, effective 10/28/20]

The rules in this division are intended to implement Iowa Code section 17A.7.

191—4.8 to 4.20 Reserved.

DIVISION II
WAIVER OF RULES

191—4.21(17A) Waivers.

191—.21(4)“a”191—.21(4)“a”

4.21(1) Scope. Division II of this chapter outlines generally applicable standards and a uniform process for the granting of individual waivers from rules adopted by the division in situations when no other more specifically applicable law provides for waivers. To the extent another more specific provision of law governs the issuance of a waiver from a particular rule, the more specific provision shall supersede the rules in this division with respect to any waiver from that rule. Division II of this chapter shall not preclude the division from granting waivers in other contexts or on the basis of other standards if a statute or agency rule authorizes the division to do so and the division deems it appropriate to do so.

4.21(2) Authority to grant waivers. The division may grant a waiver from a rule only if the division has jurisdiction over the rule and the requested waiver is consistent with applicable statutes, constitutional provisions, or other provisions of law. The division may not waive the following categories of rules:

- a. Rules setting requirements that are created or duties that are imposed by statute.
- b. Rules that provide definitions or interpretations, set fees, clarify enforcement authority, deal with fraud or are the subject of prosecutorial discretion.
- c. Rules that merely define the meaning of a statute or other provision of law or precedent if the commissioner does not possess delegated authority to bind the courts to any extent with the commissioner’s definition.

4.21(3) Criteria for order for waiver. In response to a petition completed pursuant to rule 191—4.22(17A), except for a petition seeking a waiver order issued pursuant to subrule 4.21(4), the division may in its sole discretion issue an order waiving in whole or in part the requirements of a rule if the division finds, based on clear and convincing evidence, all of the following:

- a. Application of the rule would impose an undue hardship on the person for whom the waiver is requested;
- b. Waiver from the requirements of the rule in the specific case would not prejudice the substantial legal rights of any person;
- c. Provisions of the rule subject to the petition for a waiver are not specifically mandated by statute or another provision of law;
- d. Substantially equal protection of public health, safety, and welfare will be afforded by a means other than that prescribed in the particular rule for which the waiver is requested; and
- e. If the rule implements Iowa Code chapter 502 or is being applied in conjunction with implementation of Iowa Code chapter 502, the waiver is necessary or appropriate in the public interest or for the protection of investors and is consistent with the purposes fairly intended by the policy and provisions of Iowa Code chapter 502.

4.21(4) Criteria for waiver related to approval of a manner of electronic delivery of notices of cancellation, nonrenewal or termination. This subrule is intended to implement Iowa Code sections 17A.9A and 505B.1.

a. For purposes of Iowa Code chapter 505B and this subrule, in addition to the definitions in rule 191—4.2(17A), the following definitions shall apply:

“*Intended recipient*” means the person to whom notice is required to be delivered, including but not limited to notices listed in the definition of “notice of cancellation, nonrenewal or termination” in this paragraph and in 191—paragraphs 20.80(1)“b,” 30.9(1)“b,” 35.9(1)“b,” 39.33(1)“b,” and 40.26(1)“b.”

“*Notice of cancellation, nonrenewal or termination*” means:

1. Notice of an insurance company’s termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and
3. For purposes of notices required by Iowa Code chapters 505B, 508, 509B, 513B, 514, 514B, 514D, 514G, 515, 515D, 518, 518A and 519, includes but is not limited to the following:

- An insurance company's notice of cancellation, nonrenewal, suspension, exclusion, intention not to renew, failure to renew, termination, replacement, rescission, forfeiture or lapse in an annuity policy, a life insurance policy, a long-term care insurance policy, or an insurance policy other than life;
- An insurance company's rescission or discontinuance of an accident and health insurance policy;
- An insurance company's notice of cancellation of personal lines policies or contracts;
- A health maintenance organization's notice to an enrollee of cancellation or rescission of membership;
- An employer's or group policyholder's notice to an employee or member of the termination or substantial modification of the continuation of an employer group accident or health policy; or
- A carrier's advance notice to affected small employers, participants, and beneficiaries of its decision to discontinue offering a particular type of health insurance coverage.

b. This subrule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance in Iowa, health maintenance organizations, employers, group policyholders, or carriers and to all requirements by statute or rule related to notices of cancellation, nonrenewal or termination. This subrule shall apply when an insurance company, health maintenance organization, employer, group policyholder, or carrier seeks the commissioner's approval of a manner for delivering by electronic means required notices of cancellation, nonrenewal or termination, as described in Iowa Code section 505B.1.

c. The commissioner, by order pursuant to this chapter, may approve a request for approval of a manner for delivering notices of cancellation, nonrenewal or termination by an electronic means if the commissioner has jurisdiction to enforce the statute or rule requiring the notice and if the requested approval is consistent with Iowa Code section 505B.1 and with this chapter.

d. In response to a petition submitted pursuant to rule 191—4.22(17A) and related statutes and rules, the commissioner may issue an order approving an insurer's proposed manner for delivering notices of cancellation, nonrenewal or termination by an electronic means rather than mail, if the commissioner finds, based on clear and convincing evidence, all of the following:

- (1) The proposed manner allows the commissioner, the insurer and the intended recipient to verify receipt by the intended recipient;
- (2) The proposed manner provides for consent, by the intended recipient, to have notices or documents delivered by electronic means, in compliance with Iowa Code chapter 505B; and
- (3) The proposed manner provides that the insurance company shall maintain adequate records of notices, receipts and consents. The records shall be available for review upon request by the commissioner and the intended recipient and be shall maintained for a period of five years from the date of cancellation, nonrenewal or termination.

e. Such an order would constitute approval by the commissioner to satisfy Iowa Code chapter 505B.

f. Although any proposed manner that complies with the above requirements may be approved, the following system is provided as an example, for purposes of guidance, of an insurer's system of verifiable receipt that will be approved by the commissioner if the system includes all of the following aspects:

(1) The system provides that the intended recipients shall give written consent to the insurer of delivery of required notices of cancellation, nonrenewal and termination by electronic means, in compliance with Iowa Code section 505B.1.

(2) The system provides that when an insurer is required to provide notices of cancellation, nonrenewal and termination, the insurer shall provide to the intended recipients a link to the required notice by electronic mail.

(3) The system provides that the insurer provide intended recipients with user names and passwords to log in to the insurer's notice system website.

(4) The system provides that the link required by subparagraph 4.21(4) “f”(2) shall be to a secure website that requires the intended recipients’ user names and passwords for the intended recipients to access the insurer’s notice system website and the contents of the notices.

(5) The system provides that when the intended recipients log in to the insurer’s notice system website, either the insurer’s notice to the intended recipients or the intended recipients’ online inboxes will be the first thing automatically displayed.

(6) The system provides a procedure whereby, if the intended recipients do not log in to the intended recipients’ accounts within seven days after the insurer sent the link to the intended recipients by email, the insurer shall mail paper copies of the notices to the intended recipients’ last-known physical addresses.

(7) The system provides for adequate maintenance of records by the insurer as required by subparagraph 4.21(4) “d”(3).

g. The commissioner may, upon proper request by an insurance company pursuant to rule 191—2.6(17A,22) or another applicable rule, maintain the confidentiality of information in any document or materials submitted in support of a request for approval under this rule:

(1) If release of the specific information would disclose trade secrets protected by law pursuant to Iowa Code section 22.7(3) and 191—subrule 2.12(12); or

(2) If the specific information otherwise must be withheld from public inspection pursuant to Iowa Code chapter 22 or rule 191—2.12(17A,22).
[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.22(17A) Petition for waiver. A petition for a waiver must be submitted in writing to the division as follows:

4.22(1) Applications. If the petition relates to an application or license, the petition must be made in accordance with the filing requirements for the application or license in question.

4.22(2) Contested cases. If the petition relates to a pending contested case, the petition must be filed in the contested case proceeding, using the caption of the contested case. The waiver petition shall be decided within the context of the contested case unless the presiding officer, other than the commissioner, determines that the petition should be referred directly to the commissioner.

4.22(3) Other. If the petition does not relate to an application or a pending contested case, the petition must be submitted to the division at the address in rule 191—1.4(502,505) or as instructed on the division’s website.

4.22(4) Content of petition. A petition for waiver must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE IOWA INSURANCE COMMISSIONER		
In the matter of: (Name of Person Requesting Waiver)	}	REQUEST FOR WAIVER OF RULE (Specify number of rule for which waiver is requested)

4.22(5) The petition shall provide the following information in separate numbered paragraphs:

1. The name, address and telephone number of the entity or person for whom a waiver is being requested, and the case number of any related contested case.
2. A description and citation of the specific rule from which a waiver is requested.
3. The specific waiver requested, including the precise scope and duration.
4. The relevant facts that the petitioner believes would justify a waiver under each of the criteria described in subrule 4.21(3). This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts provided in the petition and a statement of reasons that the petitioner believes justify a waiver.
5. A history of any prior contacts between the division and the petitioner relating to the regulated activity, application or license affected by the proposed waiver, including a description of each affected

license held by the petitioner, any notices of violation, contested case hearings, or investigative reports relating to the regulated activity or license within the prior five years and any waivers or waiver applications filed by the petitioner with the division within the prior five years.

6. Any information known to the petitioner regarding the division's treatment of similar cases.

7. The name, address and telephone number of any public agency or political subdivision which also regulates the activity in question or which might be affected by the granting of a waiver.

8. The name, address and telephone number of any entity or person who would be adversely affected by the granting of a waiver.

9. The name, address and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver.

10. Signed releases of information authorizing persons with knowledge regarding the request to furnish the division with information relevant to the waiver.

4.22(6) Notice. The division must acknowledge a petition upon receipt. The division must ensure that, within 30 days of the receipt of the petition, notice of the pendency of the petition and a concise summary of its contents have been provided to all persons to whom notice is required by any provision of law. In addition, the division may give notice to other persons. To accomplish this notice provision, the division may require the petitioner to serve the notice on all persons to whom notice is required by any provision of law and to provide a written statement to the division attesting that notice has been provided.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—4.23(17A) Waiver hearing procedures and ruling.

4.23(1) Procedures. The provisions of Iowa Code sections 17A.10 to 17A.18A regarding contested case hearings shall apply to any petition for a waiver filed within a contested case and shall otherwise apply to agency proceedings for a waiver only when the division so provides by rule or order or is required to do so by statute.

4.23(2) Additional information. Prior to issuing an order granting or denying a waiver, the division may request additional information from the petitioner relative to the petition and surrounding circumstances. If the petition was not filed in a contested case, the division may, on its own motion or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner and the division.

4.23(3) Division discretion. The final decision on whether the circumstances justify the granting of a waiver shall be made at the sole discretion of the division, upon consideration of all relevant factors. Each petition for a waiver must be evaluated by the division based on the unique, individual circumstances set out in the petition.

4.23(4) Ruling. An order granting or denying a waiver must be in writing and must contain a reference to the particular person and rule or portion thereof to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the precise scope and duration of the waiver if one is issued.

4.23(5) Burden of persuasion. The burden of persuasion rests with the petitioner to demonstrate by clear and convincing evidence that the division should exercise its discretion to grant a waiver from a division rule.

4.23(6) Narrowly tailored exception. A waiver, if granted, must provide the narrowest exception possible to the provisions of a rule.

4.23(7) Administrative deadlines. When the rule from which a waiver is sought establishes administrative deadlines, the division must balance the special individual circumstances of the petitioner with the overall goal of uniform treatment of all similarly situated persons.

4.23(8) Conditions. The division may place any condition on a waiver that the division finds desirable to protect the public health, safety, and welfare.

4.23(9) Time period of waiver. A waiver must not be permanent unless the petitioner can show that a temporary waiver would be impracticable. If a temporary waiver is granted, there is no automatic right

to renewal. At the sole discretion of the division, a waiver may be renewed if the division finds that grounds for a waiver continue to exist.

4.23(10) Time for ruling. The division must grant or deny a petition for a waiver as soon as practicable but, in any event, must do so within 120 days of its receipt unless the petitioner agrees to a later date. However, if a petition is filed in a contested case, the division must grant or deny the petition no later than the time at which the final decision in that contested case is issued.

4.23(11) When deemed denied. Failure of the division to grant or deny a petition within the required time period shall be deemed a denial of that petition by the division. However, the division shall remain responsible for issuing an order denying a waiver.

4.23(12) Service of order. Within seven days of its issuance, any order issued under this chapter must be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

4.23(13) Cancellation of a waiver. A waiver issued by the division pursuant to this chapter may be withdrawn, canceled, modified or revoked if, after appropriate notice and hearing, the division issues an order finding any of the following:

- a. The petitioner or the person who was the subject of the waiver order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver; or
- b. The alternative means for ensuring that the public health, safety and welfare will be adequately protected after issuance of the waiver order have been demonstrated to be insufficient; or
- c. The subject of the waiver order has failed to comply with all conditions contained in the order; or
- d. The waiver is contrary to the public health, safety and welfare in light of newly discovered evidence or changed circumstances.

4.23(14) Violations. Violation of a condition in a waiver order shall be treated as a violation of the particular rule for which the waiver was granted. As a result, the recipient of a waiver under this chapter who violates a condition of the waiver may be subject to the same remedies or penalties as a person who violates the rule at issue.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

The rules in this division are intended to implement Iowa Code section 17A.9A and Executive Order Number 11 (September 14, 1999).

191—4.24 to 4.36 Reserved.

DIVISION III
DECLARATORY ORDERS

191—4.37(17A) Petition for declaratory order.

4.37(1) Any person or agency may file a petition with the division for a declaratory order as to the applicability to specified circumstances of a statute, rule or order within the primary jurisdiction of the division.

4.37(2) The petition must be submitted to the division at the address provided in rule 191—1.4(502,505) or as instructed on the division’s website.

4.37(3) The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

BEFORE THE IOWA INSURANCE COMMISSIONER		
Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).		PETITION FOR DECLARATORY ORDER

4.37(4) The petition for declaratory order must provide the following information in separate numbered paragraphs:

1. The petitioner's name, address, and telephone number.
2. The citation to and the exact words, passages, sentences or paragraphs of the statute, rule, or order that is the subject of the petition.
3. A clear and concise statement of all relevant facts upon which the declaratory order is requested.
4. The questions the petitioner wants answered, stated clearly and concisely.
5. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers.
6. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome.
7. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity.
8. Any request by the petitioner for a meeting provided for by rule 191—4.43(17A).

4.37(5) The petition for declaratory order must be dated and signed by the petitioner or the petitioner's representative.

4.37(6) If applicable, the petition must also include the name, mailing address, and telephone number of the petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

4.37(7) A petition is deemed filed when it is received by the division. The division must provide the petitioner with a file-stamped copy of the petition if the petitioner provides the division an extra copy for this purpose.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.38(17A) Notice of petition. Within 15 days after receipt of a petition for a declaratory order, the division must give notice of the petition to all persons not served by the petitioner pursuant to rule 191—4.42(17A) to whom notice is required by any provision of law. The division may also give notice to any other persons deemed appropriate.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.39(17A) Intervention.

4.39(1) Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order (after time for notice under rule 191—4.38(17A) and before 30-day time for division action under rule 191—4.44(17A)) shall be allowed to intervene in a proceeding for a declaratory order.

4.39(2) Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the division.

4.39(3) A petition must be typewritten or legibly handwritten in ink and shall state in separately numbered paragraphs the following:

- a. Facts supporting the intervenor's standing and qualifications for intervention.
- b. The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers.
- c. Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome.
- d. A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by any governmental entity.
- e. The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented.
- f. Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding.

4.39(4) The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

[ARC 5197C, IAB 9/23/20, effective 10/28/20]

191—4.40(17A) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The division may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.41(17A) Inquiries. Inquiries concerning the status of a declaratory proceeding may be made to the division at the address disclosed in rule 191—1.4(502,505).

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.42(17A) Service and filing of petitions and other papers.

4.42(1) When service required. Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with its filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

4.42(2) Filing—when required. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the division at the address disclosed in rule 191—1.4(502,505). All petitions, briefs, or other papers required to be served upon a party shall be filed simultaneously with the division.

4.42(3) Method of service, time of filing, proof of mailing. Method of service, time of filing, and proof of mailing shall be as provided by rule 191—3.12(17A).

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.43(17A) Consideration. Upon request by the petitioner, the division must schedule an informal meeting between the original petitioner, all intervenors, and the commissioner, or a member of the commissioner's staff, to discuss the questions raised.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.44(17A) Action on petition.

4.44(1) Within the time allowed by Iowa Code section 17A.9(5), after receiving a petition for a declaratory order, the division shall take action on the petition as required by Iowa Code section 17A.9(5).

4.44(2) The date of issuance of an order is as defined in rule 191—3.2(17A).

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.45(17A) Refusal to issue order.

4.45(1) The division shall not issue a declaratory order where prohibited by Iowa Code section 17A.9(1) and may refuse to issue a declaratory order on some or all questions raised for any of the following reasons:

- a. The petition does not substantially comply with the required form.
- b. The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by failure of the division to issue an order.
- c. The division does not have jurisdiction over the questions presented in the petition.
- d. The questions presented by the petition are also presented in a current rule making, contested case, or other agency or judicial proceeding, that may definitively resolve them.
- e. The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter.
- f. The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order.
- g. There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances.
- h. The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct in an effort to establish the effect of that conduct or to challenge a division decision already made.

i. The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of the petitioner.

j. The petition requests the division to determine whether a statute is unconstitutional on its face.

4.45(2) A refusal by the division to issue a declaratory order must indicate the specific grounds for refusal and constitutes final agency action on the petition.

4.45(3) Refusal to issue a declaratory order pursuant to this rule does not preclude a petitioner from filing a new petition that seeks to eliminate the grounds for refusal to issue a ruling.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.46(17A) Contents of declaratory order—effective date.

4.46(1) In addition to the order itself, a declaratory order must contain the date of its issuance, the name of the petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

4.46(2) A declaratory order is effective on the date of issuance.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.47(17A) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order must be mailed or emailed by the division promptly to the original petitioner and all intervenors.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

191—4.48(17A) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. It is binding on the division, the petitioner, and any intervenors who consent to be bound and is applicable only in circumstances where the relevant facts and the law involved are indistinguishable from those on which the order was based. As to all other persons, a declaratory order serves only as precedent and is not binding on the division. Issuance of a declaratory order constitutes final agency action on the petition.

[ARC 4780C, IAB 11/20/19, effective 12/25/19]

The rules in this division are intended to implement Iowa Code section 17A.9.

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CHAPTER 36
INDIVIDUAL ACCIDENT AND HEALTH—MINIMUM
STANDARDS AND RATE HEARINGS
[Prior to 10/22/86, Insurance Department[510]]

DIVISION I
MINIMUM STANDARDS

191—36.1(514D) Purpose. The purpose of this chapter is to implement Iowa Code chapter 514D so as to provide reasonable standardization and simplification of terms and coverages of individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations in order to facilitate public understanding and comparison and to eliminate provisions contained in individual accident and sickness insurance policies and individual subscriber contracts of hospital, medical, and dental service corporations which may be misleading or confusing in connection either with the purchase of the coverages or with the settlement of claims and to provide for full disclosure in the sale of the coverages.

191—36.2(514D) Applicability and scope. This chapter shall apply to all individual accident and sickness insurance policies and subscriber contracts of service corporations, organized under Iowa Code chapter 514, delivered or issued for delivery to any person in this state on and after the effective date hereof, except it shall not apply to individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter, nor to policies being issued to employees or members as additions to franchise plans in existence on the effective date of this chapter. The requirements contained in this chapter shall be in addition to any other applicable regulations previously adopted.

191—36.3(514D) Effective date. This chapter shall be effective on December 31, 1981, and shall be applicable to all new filings of individual accident and sickness insurance policies and nonprofit hospital, medical and dental service contracts made after that date, and all other policies and contracts covered by this chapter and delivered or issued for delivery after June 30, 1982, shall be in compliance with this chapter.

191—36.4(514D) Policy definitions. Except as provided hereafter, no individual accident or sickness insurance policy or hospital, medical, or dental service corporation subscriber contract delivered or issued for delivery to any person in this state shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this rule.

36.4(1) “One period of confinement” means consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

36.4(2) “Hospital” may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

a. The definition of the term “hospital” shall not be more restrictive than one requiring that the hospital:

- (1) Be an institution operated pursuant to law; and
- (2) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
- (3) Provide 24-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.s).

b. The definition of the term “hospital” may state that the term shall not be inclusive of:

- (1) Convalescent homes, convalescent, rest, or nursing facilities; or
- (2) Facilities primarily affording custodial, educational or rehabilitative care; or
- (3) Facilities for the aged, drug addicts or alcoholics; or
- (4) Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except where a legal liability exists for charges made to the individual.

36.4(3) "*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;
- (2) Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

- (3) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

- (4) Provide continuous 24-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

- (5) Maintains a daily medical record of each patient.

b. The definition of such home or facility may provide that the term shall not be inclusive of:

- (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.

36.4(4) "*Skilled nursing care*" and "*convalescent nursing care*," when used in a policy, shall be defined in the policy as follows: Skilled nursing care or convalescent nursing services means any treatment which is rehabilitative in nature, which is required to restore an individual to the individual's prior level of health after an accident or illness and hospitalization, and which is related to the condition which was the cause of the confinement. Skilled nursing care and convalescent nursing care are any level of care greater than custodial care.

36.4(5) "*Custodial nursing care*" shall be defined as that level of nursing care required to assist an individual in meeting day-to-day living requirements, such as but not limited to, eating, bathing, dressing, and which care is required primarily due to reasons of age and not reasons of sickness.

36.4(6) "*Accident*" and "*accidental injury*" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

a. The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which are the direct cause, independent of disease or bodily infirmity or any other cause, and occur while the insurance is in force.

b. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

36.4(7) "*Sickness*" shall not be defined to be more restrictive than the following: Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a probationary period which will not exceed 30 days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

36.4(8) "*Preexisting condition*" shall not be defined to be more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment within a five-year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended

by a physician or received from a physician within a five-year period preceding the effective date of the insured person.

36.4(9) *“Physician”* may be defined by including words such as *“duly qualified physician”* or *“duly licensed physician.”* The use of the term “physician” requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the services are within the scope of the provider’s licensed authority and are provided pursuant to applicable laws.

36.4(10) *“Nurses”* may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words “nurse,” “trained nurse” or “registered nurse” are used without specific definition, then the use of these terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state of Iowa.

36.4(11) *“Total disability”*.

a. A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any employment or occupation for which the individual is or becomes qualified by reason of education, training or experience and who is not in fact engaged in any employment or occupation for wage or profit.

b. Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual’s inability to: (1) perform “any occupation whatsoever,” “any occupational duty,” or “any and every duty of the person’s occupation”; or (2) engage in any training or rehabilitation program.

c. An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of the person’s regular occupation or use words of similar import. An insurer may require care by a physician (other than the insured or a member of the insured’s immediate family).

36.4(12) *“Partial disability”* shall be defined in relation to the individual’s inability to perform one or more but not all of the “major,” “important,” or “essential” duties of employment or occupation or may be related to a “percentage” of time worked or to a “specified number of hours” or to “compensation.” Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

36.4(13) *“Residual disability”* shall be defined in relation to the individual’s reduction in earnings and may be related either to the inability to perform some part of the “major,” “important,” or “essential duties” of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term “residual disability,” the insurer may use “proportionate disability” or another term of similar import which in the opinion of the commissioner adequately and fairly describes the benefit.

36.4(14) *“Medicare”* shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially 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 Laws 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.

36.4(15) *“Complications of pregnancy”* shall be defined to include:

a. Conditions requiring hospital stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy; and

b. Nonelective Caesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

36.4(16) “*Mental or nervous disorders*” shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

36.4(17) “*Short-term limited-duration insurance*” means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total.

This rule is intended to implement Iowa Code section 514D.3.
[ARC 4332C, IAB 3/13/19, effective 2/20/19]

191—36.5(514D) Prohibited policy provisions.

36.5(1) Except as provided in subrule 36.4(7), no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproductive organs, varicose veins, adenoids, appendix, and tonsils. However, the permissible six months’ exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

36.5(2) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six months. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that the renewal is optional with the policyholder.

36.5(3) No policy shall exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following policy issue where the application for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and preexisting condition is not specifically excluded by the terms of the policy.

36.5(4) A disability income policy may contain a “return of premium” or “cash value benefit” so long as:

a. Such 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

b. The insurer demonstrates that the reserve basis for such policies is adequate. No other policy shall provide a return of premium or cash value benefit, except return of unearned premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability, payment of dividends on participating policies, or experience rating refunds.

36.5(5) Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

36.5(6) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

a. Preexisting conditions or diseases, except for congenital anomalies of a covered dependent child;

b. Mental or emotional disorders, alcoholism and drug addiction;

c. Pregnancy, except for complications of pregnancy;

d. Illness or medical condition arising out of:

(1) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; or service in the armed forces or units auxiliary thereto;

(2) Suicide (sane or insane), attempted suicide or intentionally self-inflicted injury;

(3) Aviation;

(4) With respect to short-term nonrenewable policies, of less than 12 months in duration, interscholastic sports;

(5) With respect to disability income protection policies, incarceration;

e. Cosmetic surgery, except that “cosmetic surgery” shall not include reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect;

f. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

g. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;

h. Treatment provided in a government hospital; benefits provided 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 performed by a member of the covered person’s immediate family and services for which no charge is normally made in the absence of insurance;

i. Dental care or treatment;

j. Eye glasses, hearing aids and examination for the prescription or fitting thereof;

k. Rest cures, custodial care, transportation and routine physical examinations;

l. Territorial limitations.

36.5(7) The provisions of this chapter shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy or unless notice of the waiver appears on the first page or specification page.

36.5(8) Except as otherwise provided in 36.7(1), the terms “Medicare supplement,” “Medigap,” and words of similar import shall not be used unless the policy is issued in compliance with 191—Chapter 37.

36.5(9) Policy provisions precluded in this subrule shall not be construed as a limitation on the authority of the commissioner to disapprove other policy provisions or coverages in accordance with Iowa Code section 514D.3(2), which, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

36.5(10) Rescinded IAB 10/30/91, effective 12/4/91.

191—36.6(514D) Accident and sickness minimum standards for benefits. The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subrules. No individual policy of accident and sickness insurance or nonprofit hospital, medical or dental service corporation contract shall be delivered or issued for delivery in this state which does not meet the required minimum standards for the specified categories unless the commissioner finds that such policies or contracts are approvable as limited benefit health insurance and the outline of coverage complies with the appropriate outline in 36.7(12).

Nothing in this rule shall preclude the issuance of any policy or contract combining two or more categories of coverage set forth in this chapter.

Nonprofit hospital and medical service associations are subject to this chapter. When such associations are prohibited from issuing subscriber contracts which include all of the benefits required in 36.6(2) or 36.6(5), they shall include so much of those benefits as are permitted and they shall be issued in conjunction with another contract including at least the remainder of the minimum benefit required. In such event, the combination of contracts will be considered to have been issued in compliance with this chapter.

36.6(1) General rules.

a. A “noncancelable,” “guaranteed renewable,” or “noncancelable and guaranteed renewable” policy shall not provide for termination of coverage of the spouse solely because of the occurrence of

an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death, the spouse of the insured, if covered under the policy, shall become the insured.

b. The terms "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of 36.7(1)"a." The terms "noncancelable" or "noncancelable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60 the insured has the right to continue the policy in force at least to age 65 while actively or regularly employed. Except as provided above, the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of 65 or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes: Provided, however, any accident and health or accident only policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while actively and regularly employed.

c. In a family policy covering both husband and wife, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the definitions of "noncancelable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse, to the age or for the durational period as specified in said definition.

d. When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

e. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro-rata basis.

f. In the event the insurer cancels or refuses to renew, policies providing pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

g. Policies providing skilled, or convalescent, or extended care benefits following hospitalization shall not condition the benefits upon admission to the nursing facility within a period of less than 14 days after discharge from the hospital.

h. Family coverage shall continue for any dependent child who is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit for children and is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of the date, the company receive due proof of such incapacity in order for the insured to elect to continue the policy in force with respect to the child, or that a separate converted policy be issued at the option of the insured or policyholder.

i. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

j. A policy may contain a provision relating to recurrent disabilities; provided, however, that no provision shall specify that a recurrent disability be separated by a period greater than six months.

k. Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the policy was in force.

l. Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

m. Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable which are lesser than the maximum amount payable under the policy.

n. Termination of the policy shall be without prejudice to coverage for any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, or payment of the maximum benefits.

o. Rescinded IAB 11/27/91, effective 1/1/92.

36.6(2) "*Basic hospital expense coverage*" is a policy of accident and sickness insurance which provides coverage for a period of not less than 31 days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness for at least the following:

a. Daily hospital room and board in an amount not less than the lesser of 80 percent of the charges for the semiprivate room accommodations or \$100 per day;

b. Miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80 percent of the charges incurred up to at least \$3,000 or ten times the daily hospital room and board benefits;

c. Hospital outpatient services consisting of (1) hospital services on the day surgery is performed, and (2) hospital services rendered within 72 hours after accidental injury, in an amount not less than \$150, and (3) X-ray and laboratory tests, to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital in an amount not less than \$100.

Benefits provided under "a" and "b" above may be provided subject to a combined deductible amount not in excess of \$100.

36.6(3) "*Basic medical-surgical expense coverage*" is a policy of accident and sickness insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for at least the following:

a. Surgical services:

(1) In amounts not less than those provided in a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least \$1,000 for any one procedure; or

(2) Not less than 80 percent of the reasonable charges.

b. Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or assistant) performing the surgical services:

(1) In an amount not less than 80 percent of the reasonable charges; or

(2) Fifteen percent of the surgical service benefit.

c. In-hospital medical services, consisting of physician services other than surgical care, rendered to a person who is a bed patient in a hospital for treatment of sickness or injury in an amount not less than 80 percent of the reasonable charges or \$50 per day for not less than 21 days during one period of confinement.

36.6(4) "*Hospital confinement indemnity coverage*" is a policy of accident and sickness insurance which provides daily benefits for hospital confinement on an indemnity basis in an amount not less than

\$40 per day and not less than 31 days during any one period of confinement for each person insured under the policy.

a. Coverage shall not be excluded due to a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

b. Except as provided in 191—Chapter 38, division II, benefits shall be paid regardless of other coverage.

36.6(5) Individual major medical expense coverage.

a. “Individual major medical expense coverage” is an accident and sickness insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$500,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles does not exceed \$10,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases not to exceed 5 percent of the aggregate maximum limit under the policy for each covered person for at least:

(1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(2) Miscellaneous hospital services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

(6) Out-of-hospital care, consisting of physicians’ services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) Not fewer than three of the following additional benefits:

1. In-hospital private duty registered nurse services.

2. Convalescent nursing care.

3. Diagnosis and treatment by a radiologist or physiotherapist.

4. Rental of special medical equipment, as defined by the insurer in the policy.

5. Artificial limbs or eyes, casts, splints, trusses or braces.

6. Treatment for functional nervous disorders, and mental and emotional disorders.

7. Out-of-hospital prescription drugs and medications.

b. If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

c. The minimum benefits required by paragraph 36.6(5) “a” may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual major medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under subparagraph 36.6(5) “a”(7) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subrule through the application of special or internal limitations, an individual major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

36.6(6) Individual basic medical expense coverage.

a. “Individual basic medical expense coverage” is an accident and sickness insurance policy that provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than \$250,000; coinsurance percentage per year per covered person not to exceed 50 percent of covered charges, provided that the coinsurance out-of-pocket maximum after any deductibles does not exceed \$25,000 per year; a deductible stated on a per person, per family, per illness, per benefit period, or per

year basis, or a combination of these bases not to exceed 10 percent of the aggregate maximum limit under the policy for each covered person for at least:

(1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed upon by the insurer and provider for a period of not less than 31 days during continuous hospital confinement;

(2) Miscellaneous hospital services;

(3) Surgical services;

(4) Anesthesia services;

(5) In-hospital medical services;

(6) Out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

(7) Not fewer than three days of the following additional benefits:

1. In-hospital private duty registered nurse services;

2. Convalescent nursing home care;

3. Diagnosis and treatment by a radiologist or physiotherapist;

4. Rental of special medical equipment, as defined by the insurer in the policy;

5. Artificial limbs or eyes, casts, splints, trusses or braces;

6. Treatment for functional nervous disorders, and mental and emotional disorders; or

7. Out-of-hospital prescription drugs and medications.

b. If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying coverage.

c. The minimum benefits required by paragraph 36.6(6) "a" may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations. An individual basic medical expense policy may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under subparagraph 36.6(6) "a"(7) and other such special or internal limitations as are authorized or approved by the commissioner. Except as authorized by this subrule through the application of special or internal limitations, an individual basic medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed upon by the insurer and provider, for covered services up to the lifetime policy maximum.

36.6(7) "*Disability income protection coverage*" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of them which:

a. Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50 percent of amounts payable immediately prior to 62;

b. Contains an elimination period no greater than:

(1) Ninety days in the case of a coverage providing a benefit of one year or less;

(2) One hundred eighty days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(3) Three hundred sixty-five days in all other cases during the continuance of disability resulting from sickness or injury; and

c. Has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy or childbirth in which case the period for disability may be one month. No reduction in benefits shall be put into effect because of an increase in social security or similar benefits during a benefit period.

If a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

Subrule 36.6(7) does not apply to those policies providing business buy-out coverage.

36.6(8) “*Accident only coverage*” is a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least \$1,000 and a single dismemberment amount shall be at least \$500.

36.6(9) *Specified disease and specified accident coverage.*

a. “Specified disease coverage” is a policy which meets one of the following definitions:

(1) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with a deductible amount, if any, not in excess of \$250 and an overall aggregate benefit limit of not less than \$5,000 and a benefit period of not less than two years for at least the following incurred expenses:

1. Hospital room and board and any other hospital-furnished medical services or supplies;
2. Treatment by a legally qualified physician or surgeon;
3. Private duty services of a registered nurse (R.N.);
4. X-ray, radium and other therapy procedures used in diagnosis and treatment;
5. Professional ambulance for local service to or from a local hospital;
6. Blood transfusions, including expense incurred for blood donors;
7. Drugs and medicines prescribed by a physician;
8. The rental of a respirator or similar mechanical apparatus;
9. Braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;
10. Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and
11. May include coverage of any other expenses necessarily incurred in the treatment of the disease.

(2) A policy which provides coverage for each person insured under the policy for a specifically named disease (or diseases) with no deductible amount, and an overall aggregate benefit limit of not less than \$25,000 payable at the rate of not less than \$50 a day while confined in a hospital and a benefit period of not less than 500 days.

b. “Specified accident coverage” is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than \$5,000 for accidental death, \$5,000 for double dismemberment, and \$2,500 for single dismemberment.

36.6(10) “*Limited benefit health insurance coverage*” is any policy or contract which provides benefits that are less than the minimum standards for benefits required under 36.6(2) to 36.6(8). Limited benefit policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by 36.7(12) is completed and delivered as required by 36.7(2). A policy covering a specified disease or combination of diseases shall meet the requirements of 36.6(9) and shall not be offered for sale as a “limited coverage.” A policy which is designed to supplement Medicare shall meet the requirements of 191—Chapter 37 and shall not be offered for sale as a “limited coverage.”

36.6(11) *Short-term limited-duration insurance coverage.*

a. “Short-term limited-duration insurance coverage” provides coverage up to an aggregate maximum of not less than \$500,000 for each initial or renewal policy term and shall include a minimum of all of the following services subject to the approved policy terms, limitations and exclusions:

- (1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;
- (2) Miscellaneous hospital services, including emergency room services;
- (3) Surgical services;
- (4) Anesthesia services;
- (5) In-hospital medical services;
- (6) Out-of-hospital care consisting of physicians’ services rendered on an ambulatory basis, and through telemedicine by remote diagnosis and treatment of patients by means of telecommunications technology, where coverage is not provided elsewhere in the policy for diagnosis and treatment of

sickness or injury, diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician;

- (7) In-hospital registered nurse services;
- (8) Convalescent nursing care;
- (9) Diagnosis and treatment by a radiologist or physiotherapist;
- (10) Rental of special medical equipment, as defined by the insurer in the policy;
- (11) Artificial limbs or eyes, casts, splints, trusses or braces;
- (12) Treatment for functional nervous disorders, mental and emotional disorders and substance use disorders; and
- (13) Out-of-hospital prescription drugs and medications.

b. If the short-term limited-duration insurance coverage establishes a separate out-of-pocket maximum for the prescription drug benefit, the short-term limited-duration insurance coverage shall contain a deductible, coinsurance and copayment out-of-pocket maximum for all benefits for each covered person, excluding prescription drug services, that shall not exceed \$5,000 multiplied by the number of months of coverage and not in excess of \$20,000 for the full policy term of any duration, and the separate prescription drug benefit shall have a deductible, coinsurance and copayment out-of-pocket maximum separate from the other required services that shall not exceed \$2,500 multiplied by the number of months of coverage and not in excess of \$10,000 for the full policy term of any duration.

c. If the short-term limited-duration insurance coverage integrates a prescription drug benefit into the plan design, the deductible, coinsurance and copayment out-of-pocket maximum for each covered person for all medical and prescription drug coverage shall not exceed \$7,500 multiplied by the number of months of coverage and not in excess of \$30,000 for the full policy term of any duration.

d. After 180 days of coverage, short-term limited-duration insurance coverage that has an initial policy term or has been renewed or extended beyond 180 days in duration shall also provide preventative and wellness services subject to deductibles, coinsurance and copayments, including annual routine office visits, immunizations, mammography examinations, prostate-specific antigen blood tests and Papanicolaou tests.

e. Short-term limited-duration insurance shall not contain preexisting condition exclusions that exceed the initial policy term. Any renewable short-term limited-duration insurance shall be guaranteed renewable.

f. Short-term limited-duration insurance shall have an expiration date specified in the policy.

g. All short-term limited-duration policies shall contain the notices required of short-term limited-duration insurance as set forth in the Public Health Service Act, 45 CFR Section 144.103.

h. All short-term limited-duration insurance shall contain a free-look period of not less than ten days after the insured receives the policy during which the insured may cancel the insurance. If the insurance is so canceled, all fees and premiums paid shall be promptly refunded and the insurance shall be voided as if the policy had not been issued. Notice of the free-look period shall be prominently displayed on the first page of the policy.

(1) For the purposes of this paragraph, the policy shall be determined to be received by the insured as follows:

1. Pursuant to Iowa Code section 554D.117 if received electronically; and
2. Four days after the policy is postmarked for delivery if sent in the mail.

(2) For the purposes of this paragraph, the insured may cancel the insurance by giving notice to the insurance company, agent, broker or other representative in any manner, including but not limited to via electronic notice or by telephone.

i. All applications for short-term limited-duration insurance shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant and identify any preexisting conditions.

This rule is intended to implement Iowa Code section 514D.4.
[ARC 4332C, IAB 3/13/19, effective 2/20/19]

191—36.7(514D) Required disclosure provisions.

36.7(1) General rules.

a. Each individual policy of accident and sickness insurance or hospital, medical, or dental service corporation subscriber contract shall include a renewal, continuation, or nonrenewal provision. The language or specifications of the provision must be consistent with the type of contract to be issued. This provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

b. Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After 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.

c. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

d. A 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 and explanation of the terms “usual and customary” or “reasonable and customary” in its accompanying outline of coverage.

e. If a policy contains any limitations with respect to preexisting conditions the limitations must appear as a separate paragraph of the policy and be labeled as “Preexisting Condition Limitations.”

f. All accident only policies shall contain a prominent statement on the first page of the policy or attached to it, in either contrasting color or in boldface type at least equal to the size of type used for policy captions, as follows:

“This is an accident only policy and it does not pay benefits for loss from sickness.”

g. All policies, except single premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or attached to it stating in substance that the policyholder shall have the right to return the policy within ten days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

h. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

i. If a policy contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall be “Conversion Privilege,” or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

j. Insurers issuing policies which provide hospital or medical expense coverage on an expense-incurred or indemnity basis other than incidentally, to a person(s) eligible for Medicare by reason of age, shall provide to the policyholder a Medicare supplement buyer’s guide in the form of the booklet “Guide to Health Insurance for People with Medicare” developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services. Delivery of the buyer’s guide shall be made whether or not the policy qualifies as a “Medicare supplement coverage” in accordance with 191—Chapter 37. Except in the case of direct response insurers, delivery of the buyer’s guide shall be made at the time of application and acknowledgment of receipt of certification of delivery of the buyer’s guide shall be provided to the insurer. Direct response insurers shall deliver the buyer’s guide upon request but not later than at the time the policy is delivered.

k. Outlines of coverage delivered in connection with policies defined in this chapter as Hospital Confinement Indemnity, Specified Disease or Limited Benefit Health Insurance Coverages to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of 36.7(6), 36.7(10) and 36.7(12), the following language which shall be printed on or attached to the first page of the outline of coverage:

This policy IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare review the Medicare Supplement Buyer's Guide, available from the company.

l. If payment will not be made for services performed by a chiropractor acting within the scope of the chiropractor's license when those services would be compensable if performed by a medical doctor, then a statement that services performed by a chiropractor are not compensable shall be included in all outlines of coverage delivered in accordance with this chapter.

m. Disclosure requirements. All insurers shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all insurers offering policies under this chapter that include a prescription drug formulary shall inform policyholders, and prospective policyholders at time of issuance, whether a prescription drug specified in the request is included in such formulary.

All insurers 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.

36.7(2) *Outline of coverage requirements for individual coverages.* No individual accident and sickness insurance policy or nonprofit hospital, medical or dental service corporation subscriber contract subject to this chapter shall be delivered or issued for delivery in this state unless an appropriate outline of coverage, as prescribed in 36.7(3) to 36.7(12), is completed as to the policy or contract and

a. Delivered with the policy; or

b. Delivered to the applicant at the time application is made and acknowledgment of receipt or certification of delivery of the outline of coverage is provided to the insurer.

If an outline of coverage was delivered at the time of application and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

The appropriate outline of coverage for policies or contracts providing hospital coverage which only meets the standards of 36.6(2) shall be that statement contained in 36.7(3). The appropriate outline of coverage for policies providing coverage which meets the standards of both 36.6(2) and 36.6(3) shall be the statement contained in 36.7(5). The appropriate outline of coverage for policies providing coverage which meets the standards of both 36.6(2) and 36.6(5) or 36.6(3) and 36.6(5) or 36.6(2), 36.6(3), and 36.6(5) shall be the statement contained in 36.7(7).

Appropriate changes in terminology may be made in the outline of coverage in the case of contracts of hospital, medical, or dental service corporations. In any other case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or contract, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

36.7(3) *Basic hospital expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(2). The items included in the outline of coverage must appear in the sequence prescribed.

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY**.

b. Basic hospital expense coverage. Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians' or surgeons' fees or unlimited hospital expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy in the following order:

- (1) Daily hospital room and board;
- (2) Miscellaneous hospital services;
- (3) Hospital outpatient services; and
- (4) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(4) *Basic medical-surgical expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of subrule 36.6(3). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

**BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE**

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY**.

b. Basic medical-surgical expense coverage. Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

- (1) Surgical services;
- (2) Anesthesia services;
- (3) In-hospital medical services; and
- (4) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(5) *Basic hospital and medical-surgical expense coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(2) and 36.6(3) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
 BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE
 OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Basic hospital and medical-surgical expense coverage. Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

c. (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

- (1) Daily hospital room and board;
- (2) Miscellaneous hospital services;
- (3) Hospital outpatient services;
- (4) Surgical services;
- (5) Anesthesia services;
- (6) In-hospital medical services; and
- (7) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(6) *Hospital confinement indemnity coverage (outline of coverage).* An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(4). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
 HOSPITAL CONFINEMENT INDEMNITY COVERAGE
 OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Hospital confinement indemnity coverage. Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. These policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

c. (A brief specific description of the benefits contained in this policy, in the following order:

- (1) Daily benefit payable during hospital confinement; and
- (2) Duration of benefit described in “c”(1).)

(NOTE: The above description of benefits shall be stated clearly and concisely.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

f. (Any benefits provided in addition to the daily hospital benefit.)

36.7(7) Major medical expense coverage (outline of coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(5) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Major medical expense coverage. Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, copayment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

- (1) Daily hospital room and board;
- (2) Miscellaneous hospital services;
- (3) Surgical services;
- (4) Anesthesia services;
- (5) In-hospital medical services;
- (6) Out-of-hospital care;
- (7) Maximum dollar amount for covered charges; and
- (8) Other benefits, if any.)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(8) Disability income protection coverage (outline of coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(6) of this chapter. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Disability income protection coverage. Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

c. (A brief specific description of the benefits contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely.)

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in “c” above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(9) Accident only coverage (outline of coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(7). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Accident only coverage. Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

c. (A brief specific description of the benefits contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with 36.6(1) "m.")

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(10) Specified disease or specified accident coverage (outline of coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of 36.6(8). The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. (Specified disease) (Specified accident) coverage. Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with 36.6(1) "m.")

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in "c" above.)

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation or right to change premiums.)

36.7(11) Medicare supplement coverage (outline of coverage). Rescinded IAB 10/30/91, effective 12/4/91.

36.7(12) Limited benefit health coverage (outline of coverage). An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards

of subrules 36.6(2) to 36.6(8). The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

a. Read your policy carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

b. Limited benefit health coverage. Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

c. (A brief specific description of the benefits, including dollar amounts, contained in this policy:)
(NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subrule 36.6(1) "n.")

d. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 36.7(12) "c.")

e. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

36.7(13) Short-term limited-duration insurance coverage.

a. Outline of coverage. An outline of coverage, in the form prescribed below, shall be issued in connection with any short-term limited-duration insurance, as set forth in subrule 36.6(11). This outline of coverage must be provided in addition to the notices required by paragraph 36.6(11) "g." The items included in the outline of coverage must appear in the sequence prescribed below, and Section A must be in at least 14-point type or, if electronic, of equivalent prominence:

[COMPANY NAME]
SHORT-TERM LIMITED-DURATION INSURANCE COVERAGE
OUTLINE OF COVERAGE

[If coverage begins before January 1, 2019, the following notice shall appear in at least 14-point type or, if electronic, of equivalent prominence:]

A. THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS OR LIMITATIONS REGARDING COVERAGE OF PREEXISTING CONDITIONS OR HEALTH BENEFITS (SUCH AS HOSPITALIZATION, EMERGENCY SERVICES, MATERNITY CARE, PREVENTIVE CARE, PRESCRIPTION DRUGS, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR POLICY MIGHT ALSO HAVE LIFETIME AND/OR ANNUAL DOLLAR LIMITS ON HEALTH BENEFITS. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. ALSO, THIS COVERAGE IS NOT "MINIMUM ESSENTIAL COVERAGE" FOR ANY MONTH IN 2018. YOU MAY HAVE TO MAKE A PAYMENT WHEN YOU FILE YOUR TAX RETURN UNLESS YOU QUALIFY FOR AN EXEMPTION FROM THE REQUIREMENT THAT YOU HAVE HEALTH COVERAGE FOR THAT MONTH.

[If coverage begins on or after January 1, 2019, the following notice shall appear in at least 14-point type or, if electronic, of equivalent prominence:]

A. THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS OR LIMITATIONS REGARDING COVERAGE OF PREEXISTING CONDITIONS OR HEALTH BENEFITS (SUCH AS HOSPITALIZATION,

EMERGENCY SERVICES, MATERNITY CARE, PREVENTIVE CARE, PRESCRIPTION DRUGS, AND MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR POLICY MIGHT ALSO HAVE LIFETIME AND/OR ANNUAL DOLLAR LIMITS ON HEALTH BENEFITS. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

B. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

C. [A brief specific description of the benefits, including dollar amounts, contained in this policy. The description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment or other out-of-pocket cost provisions applicable to the benefits described. The description of benefits shall also clearly state any applicable provider network requirements including but not limited to distinctions in cost provisions for in-network and out-of-network providers.]

D. [A description of any other policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Section C, above, including but not limited to any preexisting condition exclusions for policies.]

E. [A description of policy provisions regarding renewability or continuation of coverage, including any reservation of right to change premiums.]

b. Application for coverage for short-term limited-duration insurance. All applications for short-term limited-duration policies shall contain the notice prescribed below, which shall be in at least 14-point type or, if electronic, of equivalent prominence. One signed copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

STATEMENT TO APPLICANT BY ISSUER [PRODUCER, BROKER OR OTHER REPRESENTATIVE]:

Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under this policy. This could result in a denial or delay of payment of benefits. If you wish to purchase a short-term limited-duration policy, 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.

ALSO NOTE THAT, IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

(Signature of Producer, Broker or Other Representative of the Company)
[Typed Name and Address of Producer, Broker or Other Representative]

The above "Statement to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)
[ARC 4332C, IAB 3/13/19, effective 2/20/19]

191—36.8(507B) Requirements for replacement.

36.8(1) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

36.8(2) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in 36.8(3). 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. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in 36.8(4). In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

36.8(3) The notice required by 36.8(2) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. 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.

a. 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 of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent 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.

c. 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.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

36.8(4) The notice required by subrule 36.8(2) above for a direct response insurer shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. 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.

a. 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 of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

b. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

c. (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)

191—36.9(514D) Filing requirements.

36.9(1) *Rate filing.* Every policy, rider or endorsement form affecting benefits which is submitted for approval shall be accompanied by a rate filing unless such rider or endorsement form does not require a change in a rate. Any subsequent addition to or change in rates applicable to such policy, rider or endorsement shall also be filed.

36.9(2) *Contents of rate filings.* Each rate submission shall include an actuarial memorandum describing the basis on which rates were determined and shall indicate and describe the calculation of the ratio, hereinafter called “anticipated creditable loss ratio,” of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage. Interest shall be used in the calculation of these present values only if it is a significant factor in the calculation of this loss ratio. Each rate submission must also include a certification by a qualified actuary that to the best of the actuary’s knowledge and judgment the rate filing is in compliance with the applicable laws and regulations of Iowa and that the benefits are reasonable in relation to premiums.

36.9(3) *Previously approved forms.* Filings of rate revisions for a previously approved policy, rider or endorsement form shall also include the following:

a. A statement of the scope and reason for the revision, and an estimate of the expected average effect on premiums, including the anticipated loss ratio for the form.

b. A statement as to whether the filing applies only to new business, only to in force business, or both, and the reasons therefor.

c. A history of the experience under existing rates, including at least the data indicated in 36.9(4). The history may also include, if available and appropriate, the ratios of actual claims to the claims expected according to the assumptions underlying the existing rates. Additional data might include: substitution of actual claim runoffs for claim reserves and liabilities; determination of loss ratios with the increase in policy reserves (other than unearned premium reserves) added to benefits rather than subtracted from premiums; accumulations of experience funds; substitution of net level policy reserves

for preliminary term policy reserves; adjustment of premiums to an annual mode basis; or other adjustments or schedules suited to the form and to the records of the company. All additional data must be reconciled, as appropriate, to the required data.

d. The date and magnitude of each previous rate change, if any.

36.9(4) Experience records. Insurers shall maintain records of earned premiums and incurred benefits for each calendar year for each policy form, including data for rider and endorsement forms which are used with the policy form, on the same basis, including all reserves, as required for the accident and health policy experience exhibit. Separate data may be maintained for each rider or endorsement form to the extent appropriate. Experience under forms which provide substantially similar coverage may be combined. The data shall be for all years of issue combined, for each calendar year of experience since the year the form was first issued, except that data for calendar years prior to the most recent five years may be combined.

36.9(5) Evaluating experience data. In determining the credibility and appropriateness of experience data, due consideration must be given to all relevant factors, such as:

a. Statistical credibility of premiums and benefits, e.g., low exposure, low loss frequency.

b. Experienced and projected trends relative to the kind of coverage, e.g., inflation in medical expenses, economic cycles affecting disability income experience.

c. The concentration of experience at early policy durations where select morbidity and preliminary term reserves are applicable and where loss ratios are expected to be substantially lower than at later policy durations.

d. The mix of business by risk classification.

191—36.10(514D) Loss ratios.

36.10(1) Average annual premium.

a. New forms. With respect to a new form under which the average annual premium (as defined below) is expected to be at least \$200 benefits shall be deemed reasonable in relation to premiums provided the anticipated loss ratio is at least as great as shown in the following table:

Type of Coverage	Renewal Clause				
	OR	CR	GR	NC	
Medical Expense	60%	55%	55%	50%	
Loss of Income and other	60%	55%	50%	45%	

For a policy form, including riders and endorsements, under which the expected average annual premium per policy is \$100 or more but less than \$200, subtract five percentage points from the numbers in the table above, or if less than \$100, subtract ten percentage points.

b. The average annual premium per policy shall be computed by the insurer based on an anticipated distribution of business by all applicable criteria having a price difference, such as age, sex, amount, dependent status, rider frequency, etc., except assuming an annual mode for all policies (i.e., the fractional premium loading shall not affect the average annual premium or anticipated loss ratio calculation).

The above anticipated loss ratio standards do not apply to a class of business where such standards are in conflict with specific statutes or regulations.

c. Definitions of renewal clause.

OR—Optionally Renewable: Renewal is at the option of the insurance company.

CR—Conditionally Renewable: Renewal can be declined by the insurance company only for stated reasons other than deterioration of health.

GR—Guaranteed Renewable: Renewal cannot be declined by the insurance company for any reason, but the insurance company can revise rates on a class basis.

NC—Non-Cancelable: Renewal cannot be declined nor can rates be revised by the insurance company.

36.10(2) Rate revisions. With respect to filings of rate revisions for a previously approved form, benefits shall be deemed reasonable in relation to premiums provided the following standards are met.

a. With respect to forms issued on and after the effective date of the revision, the standards are the same as in 36.10(1) above, except that the average annual premium shall be determined based on an actual rather than an anticipated distribution of business.

b. With respect to forms issued prior to the effective date of the revision, both (1) and (2) as follows shall be at least as great as the standards in 36.10(1):

(1) The anticipated loss ratio over the entire period for which the revised rates are computed to provide coverage;

(2) The ratio of (i) and (ii); where

(i) Is the sum of the accumulated benefits, from the later of the original effective date of the form or the effective date of this chapter, to the effective date of the revision, and the present value of future benefits, and

(ii) Is the sum of the accumulated premiums from the later of the original effective date of the form or the effective date of this chapter, to the effective date of the revision and the present value of future premiums, such present values to be taken over the entire period for which the revised rates are computed to provide coverage, and such accumulated benefits and premiums to include an explicit estimate of the actual benefits and premiums from the last date as of which an accounting has been made to the effective date of the revision. Interest shall be used in the calculation of these accumulated benefits and premiums and present values only if it is a significant factor in the calculation of this loss ratio.

36.10(3) Credibility factors. Anticipated loss ratios different than those indicated in 36.10(1) and 36.10(2) will require justification based on the special circumstances that may be applicable.

a. Examples of coverages requiring special consideration are as follows:

- (1) Accident only;
- (2) Short term nonrenewable, e.g., airline trip, student accident;
- (3) Specified peril, e.g., cancer, common carrier;
- (4) Other special risks.

b. Examples of other factors requiring special consideration are as follows:

- (1) Marketing methods, giving due consideration to acquisition and administration costs and to premium mode;
- (2) Extraordinary expenses;
- (3) High risk of claim fluctuation because of the low loss frequency or the catastrophic or experimental nature of the coverage;
- (4) Product features such as long elimination periods, high deductibles and high maximum limits;
- (5) The industrial or debit method of distribution;
- (6) Forms issued prior to the effective date of these guidelines.

Companies are urged to review their experience periodically and to file rate revisions, as appropriate, in a timely manner to avoid the necessity of later filing of exceptionally large rate increases.

36.10(4) Medicare supplement policies. Rescinded IAB 10/30/91, effective 12/4/91.

191—36.11(514D) Certification. Any policy form submitted to the insurance division for approval which is subject to Iowa Code chapter 514D shall be in conformance with the applicable requirements of Iowa Code chapter 514D and with the filing requirements set forth in rule 191—20.1(505,509,514A,515,515A,515F).

191—36.12(514D) Severability. If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

191—36.13(513C,514D) Individual health insurance coverage for children under the age of 19.

36.13(1) *Purpose, applicability and effective date.*

a. The purpose of this rule is to set forth the requirements and procedures to be followed for individual health insurance coverage for children under the age of 19.

b. This rule shall apply to all “carriers” as defined in Iowa Code subsection 513C.3(5). For purposes of this rule, “carrier” means the same as it is defined in Iowa Code subsection 513C.3(5).

c. For purposes of this rule, a “child-only” policy means a health benefit plan delivered or issued for delivery to an individual who is the primary subscriber on the policy and who is under the age of 19. A “child-only” policy does not include a health benefit plan that is delivered or issued for delivery to a primary subscriber who is 19 years of age and older but that insures persons under the age of 19.

d. This rule shall become effective June 8, 2011, for policies sold or issued on or after that date.

36.13(2) *Coverage requirement for children under the age of 19, open enrollment period and notice.*

a. Carriers doing business in the state of Iowa shall offer coverage to primary subscribers under the age of 19 during the open enrollment period as established in this rule.

b. The open enrollment period for child-only policy applicants shall commence on July 1, 2011, and end on August 14, 2011. Carriers shall provide subsequent open enrollment periods for child-only policy applicants for the periods of July 1 through August 14 in the years 2012 and 2013.

c. A carrier shall advertise the open enrollment period for children under the age of 19, including the availability of child-only policy coverage, on the carrier’s website and through any other media as determined by the carrier. The advertising shall be conspicuous and provided in a manner reasonably calculated to give potential applicants timely and informative notice regarding the annual open enrollment period.

d. For child-only policy applications received during the open enrollment period, individual health insurance coverage shall be offered on a guaranteed-issue basis to individuals under the age of 19. The child-only policies shall be in compliance with federal and state law and shall be filed with the Iowa insurance division in accordance with Iowa law.

e. Carriers are not required to offer child-only policies outside the open enrollment periods provided in this subrule. However, a carrier shall permit a child under the age of 19 to apply and enroll for child-only policy coverage during a special enrollment period under the terms of the child-only policy if the child has experienced a qualifying event. A child-only policy issued during a special enrollment period after a qualifying event shall be issued on a guaranteed basis and shall not impose any preexisting conditions. For purposes of this paragraph, a “qualifying event” shall mean one or more of the following:

(1) The child lost creditable coverage as defined in Iowa Code section 514A.3B(3) as a result of termination of the parent’s or guardian’s employment or eligibility, the involuntary termination of the creditable coverage, death of the child’s parent or guardian, or the divorce or legal separation of the child’s parent or guardian, and a request for special enrollment is made within 30 days after termination of the creditable coverage.

(2) The child became a resident of Iowa during a month that was not the child’s birth month, and a request for coverage is made within 30 days after the child became a resident of Iowa.

(3) An event of marriage, birth, adoption or placement for adoption occurs and the request for special enrollment is made within 30 days after the occurrence of the event.

(4) The child was covered under a mandated continuation of a group health plan or group health insurance coverage plan until the coverage under that plan was exhausted.

(5) A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered parent’s or guardian’s health insurance coverage and the request for enrollment is made within 30 days after issuance of the court order.

(6) The child changes status and the parent or guardian becomes an eligible employee and requests enrollment within 63 days after the date of the change in status.

f. An individual applying for coverage during the open enrollment period or during a special enrollment period shall not be eligible for guaranteed-issue coverage if the individual has other coverage or if other coverage is available at the time of the effective date of coverage. Other coverage shall not include coverage through the Iowa Comprehensive Health Association (HIPIOWA) or HIPIOWA-FED.

g. A carrier that issues a policy pursuant to this rule shall comply with all other applicable statutes and administrative rules, both state and federal, regarding individual health benefit policies.

h. A child-only policy may be appropriately rated based on the health status of the child-only policy applicant.

[ARC 9498B, IAB 5/4/11, effective 6/8/11]

191—36.14 to 36.19 Reserved.

These rules are intended to implement Iowa Code chapters 507B, 510, 513C and 514D.

DIVISION II
RATE HEARINGS

191—36.20(514D,83GA,SF2201) Rate hearings.

36.20(1) Purpose, applicability and effective date.

a. *Purpose.* The purpose of this rule is to set forth a procedure to be followed for hearings about certain health insurance policy premium rate increases.

b. *Applicability.* This rule applies to all individual health insurance policies issued or to be issued in Iowa except those excluded by 2010 Iowa Acts, Senate File 2201, section 8(4A).

c. *Effective date.* This rule became effective October 1, 2010.

36.20(2) Definitions.

“Carrier” shall mean a health insurance carrier licensed to do business in the state as used in 2010 Iowa Acts, Senate File 2201, section 8.

“Commissioner” shall mean the Iowa insurance commissioner or designee.

“Consumer advocate” shall mean the division’s consumer advocate described by Iowa Code section 505.8(6) or designee.

“Division” shall mean the Iowa insurance division.

“Filing” shall mean a rate filing presented to the division for approval pursuant to this chapter, Iowa Code chapter 514D and 2010 Iowa Acts, Senate File 2201, through the National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing.

“Health insurance” shall mean the same as “health insurance” is used in 2010 Iowa Acts, Senate File 2201, section 8, and excludes the types of insurance listed in 2010 Iowa Acts, Senate File 2201, section 8(4A).

“Hearing” shall mean a public hearing for purposes of accepting comments regarding a premium rate increase for which a carrier has requested approval from the commissioner. The hearing is for the gathering of comments; it is not an adjudicatory proceeding or an administrative action.

“Plan” shall mean the policy form(s) subject to the rate change proposal.

“Rate” shall mean the premiums (or premium rates) presented to the division for approval.

36.20(3) Filing and notice required. Carriers that are required to file an application for a rate increase shall make a filing according to division procedures through the National Association of Insurance Commissioners’ System for Electronic Rate and Form Filing. When a carrier makes a request for the commissioner’s approval of a rate filing and the requested rate in the application is for a rate increase exceeding the average annual health spending growth rate stated in the most recent National Health Expenditure projection published by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services:

a. The carrier shall contact the division to obtain a hearing date, time and location.

b. Once the hearing is scheduled with the division, the carrier shall provide a notice of the intended rate increase and of the date, time and location of the rate hearing at least 45 days before the hearing.

c. The notice shall be in writing and shall be mailed to all persons insured by the plan for which the carrier is requesting approval of the rate increase.

d. The notice shall specify the proposed rate increase that is applicable to each policyholder and shall include the ranking and quantification of those factors that are responsible for the amount of the rate increase proposed.

e. The notice shall include information about how the policyholder can contact the consumer advocate for assistance.

f. The notice shall state the following:

NOTICE OF PROPOSED PREMIUM INCREASE

Dear [INSURED]

[CARRIER] has asked the Iowa Insurance Division to approve an increase in premium rates of approximately []% with a proposed effective date of [DATE].

For your policy, the increase is anticipated to be as follows:

[CURRENT MONTHLY RATE] + [PROPOSED INCREASE] = [PROPOSED MONTHLY RATE]

Your actual premium increase may be less or greater than the proposed average premium increase due to a variety of factors that are independent of the proposed premium rate increase, including but not limited to age, geographic area, and plan design. In addition, the final rate you receive may be different than that listed above due to changes in those factors while the rate is pending approval or due to input from the Iowa Insurance Commissioner.

[RANKING AND QUANTIFICATION OF THOSE FACTORS THAT ARE RESPONSIBLE FOR THE AMOUNT OF THE RATE INCREASE PROPOSED]

A public hearing will be held at [TIME], [DATE], at [LOCATION] before the Iowa Insurance Commissioner to receive comments from [CARRIER] and the Iowa Insurance Consumer Advocate on the proposed rate increase.

You may contact the Consumer Advocate for assistance or to comment on the proposed premium rate at:

Iowa Insurance Division Consumer Advocate
 Iowa Insurance Division
 1963 Bell Avenue, Suite 100
 Des Moines, Iowa 50315
 Telephone: (515)654-6600
 Iowa-toll free: 1-877-955-1212
 Fax: (515)654-6500
 E-mail: consumer.advocate@iid.iowa.gov

All comments received will be considered public records. The Consumer Advocate will post comments received on the division's website at www.iid.iowa.gov, and the Consumer Advocate will present the comments at the public hearing.

g. If an insurer wishes to use language in its notice that is different from the language in paragraph "*f.*" it must seek the approval of the commissioner prior to using different language. The request for approval shall be submitted to the commissioner via the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing.

36.20(4) Comments.

a. The consumer advocate shall collect any public testimony or comments received from policyholders regarding the rate increase request.

b. The consumer advocate shall post without delay all comments received on the division's website.

c. The consumer advocate shall provide the comments to the commissioner and present them at the hearing.

36.20(5) Evidence requested by the commissioner. At any time after the filing of the request for approval of the rate increase, the commissioner may:

a. Request additional information from the carrier, and the carrier shall furnish any additional information as requested;

b. Request the submission of additional information by any other party to the filing; and

c. Obtain independent analysis of the filing by qualified experts as permitted under Iowa Code section 505.15.

36.20(6) Hearing.

- a. The hearing shall be open to the public.
- b. The division shall make a record of the hearing. The cost of making the record shall be paid by the carrier. The cost of copies of the record requested by the carrier or by the division shall also be paid by the carrier.
- c. At the hearing, the carrier that is requesting the commissioner's approval of the rate increase may present testimony and information to support its position in addition to the information supplied with the filing. The costs of the carrier's presentation shall be paid by the carrier.
- d. The consumer advocate shall present at the hearing the public testimony and comments received.
- e. Formal rules of pleading or evidence need not be observed at any hearing.
- f. The hearing does not constitute a contested case under Iowa Code chapter 17A.

36.20(7) Confidentiality. Information submitted to the division as part of a filing and as part of the hearing process shall constitute a public record under Iowa Code chapter 22 except as provided in Iowa Code section 505.17 and 2010 Iowa Acts, Senate File 2201, section 6.

36.20(8) Record of expenses. A carrier shall maintain a record of expenses incurred by the carrier in relation to any rate hearing and shall submit it to the commissioner within 30 days following the date of the rate hearing.

36.20(9) Severability. If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of such provision to other persons or circumstances shall not be affected thereby.

[ARC 9158B, IAB 10/20/10, effective 10/1/10; ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

This rule is intended to implement Iowa Code chapter 514D and 2010 Iowa Acts, Senate File 2201.

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[Filed emergency 2/26/82—published 3/17/82, effective 3/11/82]

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[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]

[Editorial change: IAC Supplement 9/23/20]

¹ Effective date of 12/31/81 delayed 70 days by Administrative Rules Review Committee.

² 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%

Triggers for a Substantial Premium Increase	
Issue Age	Percent Increase Over Initial Premium
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%

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, nonrenewal or termination of long-term care insurance.

39.33(1) Purpose and definitions.

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or 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).

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

“*Commissioner*” means the Iowa insurance commissioner or insurance division.

“*Notice of cancellation, nonrenewal or termination*” means:

1. Notice of an insurance company’s termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company’s decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code section 514G.111 and rule 191—39.22(514G), at a minimum, an insurance company’s notice of lapse or termination of a long-term care insurance policy.

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. For any notice of cancellation, nonrenewal 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, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. 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. Notwithstanding the requirements of subrule 39.33(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code section 514G.111 and rule 191—39.22(514G).

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

[ARC 1999C, IAB 5/27/15, effective 7/1/15; ARC 2415C, IAB 2/17/16, effective 3/23/16]

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 Iowa Code section 514G.109(2), the notice required in Iowa Code section 514G.110(2) “b” and “c” 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, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315;

c. A copy of the insurer's benefit trigger determination letter must accompany the written request for an independent review.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 3683C, IAB 3/14/18, effective 4/18/18; Editorial change: IAC Supplement 9/23/20]

191—39.46(514G) Independent review request. 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, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

[ARC 3683C, IAB 3/14/18, effective 4/18/18; Editorial change: IAC Supplement 9/23/20; ARC 0001Z, IAB 9/23/20, effective 10/28/20]

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 email 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, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315, 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.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

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) 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. An application for certification as an independent review entity must be submitted in duplicate to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315. 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 division and shall be available through the division's website.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

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 disregarded*” 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 website, 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 website, 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 website 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 website.

[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]

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[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]

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[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]

[Filed ARC 2415C (Notice ARC 2078C, IAB 8/5/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 3683C (Notice ARC 3570C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]

[Editorial change: IAC Supplement 9/23/20]

[◇] 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

<input type="checkbox"/>	The answers to the questions above describe my financial situation.
Or	
<input type="checkbox"/>	I choose not to complete this information. (Check one.)
<input type="checkbox"/>	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 Data¹
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		

¹The 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.

³Example—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, email 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, email address soudeke@dhs.state.ia.us).

APPENDIX JLong-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 email 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, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

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; Editorial change: IAC Supplement 9/23/20]

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, nonrenewal or termination of enrollment.

40.26(1) Purpose and definitions.

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal 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).

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

“*Commissioner*” means the Iowa insurance commissioner or insurance division.

“*Notice of cancellation, nonrenewal or termination*” means:

1. Notice of an insurance company’s termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company’s decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B), “notice of cancellation, nonrenewal or termination” includes but is not limited to a health maintenance organization’s notice to an enrollee of cancellation or rescission of membership.

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. For any notice of cancellation, nonrenewal 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, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. 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. Notwithstanding the requirements of subrule 40.26(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B).

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

[ARC 1999C, IAB 5/27/15, effective 7/1/15; ARC 2415C, IAB 2/17/16, effective 3/23/16]

These rules are intended to implement Iowa Code chapter 514B and 1999 Iowa Acts, Senate File 276.

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CHAPTER 41
LIMITED SERVICE ORGANIZATIONS

191—41.1(514B) Definitions.

“*Act*” when used in these rules shall mean Iowa Code chapter 514B.

“*Complaint*” means a written communication expressing a grievance concerning a limited service organization.

“*Governing body*” means the persons in which the ultimate responsibility and authority for the conduct of the LSO is vested.

“*Limited health services*” include dental care services, vision care services, mental health services, behavioral health care services, substance abuse services, pharmaceutical services, podiatric care services, chiropractic services, nursing services, services of a licensed dietitian, physical therapy services, or any other category of services approved by the commissioner. “Limited health services” do not include employee assistance programs which provide only assessment and referral services or intermediate or long-term care facilities.

“*Limited service organization*” or “*LSO*” means any corporation or limited liability company or other entity which, in return for prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Entities authorized to do business pursuant to Iowa Code chapters 508, 512B, 514, 514B (health maintenance organizations), 515, and 520 shall not be required to obtain separate licensure as an LSO.

“*Outpatient provider services*” means outpatient provider services provided within or outside of a hospital. These services shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

“*Producer*” means a person engaged in solicitation or enrollment for an LSO and who ultimately delivers the certificate of membership or policy to a member.

“*Provider*” means any person or institution duly licensed or otherwise authorized to deliver or furnish limited health services.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

191—41.2(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 LSO. The application with copies in duplicate shall be executed in conformance with rule 191—41.10(514B) and shall be accompanied by the information found in Iowa Code sections 514B.3(1) to 514B.3(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, as indicated in rule 191—41.10(514B). Amendments 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—41.3(514B) Inspection of evidence of coverage. Except for groups which maintain a cafeteria plan pursuant to Section 125 of the Internal Revenue Code (28 U.S.C.A. § 125), 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 LSO within the ten-day period. Enrollees in cafeteria plans must adhere to the plan provisions concerning termination or changes in coverage.

191—41.4(514B) Governing body and enrollee representation. An LSO 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 LSO shall develop bylaws or guidelines which describe the scope of the health care services the LSO renders to enrollees directly by a provider. Initial articles of incorporation, bylaws, guidelines

of the LSO and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The articles of incorporation, 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 that 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 LSO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the LSO. 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 ensure an adequate opportunity for participation by enrollees:

41.4(1) An opportunity for adult enrollees to nominate candidates for the governing body.

41.4(2) Notice to all adult enrollees of the nomination and elective procedures. The LSO 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 LSO’s commencement of delivery of services to enrollees.

191—41.5(514B) Quality of care. Each LSO shall:

41.5(1) Advise the insurance division annually of the ratio of full-time providers and ancillary health personnel to enrollees to ensure an adequate network. Changes in the provider ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

41.5(2) Provide assurance that all personnel engaged in the provision of health services to enrollees are currently licensed or certified by the appropriate state agency where the providers are located to practice their respective professions. These personnel shall be no less qualified in their respective professions than the current level of qualification, which is maintained in the providers’ communities.

41.5(3) Provide assurance that any health care facilities utilized by the LSO are licensed by the appropriate state agency where the facilities are located. These facilities shall be 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; or as otherwise accredited or licensed in accordance with state or federal law.

41.5(4) Have a qualified administrator designated by the governing body who shall be responsible for the management of the LSO.

41.5(5) Provide for an ongoing internal peer review program.

41.5(6) Maintain a provider 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 place of employment, if applicable.
- c. Services provided, when provided, where provided, and by whom.
- d. Provider diagnosis, treatment prescribed, therapy prescribed and drugs administered.
- e. Statement in regard to the status of the patient’s health, as appropriate.

41.5(7) Provide by contract or other arrangement for peer review. 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 LSO staff on a continuing basis using standards adopted by the applicable accrediting body as a general guide. Internal peer review shall be structured to review the specific type of services for which the LSO is responsible. This review shall include but not be limited to the following:

- (1) Utilization review and evaluation of the quality of services provided enrollees.
- (2) The process or method by which services are provided.
- (3) The outcome of services.

b. External review may be satisfied either by NCQA certification or meeting the requirements of the external review group appointed by the commissioner. The criteria and methodology for selection of an external review group (ERG) are as follows:

- (1) The commissioner will appoint an ERG based on the following criteria:
 1. The group's experience in evaluating the quality of service provided.
 2. The degree to which the group is representative of the LSOs to be reviewed.
 3. The degree to which the group is knowledgeable about the delivery of the services provided by the LSO in Iowa.
 4. The group's ability to coordinate its activities with other review groups and with practitioners and providers of health services in Iowa.
 5. The group's knowledge of current and accepted provider opinion and its ability to make qualitative evaluations of clinical practice.
- (2) No provider shall review an LSO of which the provider is a member.
- (3) 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. The following are criteria and methodology by which an ERG will evaluate the effectiveness of an LSO's peer review program:

- (1) The ERG will conduct an on-site inspection of each Iowa-certified LSO every two years.
- (2) The inspection will consist of an interview with LSO staff and providers and a review of records (including clinical records of LSO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the LSO or any of its provider members which pertain to LSO quality assurance operations or LSO patients, excluding financial records.
- (3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an LSO's internal peer review program and to report its findings to the insurance division.
- (4) The following items will be considered by the ERG in making its determination:
 1. The extent and acuity of the LSO's peer review program in evaluating the clinical management of enrollees provided by LSO providers.
 2. The ability of the LSO's program to identify aberrant practices in clinical management and to take appropriate disciplinary action.
 3. The method within the LSO by which the peer review program reports its findings to the provider staff and the governing body.
 4. The authority within the LSO to correct practices which the peer review program has found to be detrimental.
 5. The system developed within the LSO to facilitate the work of the peer review program.
 6. The commitment on the part of the LSO governing body and provider staff toward an active peer review program with a goal of quality assurance.

d. The following are 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 LSO.
- (2) The LSO 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 LSO.
- (4) The insurance division may extend the time periods referred to in subparagraphs 41.5(7) "d"(1) to (3).
- (5) After considering the report of the ERG, the insurance commissioner shall determine if the LSO's certificate of authority is to be continued, suspended or revoked.

191—41.6(514B) Change of name. No name other than that certified by the division may be used. The name of the LSO may not be changed without prior approval of the division.

191—41.7(514B) Change of ownership. Each LSO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the LSO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

191—41.8(514B) Complaints.

41.8(1) Each LSO shall provide in its bylaws for a system to resolve and record complaints.

41.8(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 LSO.
- b. Complaints about the availability of such services.
- c. Complaints relating to enrollee participation in the operation of the LSO.

41.8(3) The complaints record shall be included in the annual report to the commissioner.

41.8(4) All complaint files shall be retained by the LSO until the examination for the period during which the complaint was received has been completed.

191—41.9(514B) Cancellation of enrollees.

41.9(1) Membership of an enrollee in an LSO may be terminated by the LSO 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 LSO.
- 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.
- h. Withdrawal of licensure by the LSO from the state. Upon withdrawal, an LSO has no obligation to secure replacement coverage for enrollees.

41.9(2) Membership of an enrollee in an LSO 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 LSO.
- 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. 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, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315.

41.9(3) When a hearing is requested, the commissioner may require the LSO 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 LSO the charges for such period of coverage.

41.9(4) The hearing shall be held before the commissioner or the delegated administrative law judge in the following manner:

a. Upon receipt of a request for hearing, the commissioner shall notify the LSO 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 LSO 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.

[ARC 4780C, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

191—41.10(514B) Application for certificate of authority. The application for certificate of authority shall be in the following form:

LIMITED SERVICE ORGANIZATION
APPLICATION FOR CERTIFICATE OF AUTHORITY
(Name of Limited Service Organization)

Organized as _____ under the laws of the state of _____, makes application to the commissioner of insurance for a certificate of authority to establish and operate a limited service organization in compliance with Iowa Code chapter 514B.

Attached and 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 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 LSO.

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 paragraph "3" above.

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 LSO 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, the commissioner's 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 LSO 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 LSO'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 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 workers' compensation insurance to be maintained in force by the LSO.

VERIFICATION

The undersigned deposes and states that deponent has duly executed the attached application dated _____, _____, for and on behalf of _____; that
(Year) (Name of Applicant)
the deponent is the _____ of such company, and that deponent is
(Title of Officer)

authorized to execute and file such instrument. Deponent further states 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 _____,

(Year)

(Notary Public)

191—41.11(514B) Net equity and deposit requirements.

41.11(1) Net equity requirements.

a. Each LSO shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) \$100,000 at the inception of the first year of operation, \$200,000 at the inception of the second year of operation and thereafter; or

(2) Two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

b. An LSO that has uncovered expenses in excess of \$500,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25 percent of the uncovered expense in excess of \$500,000 in addition to the tangible net equity required by paragraph 41.11(1) "a."

c. For the purpose of this rule, "net equity" shall mean the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and "net equity" shall mean net equity reduced by the value assigned to intangible assets, including, but not limited to:

- (1) Goodwill;
- (2) Going-concern value;
- (3) Organizational expense;
- (4) Start-up costs;

(5) Obligations of officers, directors or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due;

(6) Long-term prepayments of deferred charges; and

(7) Nonreturnable deposits.

41.11(2) Deposits.

a. Each LSO shall deposit with the commissioner or with any organization or trustee meeting the requirements of rule 191—32.4(508) cash, securities or any combination of these that is acceptable to the commissioner having a fair market value equal to the minimum net worth of the LSO as determined by paragraph 41.11(1)“*a.*” The amount on deposit shall remain as an admitted asset of the organization in the determination of its net worth.

b. All income from deposits shall be an asset of the LSO. An LSO may withdraw a deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these in an amount and value equal to that to be withdrawn. Securities shall be approved by the commissioner before being substituted.

41.11(3) No LSO organized under the laws of another state shall, directly or indirectly, assume risks or provide the services of an LSO, as defined in Iowa Code section 514B.33, subsection (3), unless it first obtains licensure from the commissioner and complies with the requirements of rule 191—41.11(514B).

41.11(4) As deemed necessary by the division, each LSO that is a subsidiary of another person shall file with the division, in a form satisfactory to the division, a guarantee of the LSO’s obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

41.11(5) Each LSO 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 insolvency of an LSO.

191—41.12(514B) Fidelity bond. An LSO 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.

191—41.13(514B) Annual report. An LSO 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 LSOs. 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 an LSO as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

191—41.14(514B) Cash or asset management agreements. If an LSO 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:

1. Cash receipts shall be under the direct control of the LSO that generated the receipts. If the system is under the control of the LSO’s parent or affiliate, then receipts shall be transferred to the LSO within five working days.

2. Securities purchased shall be in the name of the LSO generating the funds for the security purchase.

3. An LSO'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 LSO. Such an agreement shall be subject to prior approval by the commissioner.

4. An LSO's cash or investments shall not be commingled with the cash or investments of any other person.

5. Investments made on behalf of an LSO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.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.

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—41.15(514B) Reinsurance. Reinsurance contracts and stop-loss agreements entered into by an LSO shall be subject to prior approval and shall meet the following minimum requirements:

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.

2. Retention levels shall be reasonable in light of the LSO's financial condition and potential liabilities.

191—41.16(514B) Provider contracts. An LSO'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 for approval. 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 LSO, LSO 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 LSO acting on the providers' behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments on LSO's behalf made in accordance with terms of (applicable agreement) between LSO 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 LSO 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—41.17(514B) Producers' duties. In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in an LSO, 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), qualification 6.

191—41.18(514B) Emergency services. "Emergency services" (inpatient and outpatient), as defined in rule 191—40.20(514B), shall be provided by the LSO, either through its own facilities or through guaranteed arrangements with other providers, on a 24-hour basis unless a waiver from such services is approved by the commissioner. A provider and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since LSOs may not contract with every emergency care provider in an area, LSOs shall make every effort to inform members of participating providers.

191—41.19(514B) Reimbursement. Reimbursement to a provider of "emergency services," as defined in rule 191—40.20(514B), shall not be denied by any LSO without that organization's review of the patient's provider 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 LSO as outlined in rule 191—40.9(514B). Upon denial of reimbursement for emergency services, the LSO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

191—41.20(514B) Limited service organization requirements. An LSO shall not prohibit or otherwise restrict a participating provider from advising a covered person about the health status of the covered person or medical care or treatment of the covered person's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the provider is acting within the lawful scope of practice.

An LSO shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the LSO that, in the opinion of the provider, jeopardizes patient health or welfare.

191—41.21(514B) Disclosure requirements. All LSOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all LSOs offering policies under this chapter that include a prescription drug formulary shall inform policyholders, and prospective policyholders at time of issuance, whether a prescription drug specified in the request is included in such formulary.

All LSOs shall also disclose the existence of any contractual arrangements providing rebates received by them for drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated uses 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 function or preventing further deterioration of the medical condition caused by sickness or injury.

These rules are intended to implement Iowa Code section 514B.33.

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[Editorial change: IAC Supplement 9/23/20]

CHAPTER 72
LONG-TERM CARE ASSET PRESERVATION PROGRAM

191—72.1(249G) Purpose. The purpose of this chapter is to establish minimum standards for long-term care insurance policies and certificates to qualify for participation in the Iowa long-term care asset preservation program; establish documentation and reporting requirements for issuers of policies or certificates to qualify under the Iowa long-term care asset preservation program; provide full disclosures in the sale of long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program; and facilitate public understanding regarding long-term care insurance and long-term care insurance policies and certificates which qualify under the Iowa long-term care asset preservation program.

191—72.2(249G) Applicability and scope. The requirements of this chapter apply to any long-term care insurance policy or certificate authorized for sale by the division of insurance as qualifying under the Iowa long-term care asset preservation program under Iowa Code chapter 249G. No long-term care insurance policy or certificate which has been approved by the division of insurance as a certified long-term care insurance policy or certificate under this chapter may be advertised, solicited, or issued for delivery in this state after December 31, 2009.

[ARC 8271B, IAB 11/4/09, effective 12/9/09]

191—72.3(249G) Definitions.

“Asset disregard” means a \$1 increase in the amount of assets an individual who purchases a certified long-term care policy may retain, upon qualification for Medicaid, for each \$1 of benefit paid out under the individual’s certified long-term care policy for Medicaid-eligible long-term care services in determining eligibility for the Medicaid program.

“Asset protection” means the right extended by 441 IAC 75.5(5) to beneficiaries of certified long-term care insurance policies and certificates to an asset disregard under the Iowa long-term care asset preservation program.

“Authorized designee” means any person designated in writing to the insurance company by the policyholder or certificate holder of a certified long-term care policy or certificate for purposes of notification under paragraph 72.7(1)“h.”

“Average daily private pay rate” means the average statewide cost of nursing facility services to a private pay resident as determined by the department of human services in 441 IAC 75.23(3). The average statewide private pay rate is set annually on July 1 for one year by the Iowa department of human services.

“Case management” includes, but is not limited to, the development of a comprehensive individualized assessment and care plan and, as needed, coordination of appropriate services and the monitoring of the delivery of such services.

“Case management agency” means an agency or other entity approved by the Iowa department of human services as meeting Medicaid case management standards.

“Certificate” means any certificate delivered or issued for delivery in this state under a group long-term care policy.

“Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.

“Certificate holder” means an owner of a certified long-term care insurance certificate or the beneficiary of a certified long-term care certificate.

“Certified long-term care insurance policy or certificate” means any long-term care insurance policy or certificate certified for sale to Iowa residents by the division of insurance as meeting standards promulgated under rules 191—72.6(249G) and 191—72.7(249G).

“Cognitive impairment” means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer’s disease or similar forms of senility or irreversible dementia. This deterioration or loss of

intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

1. Short-term or long-term memory.
2. Orientation as to person, place, and time.
3. Deductive or abstract reasoning.

Cognitive impairment must result in an individual's requiring 24-hour-a-day supervision or direct assistance to maintain the individual's safety.

"Complex, yet stable medical condition" means that the individual requires 24-hour-a-day professional nursing observation or professional nursing intervention more than once a day in a setting other than an acute care wing of a hospital.

"Deficiency in activity of daily living" means that the individual cannot perform one or more of the following six activities of daily living without direct assistance:

1. Bathing, meaning cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying.
2. Dressing, meaning putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.
3. Toileting, meaning getting on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, and assistance with using and emptying bedpans and urinals.
4. Transferring, meaning moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or repositioning to promote circulation and prevent skin breakdown.
5. Continence, meaning the ability to control bowel and bladder as well as use ostomy or catheter receptacles and apply diapers and disposable barrier pads.
6. Eating, meaning reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

"Department of human services" means the Iowa division of medical services.

"Direct assistance" means that the individual cannot perform an activity of daily living safely or appropriately without continual help or oversight. Direct assistance may vary from requiring a person to physically stand by or set up the activity to the activity being totally performed by others.

"Formal long-term care services" means long-term care service for which the provider is paid.

"Home health care services" means:

1. Part-time or intermittent skilled nursing services by licensed nursing personnel provided by a home health agency or by a registered nurse or a licensed vocational nurse, when a case management provider agency has determined that no home health agency exists in the area;
2. Home health aide services provided by a home health agency;
3. Physical therapy, occupational therapy, or speech therapy and audiology services provided by a home health agency; and
4. Medical social services by a social worker or social work assistant provided by a home health agency.

"Homemaker services incidental to personal care" means the policyholder or certificate holder is eligible to receive homemaker services if personal care is being received. Homemaker services incidental to personal care are limited to the following:

1. Domestic or cleaning services;
2. Laundry services;
3. Reasonable food shopping and errands;
4. Meal preparation and cleanup;
5. Transportation assistance to and from medical appointments; and

6. Heavy cleaning which involves thorough cleaning of the home to remove hazardous debris or dirt.

A certified long-term care insurance policy or certificate shall not, if it provides homemaker services incidental to personal care, limit or exclude benefits by requiring that the provision of such services be at a level of certification or licensure greater than that required by the eligible service or by limiting benefits to services provided by Medicare-certified agencies or providers.

"Informal long-term care services" means long-term care services for which the provider is not paid.

"Insured event" means the insured is eligible to receive insurance benefits and to have these benefits qualify for an asset disregard if any one of the following criteria is met:

1. The insured has at least two deficiencies in activities of daily living (ADLs) (to qualify for home-and community-based services including, but not limited to, home health care, adult day health/social care, personal care, homemaker services incidental to personal care, respite care and residential care facility) or three deficiencies in activities of daily living (ADLs) (to qualify for nursing facility care); or

2. The insured has a cognitive impairment; or

3. The insured has a complex, yet stable medical condition.

"Integrated benefits" means the benefits contained in the policy or certificate can be used interchangeably among the various covered home- or community-based or nursing facility benefits, and there is no limit on the use of any specific covered benefit, except for monthly limits that may be set for home-and community-based care benefits and per diem limits that may be set on nursing facility services.

"Issuer" means:

1. Insurance companies;

2. Fraternal benefit societies;

3. Prepaid health care delivery plans;

4. Health care service plans;

5. Health maintenance organizations; and

6. Any other entity delivering or issuing for delivery in this state, long-term care policies or certificates.

"Long-term care asset preservation program" means the program authorized in Iowa Code chapter 249G.

"Medicaid-eligible long-term care services" include:

1. Long-term care services available under Iowa's state Medicaid plan, including care in a licensed nursing facility and home health nursing and home health aide services provided by a home health agency.

2. Long-term care services covered under the Medicaid home- and community-based services waiver for the aged and disabled, as defined in paragraph 72.7(1)"d."

"Medicaid waiver" refers to the home- and community-based services waiver for the aged and disabled approved by the United States Department of Health and Human Services Health Care Financing Administration under the provisions of Section 1915(c) of the Social Security Act which allows Iowa to provide certain community and in-home services not covered in the state Medicaid plan, which are instrumental in the avoidance or delay of institutionalization. Iowa's Medicaid waiver services include:

1. Case management;

2. Homemaker;

3. Respite care;

4. Attendant care;

5. Adult day care; and

6. Other services which, independent of the preceding home- and community-based services, are essential to prevent institutionalization.

"Personal care services" means:

1. Ambulation assistance, including help in walking or moving around (e.g., wheelchair) inside the home, changing locations in a room, moving from room to room to gain access for the purpose of

engaging in other activities. Ambulation assistance does not include movement solely for the purpose of exercise.

2. Bathing and grooming including cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying. Grooming includes hair combing and brushing, shampooing, oral hygiene, shaving and fingernail and toenail care.

3. Dressing includes putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

4. Bowel, bladder and menstrual care including assisting the person on and off toilet or commode and emptying commode, managing clothing and wiping and cleaning body after toileting, assistance with using and emptying bedpans, ostomy or catheter receptacles and urinals, application of diapers and disposable barrier pads.

5. Reposition, transfer skin care, and range of motion exercises, including moving from one sitting or lying position to another sitting or lying position, e.g., from bed to or from a wheelchair or sofa, coming to a standing position or rubbing skin and repositioning to promote circulation and prevent skin breakdown. Motion exercises shall include the carrying out of maintenance programs, i.e., the performance of the repetitive exercises required to maintain function, improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

6. Feeding and hydration assistance including reaching for, picking up, grasping utensil and cup; getting food on utensil; bringing food, utensil, cup to mouth, and manipulating food on plate; cleaning face and hands as necessary following meal.

7. Assistance with self-administration of medications.

8. A certified long-term care insurance policy or certificate shall not, if it provides personal care services, limit or exclude benefits by requiring that the provision of personal care be at a level of certification or licensure greater than that required by the eligible service, or by limiting benefits to services provided by Medicare-certified agencies or providers.

“Plan of care” means a written individualized plan of services approved by a case management provider agency which specifies the type, frequency, and providers of all formal and informal long-term care services required for the individual and the cost, if any, of any formal long-term care services prescribed. Changes in the plan of care must be documented to show that such alterations are required by changes in the client’s medical situation, functional or cognitive abilities, behavioral abilities or the availability of social supports.

“Preadmission screening program” means the program which requires that each person seeking admission to a nursing facility must be screened and approved for admission by the Iowa Foundation of Medical Care in accordance with 441 IAC 81.3(249A).

“Qualified insured” means the following:

1. An individual who by reason of age is eligible for parts “A” and “B” of the Medicare program (42 U.S.C. 1395 et seq.) who is either:

- The beneficiary of a certified long-term care policy or certificate approved by the division of insurance; or
- Enrolled in a prepaid health care delivery plan that provides long-term care services and qualifies under this rule; or

2. An individual who is eligible for an asset disregard under a certified long-term care policy or certificate. An individual does not have to be a qualified insured to purchase a certified long-term care policy or certificate.

“Quarterly/annually” refers to periods aligning with the state fiscal year of July 1 to June 30.

“Service summary” means a written summary, prepared by an issuer for a qualified insured, which identifies the following:

1. The specific certified policy or certificate.
2. The total benefits paid for services to date.
3. The amount of benefits qualifying for asset protection.

191—72.4(249G) Qualification of long-term care insurance policies and certificates. No long-term care insurance policy or certificate shall qualify for participation in the Iowa long-term care asset preservation program unless the long-term care insurance policy or certificate complies with this chapter. Long-term care insurance policies and certificates in force on July 1, 1994, may, with the signed acceptance of the policyholder or certificate holder, be amended to meet the requirements for qualification.

191—72.5(249G) Standards for marketing. No long-term care insurance policy or certificate which does not meet the requirements of this chapter and has not been approved by the division of insurance as a certified long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a certified long-term care insurance policy or certificate. Each issuer seeking to qualify a long-term care policy or certificate for participation in the Iowa long-term care asset preservation program must do the following:

72.5(1) Provide the consumer, prior to presentation of an application for long-term care insurance, information regarding the availability of consumer information and public education provided by the Senior Health Insurance Information Program using the form developed by the division.

72.5(2) Use applications to be signed by the applicant which indicate, as described as follows, that the applicant:

a. Received a complete description of the Iowa long-term care asset preservation program in a format prescribed by the commissioner, including an explanation of asset protection provided by the program and how it is achieved and the insurance division’s Senior Health Insurance Information Program consumer information telephone number.

b. Received a description of the issuer’s certified long-term care policy or certificate benefit option meeting the requirements of subrule 72.6(2).

c. Received a statement regarding Medicaid eligibility and benefits that shall be in the following format:

NOTICE TO APPLICANT
REGARDING MEDICAID ELIGIBILITY

I understand that eligibility for Medicaid is not automatic; an application is necessary. My insurance company will send me quarterly statements showing how much asset protection I have earned. This permanent asset protection is in addition to any asset exemptions available to any Iowan applying for Medicaid. I understand that should I wish to apply for public assistance it is my responsibility to apply for Medicaid. I further understand that before receiving Medicaid I will first have to use any additional assets I have not protected. I will also need to meet Medicaid’s criteria for medical necessity which may be different from the eligibility criteria used by my private insurance. Once I become a Medicaid recipient, I understand that I may have to apply a portion of my income toward the cost of my care, and that Medicaid services at that time may not be the same services I was receiving under my private long-term care insurance.

(Signature of Applicant(s))

d. Agrees to the release of information by the issuer to the state as may be needed to evaluate the Iowa long-term care asset preservation program and document a claim for Medicaid asset protection, in the following format:

CONSENT AND AUTHORIZATION
TO RELEASE INFORMATION

I hereby agree to the release of all records and information pertaining to this long-term care policy or certificate by the [insert issuer name] to the Iowa department of human services for the purposes of documenting a claim for asset protection under the state Medicaid program, evaluating the Iowa long-term care asset preservation program, and meeting Medicaid audit requirements.

I understand that the information contained in these records will be used for no purpose other than those stated above, and will be kept strictly confidential by the state of Iowa.

(Signature of Applicant(s))

e. Received a description regarding mandatory inflation protection that shall be in the following format:

NOTICE TO APPLICANT REGARDING
MANDATORY INFLATION PROTECTION

In order for this long-term care policy [certificate] to remain certified by the state of Iowa and qualify to provide asset protection for the state Medicaid program, daily coverage benefits must meet or exceed standards established by the state of Iowa. Depending on the option you choose to automatically inflate daily coverage benefits, premiums may rise over the life of the policy [certificate]. [Insert issuer name] will provide you with a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy that increases benefits over the policy period and a policy that does not increase benefits. Failure to maintain the required daily coverage benefits will result in the policy [certificate] losing its certified status and no longer being allowed to provide asset protection. It is [insert issuer name]’s responsibility to automatically inflate coverage benefit levels in order to maintain certified status; it is your responsibility to make premium payments in order to maintain certified status.

f. Received a graphic comparison showing the differences in premiums and benefits, over at least a 20-year period, between a policy or certificate that increases benefits over the policy or certificate period and a policy or certificate that does not increase benefits.

72.5(3) Report to the commissioner of the division of insurance all sales involving replacement of existing policies and certificates by certified policies or certificates within 30 days of the issue date of the newly issued certified policy or certificate. The report shall include the following:

- a.* The name and address of the insured.
- b.* The name of the company whose policy or certificate is being replaced.
- c.* The name of the producer replacing the coverage.

This report shall also include a comparison of the coverage issued with that being replaced, including a comparison of premiums and an explanation of how the replacement was beneficial to the insured. The replacing issuer shall not cancel, nonrenew, or rescind a replacement policy or certificate for any reason other than nonpayment of premium, material misrepresentation, or fraud.

72.5(4) Provide producer training as follows:

a. Provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless the producer has completed training covering at least the division’s eight-credit outline on the Iowa long-term care asset preservation program.

b. Issuers shall provide written evidence to the division of insurance that procedures are in place to ensure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a certified long-term care insurance policy or certificate unless, on an annual basis, the producer completes two hours of continuing education training specifically covering the Iowa long-term care asset preservation program and Medicaid.

c. Issuers shall use only curriculum and instructors approved by the division of insurance. Coursework must be completed in a classroom setting and may not be completed on a “take-home” basis.

d. Issuers shall submit training courses used for continuing education for approval to the outside vendor under contract with the division of insurance at least 30 days prior to the beginning of the course. Requests received later may be disapproved.

72.5(5) Include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: “THIS POLICY

[CERTIFICATE] QUALIFIES UNDER THE IOWA LONG-TERM CARE INSURANCE PROGRAM FOR MEDICAID ASSET PROTECTION. THIS POLICY [CERTIFICATE] MAY PROVIDE BENEFITS IN EXCESS OF THE ASSET PROTECTION PROVIDED IN THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM.”

72.5(6) Long-term care insurance policies or certificates sold after July 1, 1994, that are not certified under the Iowa long-term care asset preservation program must include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: “THIS POLICY [CERTIFICATE] DOES NOT QUALIFY FOR MEDICAID ASSET PROTECTION UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM. HOWEVER, THIS POLICY [CERTIFICATE] IS AN APPROVED LONG-TERM CARE INSURANCE POLICY [CERTIFICATE] UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE IOWA LONG-TERM CARE ASSET PRESERVATION PROGRAM, CALL THE SENIOR HEALTH INSURANCE INFORMATION PROGRAM OF THE DIVISION OF INSURANCE AT 1-800-351-4664.”

72.5(7) Provide that no qualified long-term care policy or certificate form shall be sold, transferred, or otherwise ceded to another issuer without first having obtained approval from the commissioner.

72.5(8) Except as provided in this subrule, an issuer shall continue to make available for purchase any qualified policy form or certificate form issued that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months. The following describe the process and result of discontinuing the availability of a policy form or certificate form:

An issuer may discontinue the availability of a policy form or certificate form if the issuer provides the commissioner, in writing, its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. The following shall be considered a discontinuance of the availability of a policy form or certificate form:

a. The sale or other transfer of a qualified policy form or certificate form to another issuer.
b. A change in the rating structure or methodology unless the issuer complies with the following requirements.

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

(3) An issuer that discontinues the availability of a policy form or certificate form under this subrule shall not file for approval of a new long-term care policy form or certificate form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate. This clause does not apply if: an issuer discontinues a policy form or certificate form as the result of changes to this rule; or all existing policyholders and certificate holders of a discontinued policy form or certificate form are given the opportunity to purchase the new policy form or certificate form without regard to health status, claims experience, or age. Issuers are not required to make this offer to policyholders or certificate holders receiving benefits under the discontinued policy form or certificate form.

[Editorial change: IAC Supplement 9/23/20]

191—72.6(249G) Minimum benefit standards for qualifying policies and certificates. No long-term care insurance policy or certificate may be advertised, solicited, or issued for delivery in this state as a qualified long-term care insurance policy or certificate which does not meet the minimum benefit standards in this rule, and which has not been approved by the division of insurance as a qualified long-term care insurance policy or certificate. These minimum standards do not preclude the inclusion

of other provisions or benefits which are not inconsistent with these standards. These standards are in addition to all other requirements for long-term care insurance policies or certificates. In order to qualify for participation in the Iowa long-term care asset preservation program, a long-term care insurance policy or certificate shall meet the following:

72.6(1) Contain a “benefit amount maximum” equivalent to at least 365 times the minimum daily nursing facility benefit defined in 72.6(6) “a.”

72.6(2) Offer a maximum benefit amount option equivalent to 365 times the minimum daily nursing facility benefit defined in 72.6(6) “a.” Issuers may offer other benefit amount options in addition to this minimum benefit amount option.

72.6(3) Provide that maximum benefits be available in dollars and not in days of care.

72.6(4) Include a provision of inflation protection which satisfies at least one of the following criteria:

a. The policy or certificate covers at least 80 percent but not more than 110 percent of the average daily private pay rate.

b. The policy or certificate provides for automatic increases in the per diem dollar level in accordance with either the consumer price index or at 5 percent each year over the previous year for each year that the contract is in force.

c. The policy or certificate provides the following:

(1) Annual per diem upgrades on a guaranteed issue basis at premiums based on the age of the policyholder or certificate holder at the time of the issuance of the qualified policy or certificate.

(2) Unless the insured takes positive action to decline them, these upgrades automatically increase the level of daily coverage to meet or exceed the minimum inflation adjusted daily benefit. The minimum inflation adjusted daily benefit is defined as the amount or amounts derived by taking the minimum daily benefit for nursing facility care at the time of purchase as specified in 72.6(6) “a” and inflating it by the consumer price index or by at least 5 percent each year over the previous year for each year that the contract is in force. The schedule of minimum per diem dollar amount increases shall be updated and maintained at the division of insurance.

(3) The issuer shall notify those policyholders or certificate holders choosing the upgrade option when the upgrades are automatically effective and what the increased premium, if any, will be. The issuer shall also provide to the policyholder or certificate holder, at the time of the upgrade, the opportunity to decline the upgrade.

(4) The issuer shall notify the policyholder or certificate holder when the insurance policy or certificate will lose its qualification status if the annual per diem benefit upgrade is declined. A qualified policy or certificate containing this inflation protection provision will remain qualified as long as the insured’s daily benefit amount equals or exceeds the minimum inflation adjusted daily benefit.

72.6(5) Provide that the unused maximum benefit amount of the policy or certificate increase proportionately with the inflation protection requirements of 72.6(4).

72.6(6) At a minimum, upon the initial effective date, provide the following:

a. A daily nursing facility benefit of at least 80 percent of the average daily private pay rate in nursing facilities rounded to the next highest \$5 increment. No policy or certificate need pay benefits in excess of the actual charges.

b. A daily home- and community-based benefit of at least 50 percent of the daily nursing facility benefit contained in the policy or certificate. No policy or certificate need pay benefits in excess of the actual charges.

c. The daily home- and community-based benefit shall not exceed the daily nursing facility benefit.

72.6(7) If issued on an expense incurred basis, provide benefits which are equal to at least 80 percent of the per diem cost incurred by the insured.

191—72.7(249G) Required policy and certificate provisions.

72.7(1) All qualified policies and certificates shall meet the following requirements:

a. Have premiums:

(1) Based on the issue age of the applicant; or

(2) Level for the life of the policy or certificate with an adjustment only for the increased benefits resulting from the inflation protection requirements of subrule 72.6(4). Nothing in this rule shall preclude an issuer from reducing premiums of a policy or certificate or using a policy form or certificate form in which the premiums are no longer required to be paid after a specified period of time.

b. Not have premiums based on the attained age of the insured.

c. Include a provision that the policy or certificate will utilize the “insured event” criteria, defined in 72.3(249G) for determining eligibility for benefits and for determining the amount of asset disregard. Approval for admission to a nursing facility under the “preadmission screening program,” as defined in 72.3(249G) shall be deemed sufficient but not necessary to meet this insured event criteria.

d. Include a provision that policy or certificate benefits can be used to purchase nursing facility care or home- and community-based care. Home- and community-based care shall include, at a minimum, but not be limited to, the following:

- (1) Home health nursing.
- (2) Home health aide services.
- (3) Attendant care.
- (4) Respite care.
- (5) Adult day care services.

All home- and community-based services shall include case management services delivered by a case management agency. An asset disregard will be provided for all benefits used by qualified insureds to purchase “Medicaid-eligible long-term care services” as defined in 72.3(249G).

e. Include a provision which allows for a 30-day period within which coverage may be canceled by the applicant by delivering or mailing the evidence of coverage to the issuer or the producer through whom it was effected for a full refund of any premium that was paid. The policy or certificate shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate to the issuer or its producer for cancellation within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. Include a provision which, in the event the qualified policy or certificate is about to lapse or the policy or certificate is about to lose qualification status under 72.6(4) “c”(4), offers the policyholder or certificate holder the option to reduce coverage to a lower benefit amount. However, this benefit amount offer, plus the amount of benefits used to date, cannot be less than the minimum benefit amount requirement specified in 72.6(1). The issuer need only allow this offer to be exercised one time. Premiums shall be based on the age of the policyholder or certificate holder at the time of the issuance of the original qualified policy or certificate.

g. Include a provision which, in the event a policyholder or certificate holder lapses a qualified policy or certificate and retains a nonforfeiture benefit, the policy or certificate will maintain its qualification status only so long as the minimum inflation adjusted daily benefit, as defined in 72.6(4) “c”(2), is met or exceeded or the policy or certificate pays at least 80 percent of actual or reasonable charges, and the total of the benefit amount paid to date and the benefit amount available is not less than 365 times the minimum inflation adjusted daily benefit. If at any point while in a nonforfeiture benefit the criteria in this paragraph are not met, the policy or certificate will lose its qualification status and the issuer shall notify the policyholder or certificate holder and the department of insurance of the loss of qualification.

h. Include a provision that, upon sale of a qualified long-term care insurance policy or certificate, the issuer shall do the following:

(1) Offer to collect and store the name and address of an individual designated as an authorized designee by the purchaser to be notified when a policy or certificate lapse is imminent. The issuer must obtain a signed statement from purchasers who do not choose to designate an authorized designee that they have been offered this opportunity and declined. It shall be the issuer’s responsibility to notify such designee prior to canceling a policy or certificate due to lack of premium payment. The designee notification shall occur no sooner than 30 days after the beginning of the 30-day grace period for premium payments. The issuer shall permit the policyholder or certificate holder to periodically update

the authorized designee. 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 authorized designee 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 the notice.

(2) Provide at least a five-month guaranteed reinstatement period for a policyholder or certificate holder whose policy or certificate has lapsed due to nonpayment of premium, who has a cognitive impairment, and who has paid all due and unpaid premiums. The reinstated policy or certificate shall have the same benefits, terms, and premiums as the policy or certificate which lapsed.

i. Include a provision that benefits shall only be paid after the payment of all other benefits to which the policyholder or certificate holder is otherwise entitled, excluding Medicaid. The issuer shall make reasonable efforts to determine whether benefits are available from other policies or certificates or from Medicare. An asset disregard will only be provided for benefits the issuer can document were used to purchase Medicaid-eligible long-term care services as defined in 72.3(249G) for a qualified insured.

j. Include a provision that the policy form shall not be changed or otherwise modified without the signed acceptance of the policyholder, or include a provision that the certificate form issued under a group long-term care policy shall not be changed or otherwise modified without the signed acceptance of the certificate holder.

72.7(2) Reserved.

191—72.8(249G) Prohibited provisions in certified policies or certificates. The following provisions may not be included in a certified policy or certificate: a restoration of benefits; a second elimination period; any cap on the daily (as opposed to monthly) home- and community-based care benefits.

191—72.9(249G) Reporting requirements. Unless otherwise noted, the requirements of this rule refer to issuer documentation and reporting requirements for qualified policies and certificates. The reports shall be submitted for each person entitled to benefits under a qualified policy or certificate. Each issuer shall do the following:

72.9(1) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa, a report to the department of human services that will include the following information on all individuals who purchased a qualified policy or certificate during the reporting period:

- a.* Name, address, telephone number, date of birth, sex, marital status, and social security number.
- b.* Policy or certificate identification information, including the following:
 - (1) The policy or certificate form number.
 - (2) The policy or certificate number.
 - (3) The policy or certificate category.
 - (4) The effective date of coverage.
- c.* Policy or certificate elimination period in days by type of service.
- d.* The maximum daily benefit for nursing facility care and for home- and community-based care.
- e.* Maximum lifetime benefit amounts.
- f.* Any options and riders in force.
- g.* Purchase type (upgrade, conversion or new issue).
- h.* Method used for calculation of the inflation protection benefit.
- i.* For expense incurred policies or certificates, the percentage of expenses payable.
- j.* The annual premium for the policy or certificate, the premium mode (monthly, bank draft, quarterly), and the type of premium calculation (level, issue age, other).

72.9(2) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who have changed or amended qualified policies or certificates during the reporting period:

- a.* Name, address, telephone number, and social security number.

- b.* Effective date of the policy or certificate change or coverage amendment.
- c.* A description of the new policy or certificate or amended policy or certificate as described in 72.9(1).

72.9(3) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who dropped their policies or certificates during the reporting period:

- a.* Name, address, telephone number, and social security number.
- b.* The date the policy or certificate was dropped.
- c.* The reason the policy or certificate was dropped, including any of the following:
 - (1) Death of insured.
 - (2) Converted policy or certificate.
 - (3) Maximum benefits expended.
 - (4) Recision.
 - (5) Voluntarily.
 - (6) Qualification of the policy or certificate lost.
 - (7) Other.
 - (8) Unknown.

72.9(4) Maintain a registry and submit on a quarterly basis in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who are denied a qualified policy or certificate during the reporting period:

- a.* Name, address, telephone number, date of birth, sex, marital status and social security number.
- b.* Reason for denial of the application, including the following:
 - (1) Application was not complete.
 - (2) Age was not in allowable range.
 - (3) Eligibility for Medicaid.
 - (4) Medical or other reasons.
 - (5) Other.

72.9(5) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on all individuals who were assessed for long-term care and benefit eligibility during the reporting period:

- a.* Name, address, telephone number, and social security number.
- b.* Date the assessment was conducted.
- c.* Name, address, and telephone number of the person or company that performed the assessment and whether the claimant was found eligible for long-term care services and for asset protection.
- d.* A listing of the insured event criteria met for all persons assessed, including complex, unstable medical conditions, deficiencies in activities of daily living, and cognitive impairment.

72.9(6) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on each service used and benefits claimed during the reporting period for each insured:

- a.* Name, address, telephone number, and social security number.
- b.* Whether the policyholder or certificate holder was currently enrolled in Medicare Parts A and B (42 U.S.C. 1395 et seq.) and either:
 - (1) A beneficiary of a Medicare supplement insurance policy or certificate approved by the division of insurance.
 - (2) Enrolled in a prepaid health care delivery plan that provides acute care and preventive service;or
 - (3) Covered under a contract under Section 1876 or 1833 of the Social Security Act (42 U.S.C. 1395 et seq.).
- c.* Service or procedure code.
- d.* Whether the claim for the service was denied or approved.
- e.* Start and end date for the service.
- f.* Number of units of service and amount billed.

g. Amount paid by the policy or certificate and the amount paid which counts toward the asset protection.

72.9(7) Maintain a registry and submit on a quarterly basis and in a format specified by the state of Iowa a report to the department of human services that will include the following information on the following aggregate information for the reporting period:

a. The number of applications for qualified long-term care insurance policies and certificates received during the quarter.

b. The number of persons denied a qualified policy or certificate and the reason for denial. Reasons for denial to be specified include the following:

- (1) Application was incomplete.
- (2) Age was not in allowable range.
- (3) Eligibility for Medicaid.
- (4) Medical or health reasons.
- (5) Other.

c. The number of qualified policies and certificates purchased during the quarter.

d. The number of qualified policyholders and certificate holders who dropped their qualified policy or certificate during the quarter for any of the following reasons:

- (1) Death of insured.
- (2) Converted policy or certificate.
- (3) Maximum benefits expended.
- (4) Recision.
- (5) Voluntarily.
- (6) Qualification of the policy or certificate lost.
- (7) Other.
- (8) Unknown.

e. The number of beneficiaries of qualified policies and certificates in force at the end of the quarter.

191—72.10(249G) Maintaining auditing information.

72.10(1) Each issuer shall maintain information as stipulated in 72.10(6) on all policyholders or certificate holders who have ever received any benefit under the policy or certificate. Such information shall be updated at least quarterly. This requirement for updating shall not require the conduct of any assessment, reassessment, or other evaluation of the policyholder's or certificate holder's condition which is not otherwise required by federal or state statute or regulation.

72.10(2) When a policyholder or certificate holder who has received any benefit dies or lapses the policy or certificate for any reason, the issuer must retain the stipulated information for a period of at least five years after the time when the policy was in force. Unless notified by the division of insurance to the contrary during this period, after the five years, the service summary provided by the issuer will be deemed to comply with all asset protection reporting, record keeping, and auditing requirements of this rule. The issuer may use microfiche, microfilm, optical storage media, or any other cost-effective method of record storage as alternatives to storage of paper copies of stipulated information.

72.10(3) At the time the policy or certificate ceases to be in force, the issuer shall notify the policyholder or certificate holder of the right to request service records as stipulated in 72.10(6).

72.10(4) The issuer shall also, upon request in writing, provide such policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if any, with a copy of the issuer's service records as required in 72.10(6) which are necessary to establish the asset disregard. These records shall be provided to the policyholder or certificate holder or the policyholder's or certificate holder's authorized designee, if requested, within 60 days of the request. The issuer may charge a reasonable fee to cover the costs of providing each set of requested service record copies.

72.10(5) The issuer shall enclose with the records a statement advising the former policyholder or certificate holder that it is in the best interest of the former policyholder or certificate holder to retain the records to establish eligibility for Medicaid.

72.10(6) The information to be maintained includes the following:

a. Evidence that the insured event has taken place. The occurrence of the insured event may be documented in any of the following ways:

(1) By case management agency staff, as part of the initial assessment of the client or as part of a subsequent reassessment.

(2) By an assessment conducted as part of the preadmission screening program of the Iowa Foundation of Medical Care.

(3) By an assessment of a resident of a nursing facility as required by Section 1919(b)(3) of the Social Security Act.

(4) For persons for whom subparagraphs (1) through (3) are not available or do not provide the required information, by an assessment, carried out by or under the supervision of a physician or a registered nurse, which is substantially comparable to any of the methods in subparagraphs (1) through (3). These assessments must be based on direct observations and interviews in conjunction with a medical record review. The physician or registered nurse carrying out or supervising the assessment must sign and certify the completion of the assessment. Each individual who completes a portion of such assessment shall sign and certify as to the accuracy of that portion of the assessment.

b. Description of services provided under the policy or certificate, including the following:

(1) Name, address, telephone number, and license number, if applicable, of provider.

(2) Amount, date, and type of services provided, and whether the services qualify for asset protection.

(3) Dollar amounts paid by the issuer, whether on an indemnity, expense incurred, or other basis.

(4) The charges of the service providers, including copies of invoices for all services counting toward asset protection.

(5) Identification of the case management agency, if applicable, and copies of all assessments and reassessments.

(6) Determination of whether the policyholder or certificate holder was a qualified insured at the time of benefit payment. The issuer may rely on written representation by the policyholder or certificate holder as to whether the required coverages were held.

c. In order for home- and community-based services to qualify for asset protection, these services must be in accord with a plan of care developed by a case management agency. If the policyholder or certificate holder has received any benefits delivered as part of a plan of care, the issuer must retain the following:

(1) A copy of the original plan of care.

(2) A copy of any changes made in the plan of care. The plan of care must document that the changes are required by changes in the client's medical situation, cognitive abilities, behavioral abilities, or the availability of social supports. Such services shall count toward asset protection after the case management agency adds the documented need for and description of the new services to the plan of care. In cases when the service must begin before the revisions to the plan of care are made, the new services will only count toward asset protection if the revisions to the plan of care are made within ten business days of the commencement of the new services. Issuers must maintain initial assessments and subsequent reassessments as part of insured event documentation.

191—72.11(249G) Reporting on asset protection.

72.11(1) Each issuer shall send an asset protection report at least quarterly to each policyholder or certificate holder who has received any benefits since the last asset protection report sent to the policyholder or certificate holder. Each asset protection report shall include the following information:

a. The amount of asset protection for which the policyholder or certificate holder had qualified prior to the quarter covered by the report.

b. The total benefits paid by the issuer for services rendered during the quarter.

c. A statement of the amount of benefits paid by the issuer for services rendered during the quarter which qualify for asset protection.

d. A summary total of the amount paid to date under the policy or certificate which qualifies for asset protection.

72.11(2) Asset protection reports shall be subject to audit by the division of insurance under the same requirements as specified in 72.13(1) “*b.*”

191—72.12(249G) Preparing a service summary.

72.12(1) Each issuer shall prepare a service summary at the client’s request specifically for the policyholder or certificate holder applying for Medicaid. The issuer shall also prepare a service summary when the policyholder or certificate holder has exhausted benefits under the policy or certificate or when the policy or certificate ceases to be in force for a reason other than the death of the policyholder or certificate holder, whichever occurs first.

72.12(2) The service summary shall identify the following:

- a.* The specific qualified policy or certificate.
- b.* The total benefits paid for services rendered to date.
- c.* The amount qualifying for asset protection.

This service summary is separate and in addition to any other information requirement in this chapter.

191—72.13(249G) Plan of action.

72.13(1) Each issuer shall, prior to qualification by the division of insurance, submit to the department of human services a plan for complying with the information maintenance and documentation requirements set forth in rules 72.9(249G) and 72.10(249G). No policy or certificate shall be qualified until the department of human services has approved the issuer’s documentation plan for the policy or certificate. The documentation plan will include the following:

a. The location where records will be kept. Records required for purposes of the Iowa long-term care asset preservation program must be available at no more than three locations, each of which shall be easily accessible to the division of insurance.

b. The issuer shall agree to give the commissioner access to all information described in rule 72.10(249G) on an aggregate basis for all policyholders or certificate holders and on an individual basis for all policyholders or certificate holders who have ever received any benefits. Access to information on persons who have not applied for Medicaid is required in order for the commissioner to determine if an issuer’s system for documenting asset protection is functioning correctly. The commissioner shall have the final decision concerning the frequency of access to the data and the size of samples for auditing or other purposes.

c. The name, job title, address, and telephone number of the person primarily responsible for the maintenance of the information required and for acting as liaison with the department of human services and the division of insurance concerning the information.

d. Methods for determining when insurance benefits or prepaid benefits qualify for asset protection, including the following:

- (1) Documentation of the insured event.
- (2) Description of services.
- (3) Documentation of charges and benefits paid.
- (4) Documentation of plans of care, when required.

e. Description of electronic and manual systems which will be used in maintaining the required information.

f. Information that will be retained which is needed to comply with this rule.

g. Copies of forms and descriptions of standard procedures for maintaining and reporting the information required, including the specific electronic medium which will be used to report required information and a description of the relevant files.

72.13(2) After the department of human services reviews a plan of action, that department shall advise the division of insurance and the issuer in writing whether the department of human services approves the plan of action. If the department of human services disapproves a plan of action, that

department shall advise the division of insurance and the issuer of the shortcomings in the plan of action and shall instruct the issuer of the methods necessary to resolve them.

191—72.14(249G) Auditing and correcting deficiencies in issuer record keeping.

72.14(1) Within one year of the first date that any policyholder or certificate holder of a particular issuer's policy or certificate has met the criteria for the insured event, and as often as the commissioner of insurance or department of human services deems necessary thereafter, the commissioner of insurance or department of human services shall conduct a systems audit of that company's records. The issuer shall be responsible for advising the department of human services and the division of insurance when this one-year period has begun. The commissioner or department of human services shall promptly inform each issuer of inaccuracies and other potential problems discovered in its systems audits and shall instruct the issuer of the methods necessary to correct any problems in the issuer's methods of operation.

72.14(2) The department of human services shall periodically reconcile a sample of individual applications to Medicaid of persons who have submitted documentation for qualification for asset protection with the reports submitted by issuers. The department of human services shall have the final decision concerning sample sizes and other auditing methods. The department of human services shall promptly advise issuers of any problems discovered and shall instruct the issuer of the methods necessary to correct any problems in the issuer's method of operation. The department of human services shall also notify the issuer of any obligations described in this subrule to hold clients harmless.

72.14(3) The department of human services may enter into voluntary arrangements with issuers of qualified long-term care insurance policies and certificates under which the department of human services would issue binding determinations as to whether or not services qualify for asset protection. Policyholders or certificate holders may submit requests for information and advice through their issuer or case management agency. When the following procedures are followed in all material respects, the written determinations of the department of human services concerning whether services qualify for asset protection shall be binding upon the department of human services in all subsequent actions, and the department of human services shall not make any assertion contradicting these determinations in any action arising in this subrule:

a. All requests for determinations as to whether or not services qualify for asset protection shall be submitted to the department of human services in writing. These requests may include, but are not limited to, requests for determinations in the following areas:

- (1) Whether the insured event has occurred and has been adequately documented.
- (2) Whether a care plan is required.
- (3) Whether a revision of a care plan is required.
- (4) Whether a service or services are in accord with the care plan.
- (5) Whether a service is of such a nature as to qualify for asset protection.
- (6) Whether the applicable amount is the amount paid by the issuer or the amount charged for the service.

b. The department of human services or one of its other authorized individuals may require issuers and case management agencies submitting requests for determination to provide all records and other information necessary for making a determination. The records and other information may include, but are not limited to, the following:

- (1) Assessments.
- (2) Care plans.
- (3) Invoices for services rendered.

The party providing the records and other information shall be responsible for their accuracy. If any records or other information is later determined to be materially inaccurate, the determination based on the inaccurate information shall be void and not be binding on the department of human services or any other person or entity in subsequent actions. In the case of a policyholder or certificate holder for whom a determination has been invalidated because information provided was determined to be inaccurate, the provisions of 72.14(6) and 72.14(7) will apply in the same manner as for any other policyholder or certificate holder.

c. The department of human services or its authorized individual shall render a determination on each request in writing. Each determination of the department of human services or its other authorized individual shall state the reason for the determination, including the following:

- (1) Relevant facts.
- (2) Documentation of facts.
- (3) Statutes.
- (4) Regulations.
- (5) Policies.

d. A copy of all determinations of the department of human services or its authorized individual shall be kept on file at the department of human services, together with the related records and information. The original of the determination shall be sent to the issuer or the case management agency who originally requested it. The recipient of the original determination shall be responsible for notifying the policyholder or certificate holder or the policyholder's or certificate holder's authorized producer.

72.14(4) When an audit or other review by the department of human services or the division of insurance reveals deficiencies in the record-keeping procedures of an issuer, the department of human services or the division of insurance will notify the issuer of the deficiencies and establish a reasonable deadline for correction. If an issuer fails to correct deficiencies discovered by the department of human services within a reasonable period of time, the department of human services will notify the division of insurance of the deficiencies. If an issuer fails to correct deficiencies discovered by the division of insurance within a reasonable period of time, the division will notify the department of human services of the deficiencies.

72.14(5) The commissioner of insurance shall reserve the right to remove qualification status of long-term care insurance policies and certificates when deemed necessary. If the division of insurance removes qualification status from a long-term care insurance policy or certificate, a policyholder or certificate holder who purchased a policy or certificate while the policy or certificate was qualified will retain the right to asset protection. A policyholder or certificate holder who purchases a policy or certificate after the removal of qualification status will have no right to asset protection.

72.14(6) If an issuer prepares a service summary which is used in a Medicaid application for a policyholder or certificate holder and the client is found eligible for Medicaid, and the policyholder or certificate holder after receiving Medicaid services is found to be ineligible for Medicaid solely by reason of errors in the issuer's service summary or documentation of services, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's errors after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(7) If the department of human services determines that an issuer's records pertaining to a policyholder or certificate holder who has received Medicaid benefits are in such condition that the department of human services cannot determine whether the policyholder or certificate holder qualifies for asset protection, the department of human services may require the issuer to pay for services counting toward asset protection required by the policyholder or certificate holder until the issuer has paid an amount equal to the amount of the issuer's error; after which the policyholder or certificate holder, if otherwise eligible, could qualify for Medicaid coverage.

72.14(8) The commissioner of insurance and the department of human services shall consult on all audits and examinations that may be required to determine compliance with this rule.

72.14(9) Compliance with 72.14(6) and 72.14(7) is a requirement for a policy or certificate to retain qualification.

191—72.15(249G) Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid or unenforceable, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

These rules are intended to implement Iowa Code Supplement chapter 249G.

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CHAPTER 76
EXTERNAL REVIEW

191—76.1(514J) Purpose. This chapter is intended to implement Iowa Code chapter 514J and the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148 as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, which amends the Public Health Service Act and adopts, in part, new 42 U.S.C. Section 300gg-19. These rules address issues which are unique to the external review process in this state and provide a uniform process for covered persons of health carriers providing health insurance coverage or the covered persons' authorized representatives to request and receive an external review of adverse determinations and final adverse determinations as defined in Iowa Code sections 514J.102(1) and 514J.102(18) and as referenced in Iowa Code section 514J.109(1). Health carriers defined in Iowa Code section 514J.102(23), and included in paragraph 76.2(2) "c" are subject to these rules.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

191—76.2(514J) Applicable law and definitions.

76.2(1) The rules contained in this chapter shall apply to any health benefit plan as defined in Iowa Code section 514J.102(19) other than those excluded under Iowa Code section 514J.103(2), for any plan that is offered or issued by a health carrier as defined in Iowa Code section 514J.102(23), if the plan was issued in Iowa, and if the external review request is filed with the commissioner on or after July 1, 2011.

76.2(2) For purposes of this chapter, the definitions in Iowa Code chapter 514J shall apply. In addition:

a. For purposes of applying the exemption in Iowa Code section 514J.103(2) "b," "Medicare supplement policy of insurance" shall mean the same as "Medicare supplement policy" as defined in rule 191—37.3(514D).

b. For purposes of this chapter, the definition of "adverse determination" in Iowa Code section 514J.102 shall include experimental or investigational treatment adverse determinations, as set forth in Iowa Code section 514J.109.

c. For purposes of this chapter, the definition of "health carrier" may include an employer self-funded plan if the employer chooses to opt in to comply with these rules.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

191—76.3(514J) Disclosure requirements. The description of external review procedures required by Iowa Code section 514J.116 shall be in the form of Appendix A or substantially similar language approved by the commissioner.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

191—76.4(514J) External review request.

76.4(1) Except for requests for expedited review, the covered person or the covered person's authorized representative shall submit a written request for external review (completed Appendix B) to the commissioner by personal delivery, by mail, by fax or by electronic transmission, including a copy of the health carrier's written notice containing the final adverse determination, within the time periods specified in Iowa Code section 514J.107(1) or 514J.109(1), as applicable. The request form and notice shall be submitted to the commissioner at Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; fax (515)654-6500; or e-mail iid.marketregulation@iid.iowa.gov.

76.4(2) Requests for expedited review may be made orally, and the commissioner may require submission of additional documentation such as physician certifications or medical information releases as is deemed practicable under the time constraints.

76.4(3) There is no charge or fee for submitting a request for external review.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16; Editorial change: IAC Supplement 9/23/20]

191—76.5(514J) Communication between covered person, health carrier, independent review organization and the commissioner.

76.5(1) Notices or other communications required by Iowa Code chapter 514J between the commissioner, the health carrier and the independent review organization shall be by e-mail or facsimile, unless otherwise specified, and shall be documented to prove transmission and receipt of the communication.

76.5(2) Notices or other communications required by Iowa Code chapter 514J from the commissioner, the health carrier or the independent review organization to the covered person shall be by e-mail, facsimile or overnight mail, and shall be documented to prove transmission and receipt of the communication.

76.5(3) The covered person or covered person's representative may provide notifications and communications to the health carrier, independent review organization and the commissioner as required by Iowa Code chapter 514J by e-mail, facsimile or overnight mail, but also may do so by first-class mail or personal delivery.

76.5(4) Any time periods or deadlines specified in Iowa Code chapter 514J shall commence upon receipt of the notice or communication and cease upon the transmission of the subsequent notice or communication.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

191—76.6(514J) Assignment of independent review organization by the commissioner.

76.6(1) The assignment by the commissioner of an independent review organization pursuant to Iowa Code chapter 514J shall be by rotation among approved independent review organizations.

76.6(2) Upon assignment by the commissioner of an independent review organization, in addition to providing notice to the health carrier and the covered person or covered person's representative as required by Iowa Code chapter 514J, the commissioner shall provide notice of the assignment to the independent review organization.

76.6(3) Within two business days of receipt by the independent review organization of notice from the commissioner pursuant to subrule 76.6(2), the independent review organization shall make a determination of its ability to perform the external review and advise the commissioner if the independent review organization is unable to perform the review due to conflict of interest or due to lack of expertise or qualification for the particular subject matter of the review.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

191—76.7(514J) Decision notification. The independent review organization shall immediately provide a copy of a draft of the decision to the commissioner for review. The commissioner shall review the draft of the decision to verify that the independent review organization has included in its draft of the decision the requirements set forth in Iowa Code section 514J.107, 514J.108, or 514J.109. The commissioner shall make any suggestions for changes to make the draft of the decision comply with the requirements. The independent review organization shall make such required changes within two business days. Once the commissioner determines that the decision meets the requirements of Iowa Code section 514J.107, 514J.108, or 514J.109, as applicable, the independent review organization shall immediately send the decision to the commissioner, the health carrier, and the covered person or covered person's authorized representative. The decision approved by the commissioner shall be delivered by telephone, fax or electronic transmission to the health carrier, the commissioner and the covered person or covered person's authorized representative, and a hard copy of the decision also shall be delivered by mail to the covered person or covered person's authorized representative.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

191—76.8(514J) Health carrier information.

76.8(1) Each health carrier shall provide to the commissioner the name, title, telephone number, fax number and e-mail address of the individual who shall be the health carrier's contact person for

external review procedures. The carrier's contact person or an appointed alternate shall be available to the commissioner during the Iowa insurance division's normal business hours, 8 a.m. to 4:30 p.m., Monday through Friday, central time, excluding state holidays. Any change in personnel or contact information shall be immediately sent to the commissioner.

76.8(2) Each health carrier shall make available to the commissioner upon request within five business days a detailed description of the process the health carrier has in place to ensure compliance with the requirements found in this chapter and in Iowa Code chapter 514J. The description shall include:

a. An explanation of how the carrier determines when a person has qualified for external review and should receive a notice from the carrier, and

b. A copy of the notice sent to persons who fall within the scope of the law.

76.8(3) Each health carrier shall provide to the commissioner, upon request, information set forth in Iowa Code section 514J.114(2) "b," in a format substantially similar to Appendix D, or as approved by the commissioner.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

191—76.9(514J) Certification of independent review organization.

76.9(1) In addition to the minimum qualifications set forth in Iowa Code section 514J.112, the following minimum standards are required for certification as an independent review organization:

a. The applicant shall provide a description of the procedures employed to comply with Iowa Code section 514J.112(1) "a."

b. The applicant shall provide the number of reviewers retained by the independent review organization and a description of the areas of expertise available from such reviewers and the types of cases such reviewers are qualified to review.

c. The applicant shall provide the names and résumés of all directors, officers, and executives of the independent review organization.

d. The applicant shall provide a description of the fees to be charged to the carrier by the independent review organization for external reviews.

e. The applicant shall provide the name of the medical director or health professional director responsible for the supervision and oversight of the independent review procedure.

76.9(2) The independent review organization shall develop written policies and procedures to ensure adherence to the requirements of this chapter and Iowa Code chapter 514J by any contractor, subcontractor, subvendor, agent or employee affiliated with the certified independent review organization.

76.9(3) In addition to the toll-free telephone service required by Iowa Code section 514J.112(1) "b," the independent review organization shall establish a facsimile and electronic mail service to receive information relating to external reviews pursuant to this chapter and Iowa Code chapter 514J.

76.9(4) The independent review organization shall provide the commissioner within ten business days of request such data, information, and reports as the commissioner determines necessary to evaluate the external review process established under Iowa Code chapter 514J or a report in the format of Appendix C to comply with Iowa Code section 514J.114(1).

76.9(5) Applications shall be submitted to the Commissioner of Insurance, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; or as designated by the commissioner. Applications must be submitted in full to be considered. The form for initially approving and for reapproving independent review organizations required by Iowa Code section 514J.111(4) shall be in the form of Appendix E. If the commissioner designates an entity to review applications, the designee may charge a fee, as permitted by Iowa Code section 514J.111(5) and as approved by the commissioner. All applicants will be notified of the certification decision.

76.9(6) A list of certified independent review organizations shall be maintained by the commissioner and shall be available through the Web site of the Iowa insurance division, www.iid.state.ia.us.

[ARC 9637B, IAB 7/27/11, effective 7/8/11; ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16; Editorial change: IAC Supplement 9/23/20]

191—76.10(514J) Fees charged by independent review organizations.

76.10(1) Fees charged by independent review organizations shall be reasonable.

76.10(2) A health carrier objecting to the fee charged by an independent review organization shall file a written notice with the commissioner and the independent review organization indicating the health carrier's objections to the fee and the reasons and any documentation for the objections.

76.10(3) Five days after receipt of the notice, the independent review organization may submit to the commissioner written documentation supporting the fee.

76.10(4) If the parties do not come to an agreement within 30 days of the initial notice, the commissioner or the commissioner's designee shall conduct a review of the fee and submissions and issue a written decision within 60 days. Factors to consider in determining whether a fee is unreasonable may include the following:

- a. The time and labor required to perform the independent review;
- b. The novelty and difficulty of the issues;
- c. The skill requisite to perform the independent review properly;
- d. The customary fee;
- e. The experience, reputation and ability of the independent review organization and those performing the independent review.

76.10(5) A party may appeal the commissioner's decision pursuant to 191—Chapter 3.
[ARC 9979B, IAB 1/25/12, effective 2/29/12]

191—76.11(514J) Penalties.

76.11(1) *Independent review organizations.* The commissioner may withdraw the approval of an independent review organization for any of the following reasons:

- a. Failure to maintain the minimum standards set forth in Iowa Code sections 514J.111 and 514J.112 or in subrule 76.9(1).
- b. Failure to comply with any of the requirements in subrules 76.9(2) through 76.9(5) or rule 191—76.10(514J).
- c. Failure to meet any time requirements for conducting a standard, an experimental or investigational, or an expedited external review.
- d. Failure to comply with any other requirements set forth in this chapter or in Iowa Code chapter 514J.

76.11(2) *Health carriers.*

- a. Failure to comply with any of the provisions of this chapter is a violation of Iowa Code chapter 507B.
- b. The commissioner may require a health carrier to provide additional time for a covered person to request an external review or submit documentation if the health carrier failed to comply with any part of Iowa Code chapter 514J or of this chapter.
- c. The commissioner may order restitution or take other corrective action pursuant to Iowa Code section 505.8(10).

[ARC 9979B, IAB 1/25/12, effective 2/29/12; ARC 2601C, IAB 6/22/16, effective 7/27/16]

These rules are intended to implement Iowa Code chapter 514J.

Appendix A

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request additional explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact us when you:

- Do not understand the reason for denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guidelines, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

Internal Appeal: All appeals to us for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [insert address of the health carrier contact person where appeals should be sent] within **180 days** of the date you receive our denial. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim, and you may request copies of information that we have that pertains to your claim. We will notify you of our decision in writing within **30 days** of receiving your appeal. If you do not receive our decision within **30 days** of receiving your appeal, you may be entitled to file a request for external review.

External Review: We have denied your request for the provision of or payment for a health care service or course of treatment. If our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, **you may have a right to have our decision reviewed** by health care professionals who have no association with us. Requests for external review may be submitted to the Commissioner of Insurance.

You may obtain an external review if:

- Our decision involved the admission, availability of care, continued stay, or other health care service that is a covered benefit; and
- We denied, reduced or terminated the requested service or treatment or payment for the service or treatment because we determined it did not meet our requirements for medical necessity, health care setting, level of care or effectiveness of the health care service or treatment you requested.
- You have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. In this situation, you may file a request for an **expedited external review** of our denial.
- The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. In this situation, you or your authorized representative may request an **expedited external review**.
- Our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational. In addition, if your treating health care professional certifies in writing that the recommended or requested health care service or treatment that is the subject of the recommendation or request would be significantly less effective if not promptly initiated, then you or your authorized representative may request an **expedited external review**.

You can obtain a copy of the External Review Request Form from: the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; telephone 877-955-1212 or 515-654-6600; facsimile 515-654-6500; Web site www.iid.iowa.gov.

Within **four months** after receipt of our notice containing the final adverse determination and this Notice of Appeal Rights, you should submit a request for external review to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; telephone 877-955-1212 or 515-654-6600; facsimile 515-654-6500; e-mail iid.marketregulation@iid.iowa.gov.

For standard external review, a decision will be made within **45 days** after the independent review organization receives your request.

For details, please review your Benefit Plan Document, contact us, or contact the Iowa Insurance Division.

[ARC 2601C, IAB 6/22/16, effective 7/27/16; Editorial change: IAC Supplement 9/23/20]

Appendix B

EXTERNAL REVIEW REQUEST FORM**SECTION 1. ELIGIBILITY FOR EXTERNAL REVIEW**

This External Review Request Form must be filed with the Iowa Insurance Division within **four months** after your health carrier denied, reduced or terminated the requested health care service or treatment or payment for the service or treatment. You or your authorized representative may request an external review under any of the following circumstances:

1. Your health carrier has made a determination that an admission, availability of care, continued stay, or other health care service that is a covered benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7 if you are requesting an expedited review.**
2. Your health carrier has made a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, Section 6, and Section 7 if you are requesting an expedited review.**
3. The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which you received emergency services, but you have not been discharged from a facility. **Please follow the directions in Sections 1 and 2, then submit completed Sections 3 and 4, Section 5 if applicable, and Section 7.**

If coverage was denied for a service or treatment specifically listed in your health insurance policy as excluded from coverage (other than what is listed in paragraphs 1 and 2 above), you will not be eligible for external review.

You also will need to have completed any internal appeals with your health carrier before you can request an external review, unless:

1. You already did request an internal appeal with your health carrier and have not received a decision and it has been 30 days since you requested the appeal; or
2. Your health carrier has waived the requirement that you complete an internal appeal before requesting an external review; or
3. You need an expedited review because time is a factor in your treatment.

SECTION 2. WHAT TO SEND AND WHERE TO SEND IT**YOU MUST SUBMIT ITEMS 1 AND 2 BELOW:**

1. This External Review Request Form, signed and dated, with the sections completed for your particular situation as described in Section 1. If you would like help completing your external review request for submission, contact the Market Regulation Bureau of the Iowa Insurance Division by calling 515-654-6465, or by e-mail at iid.marketregulation@iid.iowa.gov.
2. One of the following:
 - a. The letter from the covered person's health carrier or utilization review company that states that the decision is final and that the covered person or the covered person's authorized representative has exhausted all internal appeal procedures;
 - b. The letter from the covered person's health carrier or utilization review company that states it has waived the requirement to exhaust all of the health carrier's internal appeal procedures;
 - c. A copy of the covered person's or the covered person's authorized representative's request for internal appeal and a statement that no decision from the health carrier has been received for 30 days; or
 - d. A completed request for expedited review, Section 7 of this form.

WHERE TO SEND IT:

If you are requesting a standard external review, send all paperwork to the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315; facsimile 515-654-6500; e-mail iid.marketregulation@iid.iowa.gov. If you have questions, telephone 877-955-1212 or 515-654-6465.

If you are requesting an expedited external review, call the Iowa Insurance Division (telephone 877-955-1212 or 515-654-6465) before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

SECTION 3. INFORMATION REQUIRED FOR ALL EXTERNAL REVIEW REQUESTS

APPLICANT NAME

The applicant is a:

- Covered Person/Patient
- Provider (the covered person/patient must complete Section 4)
- Authorized Representative (submit completed Sections 4 and 5)

COVERED PERSON/PATIENT INFORMATION

Covered Person's/Patient's Name:

Address:

Telephone Number:

Daytime:

Evening:

E-mail Address:

Fax Number:

INSURANCE INFORMATION

Name of Insurer or HMO:

Covered Person's Insurance ID Number and/or Policy Number:

Insurance Claim/Reference Number:

Insurer/HMO Mailing Address:

Insurer/HMO Telephone Number:

Insurer/HMO E-mail Address:

Insurer/HMO Fax Number:

EMPLOYER INFORMATION

Employer's Name:

Is the health coverage that you have through your employer a self-funded plan? (Y/N)_____.

Some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider:

Address:

Contact Person:

Telephone Number:

E-mail Address:

Fax Number:

Patient Medical Record Number:

REASON FOR HEALTH CARRIER'S DENIAL

(Please check one.)

- The health care service or treatment was denied due to medical necessity, appropriateness, health care setting, level of care or effectiveness.
- The health care service or treatment is experimental or investigational (submit completed Section 6).
- Other: _____.

SUMMARY OF EXTERNAL REVIEW REQUEST

Enter a brief description of the claim and the request for health care service or treatment that was denied and attach a copy of the denial from your health carrier.

HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE

Describe in your own words the health care service or treatment decision in dispute and why you are appealing this denial. Indicate clearly the services being denied and the specific dates for the services being denied. Explain why you disagree. Attach additional pages if necessary and include available pertinent medical records, any information you received from your health carrier concerning the denial, any pertinent peer literature or clinical studies, and any additional information from your physician or health care provider that you want the independent review organization to consider.

SECTION 4. SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external review. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Iowa Insurance Division. I understand that the independent review organization and the Iowa Insurance Division will use this information to make a determination on my external review and that the information will be kept confidential and will not be released to anyone else. This release is valid for one year.

Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

SECTION 5. APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this request for external review.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my external review request on my behalf.

Signature of covered person/patient or legal representative (parent, guardian, conservator or other – please specify)

Date:

Address of Authorized Representative:

Authorized Representative's Telephone Number:

Daytime:

Evening:

Fax Number:

E-mail Address:

SECTION 6. REQUEST FOR EXTERNAL REVIEW OF DENIALS BASED ON THE REASON THAT THE TREATMENT WAS EXPERIMENTAL OR INVESTIGATIONAL

PHYSICIAN CERTIFICATION: EXPERIMENTAL OR INVESTIGATIONAL DENIALS

(To Be Completed by Treating Physician)

I hereby certify that I am the treating physician for _____ (covered person's/patient's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance carrier's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person/patient to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's/patient's medical condition meets certain requirements:

In my medical opinion as the insured's treating physician, I hereby certify to the following:

(NOTE: Requirements 1 through 3 below must all apply for the covered person/patient to qualify for an external review.)

1. The covered person/patient has a condition that qualifies under one or more of the following descriptions.

(Please check all descriptions that apply.)

- Standard health care services or treatments have not been effective in improving the covered person's/patient's condition.
- Standard health care services or treatments are not medically appropriate for the covered person/patient.
- There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.

2. The physician is a licensed, board-certified, or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition.
3. Scientifically valid studies using accepted protocols demonstrate that the health care service or treatment recommended or that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person/patient than any available standard health care services or treatments.

Explain:

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional information as necessary.)

Physician's Signature _____ Date: _____

Physician's Name (Please print.) _____

SECTION 7. REQUEST FOR EXPEDITED EXTERNAL REVIEW

CERTIFICATION OF TREATING HEALTH CARE PROVIDER FOR EXPEDITED EXTERNAL REVIEW REQUEST

(To Be Completed by Treating Health Care Provider)

NOTE TO THE TREATING HEALTH CARE PROVIDER:

The standard external review process can take up to 60 days from the date the patient's request for external review is received by the Iowa Insurance Division.

The independent review organization should complete an expedited external review within 72 hours.

This form is for the purpose of providing the certification necessary to trigger expedited review.

CERTIFICATION

I hereby certify that I am a treating health care provider for the patient, _____; and that one of the following is true: (Please check all that apply.)

- Adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function.
- The recommended or requested health care service or treatment that is the subject of the external review request would be significantly less effective if not promptly initiated.
- The final adverse determination concerns an admission, availability of care, continued stay, or a health care service for which the patient received emergency services, but has not been discharged from a facility.

For this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Signature _____ Date _____

Treating Health Care Provider's Name (Please print.) _____

Provider's Mailing Address:

Telephone Number:

E-mail Address:

Fax Number:

Licensure and Area of Clinical Specialty:

[**ARC 2601C**, IAB 6/22/16, effective 7/27/16; **ARC 4780C**, IAB 11/20/19, effective 12/25/19; Editorial change: IAC Supplement 9/23/20]

Appendix C

IOWA INSURANCE DIVISION
INDEPENDENT REVIEW ORGANIZATION EXTERNAL REVIEW
ANNUAL REPORT FORM

(Attach information to this form if necessary.)

External Review Annual Summary for 20__

Each independent review organization (IRO) shall submit upon request of the Commissioner an annual report with information for each health carrier in the aggregate for Iowa on external reviews performed and by type of health benefit plan.

1. IRO name:

Filing date:
2. IRO address:
3. IRO Web site:
4. Name, e-mail address, telephone number and fax number of the person completing this form:
5. Name, title, e-mail address, telephone number and fax number of the person responsible for regulatory compliance and quality of external reviews:
6. Total number of requests for external review received from the Iowa Insurance Division during the reporting period:
7. Number of standard external reviews:
8. Average number of days the IRO required to reach a final decision in standard reviews:
9. Number of expedited reviews completed to a final decision:
10. Average number of days the IRO required to reach a final decision in expedited reviews:
11. Number of medical necessity reviews decided in favor of the health carrier:

Briefly list procedures denied:
12. Number of medical necessity reviews decided in favor of the covered person/patient:

Briefly list procedures approved:

13. Number of experimental/investigational reviews decided in favor of the health carrier:
Briefly list procedures denied:
14. Number of experimental/investigational reviews decided in favor of the covered person/patient:
Briefly list procedures approved:
15. Number of reviews terminated as the result of a reconsideration by the health carrier:
16. Number of reviews terminated by the covered person/patient prior to issuance by the IRO of external review decision:
17. Number of reviews declined due to possible conflict with:
 - Health carrier:
 - Covered person/patient:
 - Health care provider:
 - Describe possible conflicts of interest:
18. Number of reviews declined due to other reasons not reflected in #17 above:

Appendix D

IOWA INSURANCE DIVISION**HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT FORM****(Attach information to this form if necessary.)****External Review Annual Summary for 20__**

Each health carrier shall submit upon request of the Commissioner an annual report with information in the aggregate for Iowa and by type of health benefit plan.

1. Health carrier name:
2. Health carrier address:
3. Health carrier Web site:
4. Name, e-mail address, telephone number and fax number of the person completing this form:
5. Name, title, e-mail address, telephone number and fax number of the person responsible for regulatory compliance:
6. Total number of external review requests of the health carrier's adverse determinations and final adverse determinations received from the Iowa Insurance Division during the reporting period:
7. From the total number of external review requests provided in Question 6, the number of requests determined eligible for an external review:
8. Total number of external review requests resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination of the health carrier and the number resolved reversing the adverse determination or final adverse determination of the health carrier:
9. Total number of external review requests that were terminated as the result of a reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative:

Appendix E

INDEPENDENT REVIEW ORGANIZATION APPLICATION

1. BASIC INFORMATION:

Name:

Street Address:

City, State, ZIP:

Telephone (a toll-free telephone service to receive information related to external reviews 24 hours a day, 7 days a week, that is capable of accepting, recording, or providing appropriate instruction to incoming telephone callers outside normal business hours):

Fax Number:

E-mail Address:

Director, Officer, or Executive Officer responsible for supervision and oversight of review procedures:

Telephone:

Fax Number:

E-mail Address:

Contact person to receive contacts, notices, and information from the Division:

Telephone:

Fax Number:

E-mail Address:

2. Names and titles of all directors, officers, and executives:
3. Identify independent review accreditation by nationally recognized private accrediting entity:
4. Identify all clinical reviewers to be assigned by your IRO by name, general certification, and specialty or subspecialty certification:

A clinical reviewer shall be a physician or other appropriate health care professional who is an expert in the treatment of the covered person's medical condition, is knowledgeable about the recommended or requested health care service or treatment through actual clinical experience treating patients with the same or similar medical condition, holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review, and has no history of disciplinary actions or sanctions.

5. I, _____ (authorized signatory), agree to the following undertakings and have provided attachments as required:
 - a. To provide notices and conduct reviews within the specified time frames.
 - b. To ensure the selection of qualified and impartial clinical reviewers and suitable matching of reviewers to specific cases.

c. To ensure the confidentiality of medical and treatment records and clinical review criteria.

d. To establish and maintain written procedures to ensure the IRO is unbiased.

Specifically, the IRO shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control with, a health benefit plan, a national, state, or local trade association of health benefit plans, or a national, state, or local trade association of health care providers. Further, neither the independent review organization nor any clinical reviewer assigned by the independent organization to conduct an external review shall have a material professional, familial, or financial conflict of interest with the health carrier, the covered person or covered person's representative, any officer, director, or management employee of the health carrier, the health care professional, the health care professional's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review, the facility at which the recommended health care service or treatment would be provided, the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the covered person whose health care service or treatment is the subject of the external review.

e. To maintain required records and provide access to those records by the commissioner upon request.

6. Set forth a description of fees to be charged by the independent review organization for external reviews:

[Filed 10/29/99, Notice 9/22/99—published 11/17/99, effective 12/22/99]

[Filed 4/10/00, Notice 1/12/00—published 5/3/00, effective 6/7/00]

[Filed 11/21/01, Notice 10/17/01—published 12/12/01, effective 1/16/02]

[Filed Emergency ARC 9637B, IAB 7/27/11, effective 7/8/11]

[Filed ARC 9979B (Notice ARC 9854B, IAB 11/16/11), IAB 1/25/12, effective 2/29/12]

[Filed ARC 2601C (Notice ARC 2430C, IAB 3/2/16), IAB 6/22/16, effective 7/27/16]

[Filed ARC 4780C (Notice ARC 4660C, IAB 9/25/19), IAB 11/20/19, effective 12/25/19]

[Editorial change: IAC Supplement 9/23/20]

CHAPTER 81
POSTDELIVERY BENEFITS AND CARE

191—81.1(514C) Purpose. The purpose of this chapter is to implement Iowa Code section 514C.12, thereby setting forth those requirements deemed appropriate by the commissioner for the general provision of coverage for benefits for postdelivery care.

191—81.2(514C) Applicability and scope. This chapter shall apply to all individual or group accident and health insurance, individual or group hospital or health care service contracts issued pursuant to Iowa Code chapter 509, 509A, 514, or 514A, and individual or group health maintenance organization contracts issued and regulated under chapter 514B, which are delivered, amended, or renewed on or after July 1, 1996.

191—81.3(514C) Postdelivery benefits. Every person issuing contracts under the scope of this chapter providing maternity benefits, which are not limited to complications of pregnancy, or newborn care benefits, shall not terminate inpatient benefits or require discharge of a mother or the newborn from a hospital following delivery earlier than determined to be medically appropriate by the attending physician after consultation with the mother and in accordance with the Guidelines for Perinatal Care, Third Edition, 1992, by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, which provide that when complications are not present, the postpartum hospital stay ranges from a minimum of 48 hours for a vaginal delivery to a minimum of 96 hours for a Cesarean birth, excluding the day of delivery. In accordance with those guidelines, in the event of a discharge from the hospital prior to the minimum stay established in the guidelines, a postdischarge follow-up visit shall be provided to the mother and newborn by providers competent in postpartum care and newborn assessment if determined medically appropriate as directed by the attending physician. Copies of this publication may be obtained through the Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315, telephone (515)654-6600.

[Editorial change: IAC Supplement 9/23/20]

These rules are intended to implement Iowa Code section 514C.12.

[Filed 12/13/96, Notice 9/25/96—published 1/1/97, effective 4/2/97]

[Editorial change: IAC Supplement 9/23/20]

REGULATED INDUSTRIES

CHAPTER 100

SALES OF CEMETERY MERCHANDISE, FUNERAL MERCHANDISE
AND FUNERAL SERVICES

[Prior to 11/25/15, see Chs 100 to 105]

191—100.1(523A) Purpose. This chapter is promulgated to implement and administer Iowa Code chapter 523A, which regulates the sale of cemetery merchandise, funeral merchandise, funeral services and any combination of those items.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 2730C, IAB 9/28/16, effective 11/2/16]

191—100.2(523A) Definitions. The definitions in Iowa Code chapter 523A are incorporated by this reference. In addition, the following definitions shall apply to this chapter:

“*Active license*” means a license that is in effect and in good standing.

“*Commissioner*” means the Iowa insurance commissioner or staff of the Iowa insurance division as designated by the commissioner.

“*Commissioner’s Web site*” means the Web site of the Iowa insurance division, www.iid.iowa.gov.

“*Continuing education*” means planned, organized learning acts designed to maintain, improve, or expand a licensed person’s knowledge and to maintain and improve the safety and welfare of the public.

“*Credit*” means at least 50 minutes spent by a licensed person in actual attendance at and in completion of an approved continuing education activity.

“*Insurance*” means life insurance policies and annuity contracts, except where the context indicates otherwise.

“*License*” means an authorization to act issued by the commissioner, authorizing a person to act as preneed seller or a sales agent.

“*Licensed person*” means any person who holds a preneed seller or sales agent license pursuant to Iowa Code chapter 523A, including any person who holds an active or restricted license.

“*Merchandise or services*” means cemetery merchandise, funeral merchandise, funeral services, or a combination thereof, as defined in Iowa Code section 523A.102, unless the context clearly indicates otherwise.

“*Person*” means an individual; corporation; business trust; estate; trust; partnership; limited liability company; association; cooperative; joint venture; government; governmental subdivision, agency, or instrumentality; public corporation; or any other legal or commercial entity.

“*Purchase agreement*” means an agreement to furnish merchandise or services when performance or delivery may be more than 120 days following the initial payment on the account.

“*Restricted license*” means an active license that has been placed on restricted status by the commissioner.

“*Sales log*” means a record of each sale of a purchase agreement.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.3(523A) Contact and correspondence.

100.3(1) Contact information. All mailed complaints, inquiries and correspondence shall be sent to Securities and Regulated Industries Bureau, Iowa Insurance Division, 1963 Bell Avenue, Suite 100, Des Moines, Iowa 50315. Telephone inquiries may be made at (877)955-1212. Electronic submissions and correspondence may be made through the commissioner’s Web site.

100.3(2) Complaints, inquiries and correspondence. The commissioner may receive and process any complaint made regarding merchandise or services, or regarding a sales agent or a preneed seller, that alleges certain acts or practices which may constitute one or more violations of the provisions of this chapter. Where appropriate, the commissioner may refer complaints, in whole or in part, to other agencies. Any member of the public or the industry, or any federal, state, or local official, may make and file a complaint with the commissioner. If required by the commissioner, complaints shall be made on forms prescribed by the commissioner.

100.3(3) Forms and instructions. Copies of all required forms and instructions are available on the commissioner's Web site.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; Editorial change: IAC Supplement 9/23/20]

191—100.4 to 100.9 Reserved.

191—100.10(523A) License status. Preneed seller licenses and sales agent licenses have the following three statuses:

100.10(1) No license. A person has no current preneed seller or sales agent active or restricted license issued by the commissioner.

100.10(2) Active license. A person has had a license issued by the commissioner, it is current in renewals, and it is otherwise in good standing.

100.10(3) Restricted license. A person has had an active license issued by the commissioner, the license is current in renewals, but the active license has been placed on restricted status by the commissioner.

a. The commissioner may place a license in restricted status for various reasons including, but not limited to, the following:

- (1) Disciplinary action.
- (2) Failure to pay state debt or child support.
- (3) Nondisciplinary reason if requested by the person.
- (4) Cessation of business.

b. A person whose license is restricted shall not enter into purchase agreements or sell merchandise or services, but may perform administrative duties related to sales made before the license was placed on restricted status.

c. A person whose license is restricted and who wishes to maintain a restricted status license shall meet the requirements for license renewal in rule 191—100.15(523A) by the required date. If the restricted license is not renewed, the license shall lapse at the end of its term.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 4848C, IAB 1/1/20, effective 2/5/20]

191—100.11(523A) Application for license. To obtain a preneed seller license as required by Iowa Code section 523A.501 or a sales agent license as required by Iowa Code section 523A.502, a person must submit an application to the commissioner pursuant to this rule. A person shall not accept any payment or funding, including the assignment of ownership of or proceeds from insurance, related to the purchase of merchandise or services in Iowa, if the sale of the merchandise or services is subject to Iowa Code chapter 523A, unless the person holds an active license. Application forms and instructions may be obtained from the commissioner's Web site.

100.11(1) Preneed seller application. A person that desires to be licensed as a preneed seller must submit all of the following:

a. A completed application form.

b. A signed waiver and the required fee allowing the commissioner to request and obtain, pursuant to Iowa Code section 523A.501, criminal history data information for each owner and director of the applicant, including, but not limited to, for each sole proprietor, partner, director, officer, managing partner, member, shareholder with 10 percent or more of the stock, or other person with a financial interest in the preneed seller, who has the ability to control or direct control of trust funds under Iowa Code chapter 523A, as determined by the commissioner.

c. A financial history, if requested by the commissioner, for each owner and director of the applicant, including, but not limited to, for each sole proprietor, partner, director, officer, managing partner, member, or shareholder with 10 percent or more of the stock.

d. Evidence of a fidelity bond or insurance or a statement that demonstrates compliance with Iowa Code section 523A.201.

e. Payment of the appropriate license fee.

100.11(2) Sales agent application. An individual who desires to be licensed as a sales agent must satisfy the following requirements:

- a. Be at least 18 years of age.
 - b. Submit a completed application form.
 - c. Submit a signed waiver and the required fee allowing the commissioner to request and obtain criminal history data information, pursuant to Iowa Code section 523A.501.
 - d. Pay the appropriate license fee.
- [ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.12(523A) Processing of application for a license.

100.12(1) *Information to be reviewed for evaluation of application for a license.* In order to determine whether to approve or deny an application for a license, the commissioner shall review all information that is submitted with the application, obtained through criminal history investigation pursuant to Iowa Code sections 523A.501(3) and 523A.502(4), and submitted pursuant to a commissioner's request.

a. The commissioner may require any documents reasonably necessary to verify the information contained in the application or to verify that the individual making application has the character and competency required to receive a license. The commissioner also may request fingerprints and reimbursement of costs for investigating a criminal history, pursuant to Iowa Code sections 523A.501(3) and 523A.502(4).

b. The commissioner shall conduct the criminal history data request and other investigations pursuant to Iowa Code sections 523A.501(3) and 523A.502(4). For purposes of preneed sellers' licenses, pursuant to Iowa Code section 523A.501(3), the commissioner's investigation of criminal history data and financial history shall be limited to persons who have the ability to control or to direct the control of trust funds under Iowa Code chapter 523A, as determined by the commissioner. The commissioner may deny the application for a license based on an applicant's conviction in any jurisdiction for a criminal offense involving dishonesty or a false statement.

100.12(2) *Incomplete application.* If the application form is not completed according to the instructions, or if all of the information in the instructions or requested by the commissioner is not provided, the commissioner shall reject the application and send a notice to the applicant identifying the problems with the license application and listing any corrective action necessary before the resubmission of an application.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.13(523A) Approval and denial of license applications; issuance of license.

100.13(1) *Approval of license application.* If the commissioner approves a license application, the commissioner shall issue a license, the term of which shall begin the day the license is issued and end April 15.

100.13(2) *License denial.* The commissioner may deny a license application based on information received during the application process, on any ground listed in Iowa Code section 523A.503 or rules 191—100.16(523A) and 191—100.40(523A).

a. *Notice of denial.* When the commissioner denies an application for a preneed seller or sales agent license, the commissioner shall send a denial letter to the applicant by certified mail, return receipt requested, or in the manner of service of an original notice. The denial letter shall serve as notice of the denial and shall explain why the commissioner denied the application.

b. *Appeal.* An applicant that desires to contest the denial of an application may request a contested case proceeding pursuant to 191—Chapter 3 within 30 calendar days of the date the notice of denial is mailed. A failure to timely request a hearing constitutes failure to exhaust administrative remedies. License denial hearings under this chapter shall be conducted pursuant to 191—Chapter 3. License denial hearings and all documents related thereto are contested cases open to the public pursuant to Iowa Code chapters 17A and 22. While each party shall have the burden of establishing the matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.14(523A) Continuing education requirements. For each license term, each licensed sales agent shall complete a minimum of three credits of continuing education in courses acceptable to the commissioner, which may include independent study courses, pursuant to paragraph 100.14(2)“g.” Completion of the required continuing education is mandatory for the renewal of a sales agent license. “Independent study” means a subject, program or activity that a person pursues autonomously that meets the requirements of this rule and that includes a test at the conclusion of the independent study. Independent study includes but is not limited to programs conducted using television, the Internet, video, sound-recorded programs, correspondence work, and other similar media.

100.14(1) Exemption. The requirements of this rule do not apply to:

- a. A licensed funeral director.
- b. A licensed insurance producer.
- c. A licensed sales agent who served full time in the U.S. armed forces on active duty during a substantial part of the continuing education term and who submits evidence of such service.

100.14(2) General rules for continuing education credits.

a. The topic of at least one of the three continuing education credits earned each license term must be business ethics.

b. Proof of completion of a continuing education course shall, at a minimum, include all of the following, in a format acceptable to the commissioner:

(1) The date of the course, the location of the course, the course title, the course subject, and the identity and qualifications of the presenters.

(2) The number of course credits.

(3) Proof of successful completion of the course provided by the person conducting or sponsoring the course.

c. A sales agent cannot receive continuing education credit for courses taken prior to the issuance of an initial license.

d. A sales agent cannot receive continuing education credit for the same course twice in one license term.

e. A sales agent cannot carry over to the next license term more than three continuing education credits earned in excess of the sales agent’s license term requirements.

f. An instructor of a course is entitled to the same credit as a student completing that course; the instructor may receive such credit once during a license term, regardless of how many times the instructor teaches the class.

g. A sales agent may receive continuing education credit for independent study courses that are part of a recognized national designation program. A sales agent may receive up to three continuing education credits for independent study courses during a license term. A sales agent shall maintain a record from the course provider that the course was completed and the examination was passed.

100.14(3) Maintenance of records of completion of continuing education requirements. A sales agent shall maintain for three years after the license term during which the course was taken the original proof of completion and descriptions and outlines of all completed continuing education courses.

100.14(4) Standards for acceptable continuing education courses. The commissioner shall find a continuing education course acceptable if it meets all of the following criteria:

a. The course constitutes an organized program of learning which contributes directly to the professional competency of the licensee.

b. The course is conducted by individuals who have specialized training concerning the subject matter of the course.

c. The person conducting or sponsoring the course provides proof of attendance to attendees.

d. The activity pertains to subject matters which integrally relate to the sale of merchandise or services and purchase agreements subject to Iowa Code chapter 523A.

(1) The following are examples of acceptable course topics:

1. Ethics.

2. Mortuary science law; public health; and technical standards, requirements and issues regarding the handling and interment of deceased human remains.

3. Insurance.
 4. Iowa laws and administrative rules related to Iowa Code chapters 523A and 523I.
 5. Technical information related to merchandise or services used in the death care industry.
 6. Medicaid and the Iowa estate recovery law, Iowa Code section 249A.5(2) and 441—subrule 76.12(7).
 7. Relevant federal laws and regulations such as the Federal Trade Commission Funeral rule (16 CFR Part 453).
 8. Information provided in programs or courses offered or sponsored by a state or national funeral association that otherwise meets the criteria in this subrule.
- (2) The following are examples of course topics that are not acceptable for continuing education credit:
1. Sales.
 2. Motivation.
 3. Purchaser prospecting.
 4. Supportive office skills (e.g., typing, filing, computer systems).
 5. Other subjects not specifically related to the death care industry.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.15(523A) License renewal.

100.15(1) Procedure for renewal. The commissioner shall renew preneed sellers' licenses, pursuant to Iowa Code section 523A.501(7), or sales agents' licenses, pursuant to Iowa Code section 523A.502(5), for both active and restricted status licenses, if the preneed sellers or sales agents provide to the commissioner all of the following, which must be received by the commissioner on or before April 15 of each year:

a. Annual report. A preneed seller or sales agent shall file a complete and accurate annual report in the form and manner directed by the commissioner. A preneed seller's report must include information on affiliated sales agents as provided in the instructions. The form and instructions may be obtained through the commissioner's Web site.

b. Verification of completion of continuing education. A sales agent shall have completed the continuing education required by rule 191—100.14(523A) and shall attest to completion of the continuing education and compliance with all instructions on the commissioner's Web site.

c. Renewal fee. A preneed seller or sales agent shall submit a renewal fee as set out in rule 191—100.18(523A). Failure to include the proper amount shall be cause for the renewal to be rejected.

100.15(2) Renewal of a restricted license. A preneed seller or sales agent whose license is in restricted status and who seeks to continue to conduct actions administering purchase agreements created before the license is placed in restricted status must comply with the renewal process of this rule.

100.15(3) Lapse of license. If one of the items required by subrule 100.15(1) is not provided by April 15 of each year or is incomplete or if no application for renewal is received, the preneed seller or sales agent license shall lapse. The commissioner shall notify the preneed seller or sales agent of the reason for the lapse.

100.15(4) Commissioner's option not to permit renewal. The commissioner may choose not to renew a license for any of the reasons listed in Iowa Code section 523A.503 or rules 191—100.16(523A) and 191—100.40(523A).

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 2730C, IAB 9/28/16, effective 11/2/16]

191—100.16(523A) Prohibited activities related to licensing.

100.16(1) Fraudulent or deceptive acts in procuring a license. An individual shall not engage in fraudulent or deceptive acts in procuring a preneed seller or sales agent license. Prohibited acts include but are not limited to the following:

- a.* False representations of a material fact, whether by conduct or by false or misleading statements.
- b.* Concealing or omitting anything that should have been disclosed or included with the application.
- c.* Filing a false identification.

- d. Filing an untrue certification or affidavit.
- e. Falsifying documents.

100.16(2) Prohibited activities by persons without a preneed seller or sales agent license.

a. A person to whom a license has not been issued by the commissioner, or a person whose license has expired or is restricted, shall not conduct any of the activities for which an active license is required pursuant to Iowa Code chapter 523A or this chapter, including the following:

- (1) Post or display the person's license;
- (2) Use a license certificate or a license number, except in communications with the commissioner;
- (3) Agree to provide any merchandise or services subject to Iowa Code chapter 523A after the date the license expired or became restricted, unless the merchandise or services are provided pursuant to an existing purchase agreement.

b. This subrule does not prohibit payments to an unlicensed person upon the person's delivery of merchandise or services after the death of a beneficiary, including the payment of the proceeds of insurance at the time of death of the insured.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.17(523A) Reinstatement of a restricted license.

100.17(1) Definition. The term "reinstatement" as used in this rule means changing the status of a license from restricted to active.

100.17(2) Application for reinstatement. Any preneed seller or sales agent whose license is restricted may request reinstatement by filing an application for reinstatement with the commissioner. Instructions can be found on the commissioner's Web site. If the licensed person meets all conditions of licensure, the commissioner shall reinstate the license.

100.17(3) Reinstatement after disciplinary action. If the restricted status of the license was the result of a disciplinary action, or was a forfeiture by the preneed seller or sales agent in connection with a disciplinary action, reinstatement must be in accordance with the terms of the applicable order or consent agreement. An application for reinstatement shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis for placing the license in restricted status no longer exists. Before determining whether to grant reinstatement, the commissioner may review a financial history report for the time period during which the license was restricted.

100.17(4) Reinstatement after preneed seller's change of ownership or cessation of business operations. If the restricted status of a preneed seller's license was the result of the preneed seller's change of ownership or cessation of business operations under rule 191—100.35(523A), an application for reinstatement shall allege facts which, if established, will be sufficient to enable the commissioner to determine that the basis for placing the license in restricted status no longer exists. Before determining whether to grant reinstatement, the commissioner may review a financial history report for the time period during which the license was restricted.

100.17(5) Reinstatement after failure to pay child support. If the restricted status of the license was the result of a suspension for failure to pay child support pursuant to paragraph 100.40(2) "j," the application for reinstatement shall include proof from the Iowa child support recovery unit that the outstanding child support has been paid.

100.17(6) Reinstatement after failure to pay student loan debt. Rescinded IAB 1/1/20, effective 2/5/20.

100.17(7) Reinstatement after failure to pay state debt. If the restricted status of the license was the result of a suspension for failure to pay state debt pursuant to paragraph 100.40(2) "l," the application for reinstatement shall include proof from the centralized collection unit of the department of revenue that the outstanding state debt has been paid.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 4848C, IAB 1/1/20, effective 2/5/20]

191—100.18(523A) Payment of fees.

100.18(1) Manner of payment. Fees shall be paid by electronic payment as permitted by the commissioner.

100.18(2) Nonrefundable. Fees are not refundable.

100.18(3) Specific fees. Fees are set by Iowa Code chapter 523A and by this chapter.

a. The license fee for a preneed seller applicant is \$25, plus \$15 for each criminal history request made on each individual for whom a criminal history is required by Iowa Code section 523A.501(3).

b. The license fee for a sales agent applicant is \$10, plus \$15 for each criminal history background check.

c. The fee for a license renewal is \$15 for a preneed seller and \$10 for a sales agent.
[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.19(523A) Master trusts.

100.19(1) Creation of master trusts. Pursuant to Iowa Code section 523A.203, a preneed seller may commingle the care funds of multiple beneficiaries in a master trust. When a preneed seller enters into a master trust agreement and establishes a master trust agreement at a financial institution:

a. The title of the financial account shall include the name of the preneed seller and be identified as a master trust account.

b. Either the preneed seller or the financial institution shall be the trustee of the master trust account.

c. Either the preneed seller or the financial institution shall maintain the detailed listing as required by Iowa Code section 523A.203(3) by keeping the following:

- (1) One listing of the amount deposited in trust for each beneficiary; and
- (2) A separate accounting of each purchaser's principal, interest, and income, and balance in trust for each beneficiary who has care funds in the master trust account.

100.19(2) Reporting of master trusts.

a. As part of the preneed seller's annual report required by paragraph 100.15(1) "a," a preneed seller shall submit all of the following:

- (1) The aggregate amount of deposits made to the master trust account during the calendar year.
- (2) The aggregate amount of withdrawals made from the master trust account during the calendar year.

(3) Information detailing the name of any beneficiary related to a deposit to or withdrawal from the master trust account with the amount deposited or withdrawn by the beneficiary. The report shall include aggregate amounts of deposits and withdrawals for each beneficiary.

(4) Transactions, as described in the division's instructions for the annual report, for the calendar year in which the transactions took place.

b. A financial institution shall submit a report annually that includes all of the following information relating to activities in the master trust:

(1) The aggregate amount of deposits made to the master trust account for each beneficiary during the calendar year.

(2) The aggregate amount of withdrawals made from the master trust account for each beneficiary during the calendar year.

(3) Transactions, as described in the division's instructions for the annual report, for the calendar year in which the transactions took place.

(4) A copy of the bank account statement for the master trust account.

[ARC 2730C, IAB 9/28/16, effective 11/2/16]

191—100.20(523A) Trust interest or income. A preneed seller may withdraw interest or income, as defined by Iowa Code section 523A.102(16), from trusts holding funds which are established pursuant to Iowa Code section 523A.201(8) and which are related to purchase agreements executed on or after July 1, 1987, in accordance with this rule.

100.20(1) Amount of trust interest or income which may be withdrawn. Trust interest and income must remain in trust and cannot be withdrawn by a preneed seller, except that a preneed seller may withdraw from a purchase agreement trust fund any interest and income credited to the trust during the preceding calendar year in excess of the sum of the following amounts, which sum must be retained in trust:

a. Fifty percent of the total interest and income credited to the trust during the preceding calendar year, and

b. An additional amount necessary to adjust the trust funds for inflation, as set by the commissioner based on the consumer price index pursuant to rule 191—100.22(523A).

100.20(2) Allocation of trust interest or income to purchasers' accounts. Interest and income not withdrawn from a purchase agreement trust fund shall be allocated pro rata to the purchase agreement accounts remaining in the trust at the end of the month in which the withdrawal was made.

100.20(3) Credit for trust interest or income withdrawn. The early withdrawal of interest or income under this rule does not affect the purchaser's right to a credit of such interest or income in the event of a nonguaranteed price agreement, cancellation of the purchase agreement, or nonperformance by the preneed seller.

100.20(4) Time period during which trust interest or income may be withdrawn. Interest or income withdrawals permitted by this rule shall be made up to 180 days after the calendar year in which the interest or income was earned.

100.20(5) Application of contract law. A purchase agreement may limit or prohibit a preneed seller's ability to withdraw income or interest. However, in the event of a conflict with the limitations set forth in this rule, the preneed seller must comply with the requirements of this rule.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.21(523A) Cancellation refunds. The requirement set forth in Iowa Code section 523A.602(2) "b"(1) applies to any purchase agreement executed on or after July 1, 2001.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.22(523A) Consumer price index adjustment. The inflation factor adjustment to be used for Iowa Code sections 523A.201(8) and 523A.602(2) "b"(1), for years 1987 and later, shall be the consumer price index for all urban consumers (CPI-U) issued by the U.S. Department of Labor's Bureau of Labor Statistics.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.23(523A) Preneed seller's use of surety bond in lieu of trust.

100.23(1) In lieu of the trust requirements of Iowa Code section 523A.405 as amended by 2015 Iowa Acts, House File 632, section 36, a preneed seller may file with the commissioner a surety bond. The surety bond shall be in the form as directed by the commissioner and as available on the commissioner's Web site.

100.23(2) A surety bond claimant, for purposes of this rule, includes any purchaser whose purchase agreement predates the effective date of the surety bond or was executed during the surety bond's period of coverage and whose purchase agreement has not been rescinded, fulfilled, or secured by another bond, by other insurance, or by trust funds.

100.23(3) Except as provided in subrule 100.23(6), no suit or action shall be commenced by a surety bond claimant later than one year after the expiration date of the surety bond.

100.23(4) Any surety bond claimant as set forth in subrule 100.23(2) may maintain an action on the surety bond. A surety's aggregate liability shall not exceed the penal sum of the bond.

100.23(5) A surety shall not cancel a surety bond except upon written notice of cancellation given by the surety to the commissioner by certified mail. The effective date of the cancellation shall not be less than 60 days after the commissioner receives the surety's notice. The surety shall specify the reason for the cancellation.

100.23(6) The surety shall not be liable for any surety bond claim related to the preneed seller's insolvency or cessation of business unless the surety claim is made within five years of the date of insolvency or business cessation.

100.23(7) If the surety notifies the preneed seller that the surety intends to cancel a surety bond, the preneed seller, within 30 days, shall:

a. Submit to the commissioner a substitute surety bond complying with this rule; or

b. Deposit funds in an amount as required by Iowa Code chapter 523A to a trust account established by the preneed seller.

100.23(8) A preneed seller shall maintain an adequate surety bond and shall continuously monitor the surety amount to assure its adequacy. The surety bond amount shall be calculated based on the value of the purchase agreements sold and not performed or canceled and for which no trust fund or insurance is in place.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.24 Reserved.

191—100.25(523A) Funeral and cemetery merchandise warehoused by preneed sellers.

100.25(1) *Applicability.* This rule applies only to storage existing on or before July 1, 2007, under purchase agreements executed between July 1, 1987, and July 1, 2007.

100.25(2) *Warehousing not permitted.* After July 1, 2007, warehousing shall not be used as an alternative to the trust requirements of Iowa Code chapter 523A.

100.25(3) *Approval of storage facilities by commissioner.* Notwithstanding subrule 100.25(2), if a preneed seller receives approval in writing from the commissioner pursuant to subrule 100.25(4), the trust requirements of Iowa Code sections 523A.201 and 523A.202 do not apply to either:

- a. Payments for outer burial containers made of either polystyrene or polypropylene; or
- b. Cemetery merchandise delivered to the purchaser or stored in a storage facility not owned or controlled by the preneed seller.

100.25(4) *Storage facility application.* The commissioner shall approve a preneed seller's application to have a storage facility designated as an approved storage facility for purposes of subrule 100.25(3) if the following conditions are met:

a. *Insurance coverage and financial condition.* The storage facility shall demonstrate that adequate insurance against loss and damage has been purchased and that the storage facility's financial condition is commensurate with any financial obligations assumed. Proof of the storage facility's financial condition shall include submission of audited financial statements completed in accordance with generally accepted accounting principles, which shall include the following:

- (1) A balance sheet prepared as of a date within 120 days prior to the application; and
- (2) A profit and loss statement and any changes in financial position for each of the three fiscal years preceding the date of the balance sheet or, if the storage facility has been in existence less than three years, for the period of the storage facility's existence.

b. *Records system and maintenance.* The storage facility must demonstrate that it has a system that adequately records:

(1) For each item in storage: an identification and a description; the ownership; name and address of the preneed seller; an order number; the order date; and the storage date.

(2) An aggregate listing and numerical totals for the entire storage facility and for each state or province.

c. *Title, delivery, identification, payments.* The storage facility shall agree to comply with subrule 100.25(5).

d. *Storage requirements.* The storage facility shall provide storage that adequately provides both accessibility and protection against damage.

e. *Consent to audits and inspections.* The storage facility shall provide written consent to authorize audits, reviews and inspections by the commissioner pursuant to paragraph 100.25(5) "e" and written consent to provide reports requested pursuant to paragraph 100.25(5) "g."

f. *Compliance with law.* The storage facility shall be in compliance with all applicable laws regulating the applicant's activities as a warehouse keeper, manufacturer, supplier, or preneed seller of cemetery or funeral merchandise.

100.25(5) *Storage facility duties.*

a. *Title.* The storage facility shall provide to the preneed seller a minimum of two copies of a title certificate. The title certificate should not be issued until the merchandise is stored in substantially

complete condition. Each preneed seller shall deliver at least one copy of the title certificate to the purchaser and shall retain one copy in the preneed seller's records.

b. Delivery requirements. The storage facility shall not accept prepayment of delivery expenses or charges. The storage facility shall provide written disclosure to the preneed seller that delivery costs will be billed at the time of delivery. The storage facility shall require the purchaser's signature, or the signature of the purchaser's legal representative, prior to the delivery of the cemetery or funeral merchandise.

c. Storage requirements. The storage facility shall adequately provide accessibility to the stored merchandise and adequately protect the stored merchandise against damage.

d. Identification of merchandise. The storage facility shall allow for visual inspection and counting; have storage by type or style; identify the location of the item by a shelf and bin- or slot-type system or reasonable alternative; and keep totals for each type of merchandise item in storage.

e. Audits and examinations. The storage facility shall allow the commissioner to examine the books, papers, records, memoranda or other documents of the storage facility and stored merchandise for the purpose of verifying compliance with Iowa Code chapter 523A and this rule. Unless waived by the commissioner in writing, the transportation, meal and lodging expenses of the auditors and examiners shall be reimbursed by the storage facility.

f. Identification of merchandise. All cemetery merchandise must be appropriately marked, identified and described in a manner to distinguish it from other similar items of merchandise, unless the commissioner has given to the seller prior written waiver of this requirement upon a showing of good cause.

g. Reports. The commissioner may request reports containing information about the storage facility, including but not limited to the following:

(1) A description of the storage facility, including the name, address of the principal business office, state or province of organization, date of organization, type of entity (e.g., corporation or partnership), and location of all storage facilities;

(2) A description of the storage program; and

(3) A detailed description of all merchandise currently in storage, which shall include all of the following:

1. The date the merchandise was first placed in storage;

2. The full name of the purchaser or the person on whose behalf the merchandise was purchased;

3. The location of the merchandise, which shall include the location within the facility utilizing a numbering system that provides the exact location of each item;

4. The name and address of the preneed seller;

5. The total number of items, by category, in storage at the facility for preneed sellers located in this state; and

6. The total number of items, by category, in storage at the facility.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.26 to 100.29 Reserved.

191—100.30(523A) Standards of conduct for preneed sellers and sales agents. Rules 191—100.30(523A) through 191—100.36(523A) are intended to establish certain minimum standards and guidelines of conduct for preneed sellers and sales agents by identifying required actions or practices. Failure to comply with these rules may be grounds for action under Iowa Code chapter 523A or rule 191—100.40(523A) or 191—100.41(523A).

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.31(523A) Advertisements, sales practices and disclosures.

100.31(1) Advertising.

a. A preneed seller or sales agent shall not engage in any act or practice that violates Iowa Code section 523A.702 or 523A.703, whether or not actual harm or injury occurs, including but not limited to making untrue or improbable statements in advertisements.

b. An advertisement for the solicitation or sale of a purchase agreement which is to be funded by insurance shall adequately disclose the following:

- (1) The fact that insurance is to be involved or used to fund a purchase agreement, and
- (2) The nature of the relationship among the sales agent, the preneed seller, the provider of merchandise or services, and any other person.

100.31(2) *Unethical, harmful or detrimental sales practices.* A preneed seller or sales agent shall not engage in any act or practice which may be harmful or detrimental to the public, whether or not actual harm or injury occurs, while engaged in activities regulated by Iowa Code chapter 523A, or materially related to such activity, including but not limited to:

a. Encouraging cancellation of a purchase agreement if cancellation is not in the best interests of the purchaser.

b. Encouraging a change in the funding method of a purchase agreement, including a change from one insurance company to another, if the change is not in the best interest of the purchaser.

c. Failure to leave a residence when requested to do so.

d. Intimidation or physical abuse, including improper sexual contact or conduct.

e. Any other act or practice that takes unfair or unreasonable advantage of the vulnerability of a purchaser or prospective purchaser based on age, poor health, infirmity, impaired understanding, restricted mobility, or disability.

100.31(3) *Disclosures.*

a. Reserved.

b. Prior to accepting an application, initial premium, or deposit for insurance which is to fund a purchase agreement, a preneed seller or sales agent must adequately disclose to the potential purchaser in writing all of the following:

(1) The relationship of the insurance to the funding of the purchase agreement and the nature and existence of any guarantees relating to the purchase agreement.

(2) The impact on the purchase agreement of any of the following:

1. Changes in the insurance including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

2. Penalties to be incurred by the policyholder as a result of failure to make premium payments;

3. Penalties to be incurred or moneys to be received as a result of cancellation or surrender of the insurance.

(3) All merchandise or services to be supplied pursuant to the contract or purchase agreement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need.

(4) All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the insurance and the amount actually needed to fund the purchase agreement.

(5) Any penalties including, but not limited to, penalties for the inability of the preneed seller to deliver merchandise or services or to fulfill the purchase agreement guarantee.

(6) Any restrictions including, but not limited to, geographic restrictions.

(7) Whether any sales commission or other form of compensation is being paid related to the insurance and the identity of the individual or entity to which the compensation is to be paid. It is not necessary that the amount be disclosed.

c. Reserved.

d. Regardless of the type of funding for the purchase agreement, at the time of providing a written itemized cost estimate for the purchase of preneed merchandise or services:

(1) The sales agent shall provide to the potential purchaser a copy of the Iowa insurance division's Guide to Prearranged Funeral Plans, or a document in similar format and with substantially similar language.

(2) The sales agent shall include on the cost estimate clear statements indicating:

1. The date after which the estimate or proposal expires.

2. That prices are subject to change after the cost proposal expires.

3. That the prices provided are a nonbinding estimate and do not create a binding contract or agreement with the preneed seller.

(3) The sales agent shall provide a copy of the cost estimate to the potential purchaser and shall retain a copy of the cost estimate in the preneed seller's records for at least five years.

For purposes of this rule, a price list is not a cost estimate.

e. Regardless of the type of funding for the purchase agreement, a purchase agreement that describes the purchase price as "guaranteed" shall disclose the nature and details of the guarantee. For items described as "guaranteed," the purchaser, beneficiary and the beneficiary's estate shall not be obligated to pay additional costs if costs at the time merchandise or services are delivered or provided are greater than the funds available from the allocable portion of payments and accumulated income or growth, as long as the funding is not limited in any manner, such as by the failure to make contractual or premium payments.

f. If a purchase agreement is to be funded by a trust, the purchase agreement shall disclose that 100 percent of all payments related to merchandise or services described in the purchase agreement as "nonguaranteed" shall be placed in trust in accordance with Iowa Code section 523A.201(2).

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.32 Reserved.

191—100.33(523A) Records maintenance and retention.

100.33(1) *By preneed sellers.*

a. Time for retaining records. If no other legal provision governs record retention, a preneed seller shall keep all records required to be kept by this rule either from the date of the preneed seller's last examination by the commissioner or for a minimum of five years after the date of the death of the beneficiary, whichever is sooner.

b. Confidentiality. The preneed seller shall keep social security numbers confidential.

c. Sales log and numbering of purchase agreements. A preneed seller shall maintain a sales log of purchase agreements, assigning numbers in sequential order to each purchase agreement sold during a calendar year.

(1) Prenumbered contracts are not required. If a contract is not prenumbered, the sales agent shall write the contract number on the purchase agreement at the time it is executed or in a document provided later to the purchaser.

(2) The copy of the purchase agreement given to the purchaser shall include the contract number assigned to the purchase agreement.

(3) If a correction to the contract number is required, the correction shall be recorded in the sales logs, and documentation that retains evidence of the initial number used shall be maintained.

(4) Preneed sellers shall use the following numbering system, unless they receive written permission from the commissioner to use a different system.

1. The first portion of the number shall be the year the contract was written.

2. The second portion of the number shall be sequential and indicate the number of contracts executed by the preneed seller, to date, in the applicable calendar year.

3. Additional suffixes may be used as follows:

- A preneed seller with multiple locations may use a suffix to identify each location by number.
- A preneed seller with multiple sales agents may use a numerical suffix to identify the sales agent.

4. Each part of the number shall be separated by a hyphen.

An example of the numbering system is provided on the commissioner's Web site.

d. Transaction records. A preneed seller shall document all transactions with purchasers and prospective purchasers and maintain accurate copies and records of all purchase agreements.

e. Deposit records. Preneed sellers shall maintain records of all deposits made into accounts related to purchase agreements. If purchase agreement payments made to a preneed seller and funds not related to a purchase agreement are commingled and deposited together in a single account, or

if a deposit to an account involves purchase agreement payments related to more than one purchase agreement, the preneed seller shall retain a detailed summary of each deposit showing the amounts related to the different purchase agreements.

f. Record of sales agents. A preneed seller shall maintain a list of all sales agents who sold purchase agreements on behalf of the preneed seller during each calendar year. The records shall include the license number of each sales agent and the dates of the sales agent's employment. Upon the commissioner's request, these records shall be provided to the commissioner.

100.33(2) *By sales agents.* A sales agent shall maintain a sales log for a minimum of five years after the sale. The sales log shall include all of the information required for the sales agent's annual report. Instructions and an example are available on the commissioner's Web site.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 2730C, IAB 9/28/16, effective 11/2/16]

191—100.34(523A) Changes in funding methods for or terms of purchase agreements. When a preneed seller or sales agent changes the funding method for a prepaid purchase agreement, this rule applies.

100.34(1) *Change in funding of a purchase agreement.* When a purchaser changes the funding source for a purchase agreement from a bank account or trust account to funding through insurance, or from insurance funding from one insurance company to another:

a. This type of change is deemed to be an amendment to the purchase agreement, not a cancellation of the original purchase agreement.

b. The amendment to the purchase agreement may include other minor updates to the statement of goods and services.

c. The preneed seller shall do all of the following:

(1) Obtain a written, signed and dated statement from the purchaser requesting the change in funding and acknowledging the transaction in a way that demonstrates the purchaser understood the change in funding transaction. A copy of the signed statement shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(2) Describe the change in funding in a written amendment to the purchase agreement. The amendment shall be signed and dated by the purchaser and the preneed seller. A copy of the signed amendment shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(3) If the funding change is from a bank account to an insurance account, record the amendment on the preneed seller's annual report as a reduction in cash accounts and an increase in insurance accounts.

(4) If the funding change is from a trust account to an insurance account:

1. Confirm that the policy shall have an increasing benefit, as specified in Iowa Code section 523A.401(6).

2. Record the amendment on the preneed seller's annual report as both a withdrawal from trust and an addition of insurance. Instructions are available on the commissioner's Web site.

3. Comply with record-keeping and reporting requirements for the sale of new insurance in Iowa Code sections 523A.401 and 523A.402.

(5) If the change in funding is from one insurance company to another:

1. Document compliance with the disclosure requirements of rule 191—15.8(523A).

2. Comply with the replacement requirements of rule 191—16.24(507B).

3. Record the amendment on the preneed seller's annual report as a change in funding from one insurance company to another. Instructions are available on the commissioner's Web site.

(6) For record maintenance purposes, use the number for the original purchase agreement, not a new assigned number.

100.34(2) *Cancellation of a purchase agreement.* When a purchaser makes substantive changes to a purchase agreement:

a. This type of change is deemed to be a cancellation of the existing purchase agreement and requires the preneed seller to execute a new purchase agreement.

b. The preneed seller shall do all of the following:

(1) Obtain a written signed and dated statement from the purchaser which cancels the existing purchase agreement. A copy of the signed statement shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(2) Obtain a written signed and dated statement from the purchaser which demonstrates that the purchaser understood the change from one purchase agreement to the other. A copy of the signed statement shall be provided to the purchaser, and a copy shall be retained by the preneed seller.

(3) Comply with the rescission requirements of Iowa Code section 523A.602.

(4) For record maintenance purposes, assign a new number for the new purchase agreement.

(5) Record the cancellation of the initial purchase agreement on its annual report.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.35(523A) Preneed seller's change of ownership and cessation of business operations.

100.35(1) *Sale or transfer of purchase agreements or of business.* A preneed seller shall not change ownership of a business, sell all or part of a business, cease business, or sell or transfer purchase agreements as part of the sale of a business or the assets of a business, unless:

a. The preneed seller has notified the commissioner of the change at least 90 days prior to the sale or transfer.

b. The person receiving assets and purchase agreements has an active preneed seller's license at the time of the sale or transfer.

c. A certified public accountant has performed and filed with the commissioner an agreed-upon procedures (AUP) report or other audit acceptable to the commissioner, as required by Iowa Code section 523A.207.

d. The commissioner has conducted an examination of the sales and market practices of the preneed seller, if the commissioner requests.

e. The preneed seller has provided the commissioner with any other information required for the commissioner to approve the sale or transfer.

100.35(2) *Cessation of business by a preneed seller.* At least 90 days prior to the cessation of business operations, if a preneed seller voluntarily or involuntarily ceases doing business, and the preneed seller's obligation to provide merchandise or services has not been assumed by another preneed seller holding an active preneed seller's license, the preneed seller shall:

a. Send a notice to the commissioner, in a manner as directed by the commissioner. Pursuant to subrule 100.10(3), the commissioner shall place the preneed seller's license on restricted status when the preneed seller ceases doing business.

b. Send written notice of the proposed cessation of business to the purchaser and beneficiary, if different than the purchaser, of each purchase agreement by certified mail, return receipt requested. The notice shall indicate the preneed seller's ability to transfer any trust funds and transfer the proceeds from any insurance to another licensed preneed seller.

c. During the 90 days prior to the cessation of business operations, the preneed seller shall work with financial institutions and insurance companies to modify the title to financial accounts and modify assignments and ownership of annuities and insurance policies as necessary or distribute trust funds to the purchaser or transfer to another licensed preneed seller.

100.35(3) *Failure to notify the commissioner of a change of ownership, sale of a business, or cessation of business.*

a. A preneed seller's failure to notify the commissioner, as set forth in this rule, of a change of ownership of a business, sale of all or part of a business, cessation of business, or sale or transfer of purchase agreements as part of the sale of a business or the assets of a business may be a ground for penalty under rule 191—100.40(523A) or 191—100.41(523A).

b. If trust funds are transferred without compliance with this rule or with Iowa Code sections 523A.207 and 523A.602, the commissioner may petition for the appointment of a receiver pursuant to Iowa Code section 523A.811.

100.35(4) Annual reports. A preneed seller holding a restricted license shall continue to file annual reports pursuant to Iowa Code section 523A.204 regarding any purchase agreement not transferred to another seller holding a current preneed seller's license through an assumption agreement or otherwise.

For purposes of this rule, the sale of a business shall include any change of controlling interest in any corporation or other business entity.
[ARC 2258C, IAB 11/25/15, effective 12/30/15]

191—100.36 to 100.39 Reserved.

191—100.40(523A) Prohibited practices for preneed sellers and sales agents.

100.40(1) The commissioner may impose sanctions as set forth in Iowa Code section 523A.807 and rules 191—100.40(523A) and 191—100.41(523A), or place a license in restricted status, if the commissioner finds that a preneed seller, sales agent, or owner, partner, member, director, shareholder or manager of a licensed business entity has violated or failed to comply with Iowa Code chapter 523A, this chapter, or any associated rules or implementing orders, or is otherwise unable to conduct activities as a preneed seller or sales agent.

100.40(2) Grounds for discipline include but are not limited to the following acts or practices:

a. *Fraudulent or deceptive practices.* Engaging in any act or practice that violates Iowa Code section 523A.701, 523A.702 or 523A.703, whether or not actual harm or injury occurs, including but not limited to:

- (1) Falsifying business records; or
- (2) Misappropriating funds.

b. *Responsibility for sales activities of others.* A preneed seller's consent or acquiescence to violation of this chapter or Iowa Code chapter 523A by any person acting on the preneed seller's behalf.

c. *Law violations.*

(1) Violating any state or federal law applicable to the conduct of the applicant's or licensee's business including, but not limited to, the following:

1. The provisions of Iowa Code chapter 156 pertaining to the licensure of funeral directors in the state of Iowa;
2. Regulations promulgated by the Federal Trade Commission relating to merchandise or services, or funeral or cremation establishments;
3. Applicable tax or public health laws, ordinances or regulations; or
4. Laws, rules, ordinances, or regulations occurring outside of Iowa if the commissioner determines that such violation may adversely implicate the licensee's or applicant's compliance with Iowa laws, rules, orders, ordinances, or regulations.

(2) Conviction of a criminal offense, in any jurisdiction, involving dishonesty or a false statement, including but not limited to fraud, theft, misappropriation of funds, falsification of documents, deceptive acts or practices, or other related offenses. "Conviction" shall include a plea of guilty or a finding of guilt and shall include a deferred judgment.

d. *Sales prohibited by order.* The sale of merchandise or services by a preneed seller or sales agent who has been prohibited from selling services or merchandise in an order issued pursuant to Iowa Code section 523A.807(3).

e. *Returned checks or declined credit transactions.* Submitting to the commissioner an electronic payment which is returned to the commissioner by a bank without payment, or submitting a payment to the commissioner by credit card which the credit card company does not approve, or canceling or refusing amounts charged to a credit card by the commissioner.

f. *Failure to maintain records.* Failure to maintain records as required by Iowa Code chapter 523A or any associated rules or orders.

g. Failure to cooperate with an examination or investigation. Failure to submit to an examination, failure to comply with a reasonable written request of an examiner, or failure to cooperate with an investigation conducted by the commissioner as required by Iowa Code sections 523A.206, 523A.803, 523A.808 and 523A.811 and any associated rules or orders.

h. Insolvency or unsound financial condition. Being or becoming insolvent or of unsound financial condition, the determination of which shall be based on but not limited to the following factors:

- (1) The licensee's or license applicant's net worth;
- (2) Whether a financial institution has closed or otherwise taken adverse action against an account held by or on behalf of the licensee or license applicant;
- (3) The licensee or license applicant has exhibited a pattern of writing bad checks or otherwise overdrawing a business or trust account as a result of insufficient funds;
- (4) Untimely payment by the licensee or license applicant of business obligations in a manner that threatens the operation of the business;
- (5) Untimely placement by the licensee of consumer funds into trust;
- (6) Failure of the licensee or license applicant to pay sales tax, unemployment tax or other tax owed in the course of business; or
- (7) Any other act, practice or omission that provides a reasonable basis to question the ability of the licensee or license applicant to comply with the requirements of Iowa Code chapter 523A and related regulations.

i. Inability to perform.

(1) Inability to provide the merchandise or services which the licensee purports to sell, including but not limited to failing to employ or have a contractual arrangement with at least one person who is licensed to perform mortuary science services, as described in Iowa Code chapter 156, if such services are included in a purchase agreement.

(2) Inability to reasonably provide merchandise or services due to an impairment, drug or alcohol addiction, or other act, conduct or condition. A licensee who has had a physical or mental impairment or illness during the license period may request to be placed on restricted status by the commissioner. Any such request shall be submitted on a form as specified by the commissioner and must include a signed statement of a licensed health care professional which attests to the existence of a disability or illness during the license period.

j. Suspension for failure to pay child support.

(1) Upon receipt of a certificate of noncompliance from the child support recovery unit (CSRU), the commissioner shall issue a notice to the sales agent that the sales agent's pending application for licensure, pending request for renewal, or current license will be suspended 30 days after the date of the notice. Notice shall be sent by regular mail to the sales agent's last-known address.

(2) The notice shall contain the following items:

1. A statement that the commissioner intends to suspend the sales agent's application, request for renewal or current license in 30 days;
2. A statement that the sales agent must contact the CSRU to request a withdrawal of the certificate of noncompliance;
3. A statement that the sales agent's application, request for renewal or current license will be suspended if the certificate of noncompliance is not withdrawn;
4. A statement that the sales agent does not have a right to a hearing before the commissioner, but that the sales agent may file an application for a hearing in district court pursuant to Iowa Code section 252J.9;
5. A statement that the filing of an application with the district court will stay the proceedings of the commissioner; and
6. A copy of the certificate of noncompliance.

(3) The filing of an application for hearing with the district court will stay all suspension proceedings until the commissioner is notified by the district court of the resolution of the application.

(4) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the CSRU or a notice from a clerk of court that an application for hearing has been filed, the commissioner

shall suspend the sales agent's application, request for renewal or current license 30 days after the notice is issued.

(5) Upon receipt of a withdrawal of the certificate of noncompliance from the CSRU, suspension proceedings shall halt, and the named sales agent shall be notified that the proceedings have been halted. If the sales agent's license has already been suspended, the license shall be reinstated if the sales agent is otherwise in compliance with rules issued by the commissioner. All fees required for license renewal or license reinstatement must be paid by sales agents, and all continuing education requirements must be met before a sales agent license will be renewed or reinstated after a license suspension or revocation pursuant to this paragraph.

k. Suspension for failure to pay student loan. Rescinded IAB 1/1/20, effective 2/5/20.

l. Suspension for failure to pay state debt.

(1) The commissioner shall deny the issuance or renewal of a sales agent license upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures in Iowa Code chapter 272D. In addition to the procedures set forth in Iowa Code chapter 272D, this subrule shall apply.

(2) Upon receipt of a certificate of noncompliance from the centralized collection unit of the department of revenue according to the procedures set forth in Iowa Code chapter 272D, the commissioner shall issue a notice to the sales agent that the sales agent's pending application for licensure, pending request for renewal, or current sales agent license will be suspended 60 days after the date of the notice. Notice shall be sent to the sales agent's last-known address by restricted certified mail, return receipt requested, or by personal service in accordance with the Iowa Rules of Civil Procedure. Alternatively, the applicant or licensed sales agent may accept service personally or through authorized counsel.

(3) The notice shall contain the following items:

1. A statement that the commissioner intends to suspend the sales agent's application, request for renewal or current sales agent license in 60 days;

2. A statement that the sales agent must contact the centralized collection unit of the department of revenue to schedule a conference or to otherwise obtain a withdrawal of the certificate of noncompliance;

3. A statement that the sales agent's application, request for renewal or current sales agent license will be denied or suspended if the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue within 60 days of the issuance of notice under this rule; or, if the current sales agent license is on suspension, a statement that the sales agent's current sales agent license will be revoked;

4. A statement that the sales agent does not have a right to a hearing before the commissioner, but that the sales agent may file an application for a hearing in district court pursuant to Iowa Code section 272D.9;

5. A statement that the filing of an application with the district court will stay the proceedings of the commissioner; and

6. A copy of the certificate of noncompliance.

(4) Sales agents shall keep the commissioner informed of all court actions and all actions taken by the centralized collection unit of the department of revenue, and sales agents shall provide to the commissioner, within seven days of filing or issuance, copies of all applications filed with the district court pursuant to all court orders entered in such actions and copies of all withdrawals of certificates of noncompliance by the centralized collection unit of the department of revenue.

(5) The effective date of revocation or suspension of a sales agent license shall be 60 days following service of the notice upon the applicant or sales agent.

(6) In the event an applicant or licensed sales agent timely files a district court action following service of a notice by the commissioner, the commissioner's suspension proceedings will be stayed until the commissioner is notified by the district court of the resolution of the application. Upon receipt of a court order lifting the stay, or otherwise directing the commissioner to proceed, the commissioner shall continue with the intended action described in the notice. For purposes of determining the effective date

of the denial of the issuance or renewal of a sales agent license, the commissioner shall count the number of days before the action was filed and the number of days after the court disposed of the action.

(7) If the commissioner does not receive a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue or a notice from a clerk of court that an application for hearing has been filed, the commissioner shall suspend the sales agent's application, request for renewal or current sales agent license 60 days after the notice is issued.

(8) Upon receipt of a withdrawal of the certificate of noncompliance from the centralized collection unit of the department of revenue, suspension proceedings shall halt, and the named sales agent shall be notified that the proceedings have been halted. If the sales agent's license has already been suspended, the license shall be reinstated if the sales agent is otherwise in compliance with this chapter. All fees required for license renewal or license reinstatement must be paid by the sales agent, and all continuing education requirements must be met before a sales agent license will be renewed or reinstated after a license suspension or revocation pursuant to Iowa Code chapter 272D.

(9) The commissioner shall notify the sales agent in writing through regular first-class mail, or such other means as the commissioner deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a sales agent license, and shall similarly notify the sales agent when the sales agent license is reinstated following the commissioner's receipt of a withdrawal of the certificate of noncompliance.

(10) Notwithstanding any statutory confidentiality provision, the commissioner may share information with the centralized collection unit of the department of revenue for the sole purpose of identifying sales agents subject to enforcement under Iowa Code chapter 272D.

[ARC 2258C, IAB 11/25/15, effective 12/30/15; ARC 4848C, IAB 1/1/20, effective 2/5/20]

191—100.41(523A) Disciplinary procedures.

100.41(1) Investigations. The commissioner is authorized by Iowa Code sections 17A.13(1) and 523A.803 to conduct such investigations as the commissioner deems necessary to determine whether any person has violated or is about to violate Iowa Code chapter 523A. The commissioner is authorized to issue and enforce subpoenas to compel testimony and to compel the production of books and records, as more fully described in Iowa Code section 523A.803. Upon the commissioner's determination that probable cause exists to commence a disciplinary proceeding, the procedures contained in 191—Chapter 3 shall apply.

100.41(2) Legal relationship of sales agent to preneed seller. For purposes of Iowa Code section 523A.502(1), a sales agent offering preneed services on behalf of a preneed seller is deemed to have a legal relationship as an agent of the preneed seller. The determination of whether a sales agent and a preneed seller have a principal-agent relationship will be made by the commissioner based on the totality of the circumstances surrounding the business relationship.

100.41(3) Factors used to determine whether a preneed seller has agreed to provide merchandise or services.

a. Unless the lack of a mutual agreement has been appropriately documented in the preneed seller's preneed purchaser file records, a preneed seller has agreed "to furnish cemetery merchandise, funeral merchandise, funeral services, or a combination thereof" and received an "initial payment," for purposes of Iowa Code section 523A.102(23), if:

(1) A sales agent of the preneed seller has met in person, or had an interactive discussion by telephone or another form of electronic communication, and discussed specific items of merchandise or services and the price of the applicable merchandise or services with a potential purchaser and the potential purchaser did any of the following:

1. Transferred ownership of insurance to the preneed seller,
2. Assigned proceeds of insurance to the preneed seller, or
3. Established a financial account made payable on death to the preneed seller.

(2) A sales agent of the preneed seller has met in person, or had an interactive discussion by telephone or another electronic communication, and discussed specific items of merchandise or services and the applicable prices with the owner of a financial account for which the preneed seller has been

named as the pay-on-death beneficiary to receive funds upon the death of the owner of the financial account.

b. Written documents retained in the preneed seller's records may rebut the presumption that a purchase agreement exists.

100.41(4) Penalties. Persons violating Iowa Code chapter 523A, this chapter, or any associated rules or implementing orders may be subject to one or more of the following penalties.

a. Pursuant to Iowa Code sections 523A.204(4) and 523A.502A, the failure of a licensee to timely file an annual report shall result in the license being placed on restricted status. The licensee is not authorized to solicit or execute or amend any purchase agreement under Iowa Code chapter 523A until the license has been reinstated.

b. If the commissioner issues or renews a license and subsequently determines that the payment method was declined or returned without payment to the commissioner, the license shall be immediately placed on restricted status until the payments are made and any fees or penalties charged by the commissioner are paid, at which time the license may be reinstated at the request of the applicant.

c. The commissioner may impose the disciplinary sanctions of Iowa Code chapter 523A, and of this chapter, alone or in combination, against a preneed seller or sales agent, or as a condition of licensure of an applicant for a preneed seller license or sales agent license or as a condition of renewal of a license. Sanctions include but are not limited to the following:

- (1) Issuing a warning letter or a letter of reprimand.
- (2) Requiring additional education or training.
- (3) Requiring certain specified procedures or methods of operation.
- (4) Ordering the payment of consumer restitution.
- (5) Placing a licensee on probationary status with or without the imposition of reasonable conditions to control or monitor conduct, such as periodic reports.
- (6) Imposing costs associated with the commissioner's investigation and enforcement activities.
- (7) Imposing any other sanction allowed by law.

d. A person with a restricted or expired license is subject to disciplinary action, injunctive action, criminal sanctions and any other available legal remedies in the event of any violation of Iowa Code chapter 523A, or any rules adopted or orders issued pursuant thereto.

[ARC 2258C, IAB 11/25/15, effective 12/30/15]

These rules are intended to implement Iowa Code chapter 523A.

[Filed ARC 2258C (Notice ARC 2173C, IAB 9/30/15), IAB 11/25/15, effective 12/30/15]

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[Editorial change: IAC Supplement 9/23/20]

INSPECTIONS AND APPEALS DEPARTMENT[481]**CHAPTER 1
ADMINISTRATION**

- 1.1(10A) Organization
- 1.2(10A) Definitions
- 1.3(10A) Administration division
- 1.4(10A) Investigations division
- 1.5(10A) Health facilities division
- 1.6(10A) Administrative hearings division
- 1.7(10A) Administering discretion
- 1.8(10A) Employment appeal board
- 1.9(10A,237) Child advocacy board
- 1.10(10A,13B) State public defender
- 1.11(10A,99D,99F) Racing and gaming commission

**CHAPTER 2
PETITIONS FOR RULE MAKING**

- 2.1(17A) Petition for rule making
- 2.2(17A) Briefs
- 2.3(17A) Inquiries
- 2.4(17A) Agency consideration

**CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)**

- 3.1(17A) Petition for declaratory order
- 3.2(17A) Notice of petition
- 3.3(17A) Intervention
- 3.4(17A) Briefs
- 3.5(17A) Inquiries
- 3.6(17A) Service and filing of petitions and other papers
- 3.7(17A) Consideration
- 3.8(17A) Action on petition
- 3.9(17A) Refusal to issue order
- 3.12(17A) Effect of a declaratory order

**CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)**

- 4.3(17A) Public rule-making docket
- 4.4(17A) Notice of proposed rule making
- 4.5(17A) Public participation
- 4.6(17A) Regulatory analysis
- 4.10(17A) Exemptions from public rule-making procedures
- 4.11(17A) Concise statement of reasons
- 4.13(17A) Agency rule-making record

**CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)**

- 5.1(17A,22) Definitions
- 5.3(17A,22) Requests for access to records

- 5.6(17A,22) Procedure by which a subject may have additions, dissents, or objections entered into the record
- 5.9(17A,22) Disclosures without the consent of the subject
- 5.10(17A,22) Routine use
- 5.11(17A,22) Consensual disclosure of confidential records
- 5.12(17A,22) Release to subject
- 5.13(17A,22) Availability of records
- 5.14(17A,22) Authority to release confidential records
- 5.15(17A,22) Personnel files
- 5.16(17A,22) Personally identifiable information

CHAPTER 6

UNIFORM WAIVER AND VARIANCE RULES

- 6.1(10A,17A,ExecOrd11) Applicability
- 6.2(10A,17A,ExecOrd11) Definitions
- 6.3(10A,17A,ExecOrd11) Interpretive rules
- 6.4(10A,17A,ExecOrd11) Compliance with statute
- 6.5(10A,17A,ExecOrd11) Criteria for waiver or variance
- 6.6(10A,17A,ExecOrd11) Filing of petition
- 6.7(10A,17A,ExecOrd11) Content of petition
- 6.8(10A,17A,ExecOrd11) Additional information
- 6.9(10A,17A,ExecOrd11) Notice
- 6.10(10A,17A,ExecOrd11) Hearing procedures
- 6.11(10A,17A,ExecOrd11) Ruling
- 6.12(10A,17A,ExecOrd11) Public availability
- 6.13(10A,17A,ExecOrd11) Voiding or cancellation
- 6.14(10A,17A,ExecOrd11) Violations
- 6.15(10A,17A,ExecOrd11) Defense
- 6.16(10A,17A,ExecOrd11) Appeals
- 6.17(10A,17A,ExecOrd11) Sample petition for waiver or variance

CHAPTER 7

CONSENT FOR THE SALE OF GOODS AND SERVICES

- 7.1(68B) General prohibition
- 7.2(68B) Definitions
- 7.3(68B) Conditions of consent for officials
- 7.4(68B) Application for consent
- 7.5(68B) Effect of consent
- 7.6(22,68B) Public information
- 7.7(68B) Appeal

CHAPTER 8

LICENSING ACTION FOR NONPAYMENT OF CHILD SUPPORT AND PROHIBITION OF LICENSING ACTION FOR STUDENT LOAN DEFAULT/NONCOMPLIANCE WITH AGREEMENT FOR PAYMENT OF OBLIGATION

- 8.1(252J) Certificates of noncompliance
- 8.2(272C) Licensing actions against individuals who default or are delinquent on student loan debt or on a related service obligation prohibited

CHAPTER 9
CONTESTED CASES

9.1(10A,17A)	Applicability
9.2(10A,17A)	Initiation of a contested case proceeding
9.3(10A,17A)	Director review
9.4(10A,17A)	Rehearing
9.5(10A,17A)	Judicial review

CHAPTER 10
RULES OF PROCEDURE AND PRACTICE

BEFORE THE ADMINISTRATIVE HEARINGS DIVISION

10.1(10A)	Definitions
10.2(10A,17A)	Time requirements
10.3(10A)	Requests for a contested case hearing
10.4(10A)	Transmission of contested cases
10.5(17A)	Notices of hearing
10.6(10A)	Waiver of procedures
10.7(10A,17A)	Telephone proceedings
10.8(10A,17A)	Scheduling
10.9(17A)	Disqualification
10.10(10A,17A)	Consolidation—severance
10.11(10A,17A)	Pleadings
10.12(17A)	Service and filing of documents
10.13(17A)	Discovery
10.14(10A,17A)	Subpoenas
10.15(10A,17A)	Motions
10.16(10A,17A)	Prehearing conference
10.17(10A)	Continuances
10.18(10A,17A)	Withdrawals
10.19(10A,17A)	Intervention
10.20(17A)	Hearing procedures
10.21(17A)	Evidence
10.22(17A)	Default
10.23(17A)	Ex parte communication
10.24(10A,17A)	Decisions
10.25	Reserved
10.26(10A,17A,272C)	Board hearings
10.27	Reserved
10.28(10A)	Recording costs

CHAPTER 11
PROCEDURE FOR CONTESTED CASES INVOLVING PERMITS
TO CARRY WEAPONS AND ACQUIRE FIREARMS

11.1(17A,724)	Definitions
11.2(724)	Appeals
11.3(17A,724)	Notice of hearing
11.4(17A,724)	Agency record
11.5(17A)	Contested case hearing
11.6(17A)	Service and filing of documents
11.7(17A)	Witness lists and exhibits
11.8(17A)	Evidence
11.9(17A)	Withdrawals and dismissals

11.10(17A)	Default
11.11(10A)	Attorney fees, court costs, and contested case costs
11.12(724)	Probable cause
11.13(724)	Clear and convincing evidence
11.14(17A)	Rehearing

CHAPTERS 12 to 14

Reserved

CHAPTER 15

IOWA CODE OF ADMINISTRATIVE JUDICIAL CONDUCT

15.1(10A)	Canon 1
15.2(10A)	Canon 2
15.3(10A)	Canon 3
15.4(10A)	Canon 4
15.5(10A)	Scope, definitions, and application

CHAPTERS 16 to 19

Reserved

AUDITS DIVISION

CHAPTERS 20 and 21

Reserved

CHAPTER 22

HEALTH CARE FACILITY AUDITS

22.1(10A)	Audit occurrence
22.2(10A)	Confidentiality

CHAPTERS 23 to 29

Reserved

INSPECTIONS DIVISION

CHAPTER 30

FOOD AND CONSUMER SAFETY

30.1(10A,137C,137D,137F)	Food and consumer safety bureau
30.2(10A,137C,137D,137F)	Definitions
30.3(137C,137D,137F)	Licensing and postings
30.4(137C,137D,137F)	License fees
30.5(137F)	Penalty and delinquent fees
30.6(137C,137D,137F)	Returned checks
30.7(137F)	Double licenses
30.8(137C,137D,137F)	Inspection frequency
30.9(22)	Examination of records
30.10(17A,137C,137D,137F)	Denial, suspension, or revocation of a license to operate
30.11(10A,137C,137D,137F)	Formal hearing
30.12(137F)	Primary servicing laboratory

CHAPTER 31

FOOD ESTABLISHMENT AND FOOD
PROCESSING PLANT INSPECTIONS

31.1(137F)	Inspection standards for food establishments. ²
31.2(137F)	Inspection standards for food processing plants
31.3(137D,137F)	Adulterated food and disposal

- 31.4(137D,137F) False label or defacement
- 31.5(137F) Temporary food establishments and farmers market time/temperature control for safety food licensees

CHAPTERS 32 and 33
Reserved

CHAPTER 34
HOME BAKERIES

- 34.1(137D) Inspection standards
- 34.2(137D) Enforcement
- 34.3(137D) Labeling requirement
- 34.4(137D) Annual gross sales
- 34.5(137D) Criminal offense—conviction of license holder

CHAPTER 35
CONTRACTOR REQUIREMENTS

- 35.1(137C,137D,137F) Definitions
- 35.2(137C,137D,137F) Contracts
- 35.3(137C,137D,137F) Contractor
- 35.4(137C,137D,137F) Contractor inspection personnel
- 35.5(137C,137D,137F) Investigation
- 35.6(137C,137D,137F) Inspection standards
- 35.7(137C,137D,137F) Enforcement
- 35.8(137C,137D,137F) Licensing
- 35.9(137C,137D,137F) Records
- 35.10(137C,137D,137F) Reporting requirements
- 35.11(137C,137D,137F) Contract rescinded

CHAPTER 36
Reserved

CHAPTER 37
HOTEL AND MOTEL INSPECTIONS

- 37.1(137C) Building and grounds
- 37.2(137C) Guest rooms
- 37.3(137C) Bedding
- 37.4(137C) Lavatory facilities
- 37.5(137C) Glasses and ice
- 37.6(137C) Employees
- 37.7(137C) Room rates
- 37.8(137C) Inspections
- 37.9(137C) Enforcement
- 37.10(137C) Criminal offense—conviction of license holder

CHAPTERS 38 and 39
Reserved

CHAPTER 40
FOSTER CARE FACILITY INSPECTIONS

- 40.1(10A) License surveys
- 40.2(10A) Unannounced inspections
- 40.3(10A) Results
- 40.4(10A) Ownership of records

CHAPTER 41

PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)

41.1(135H)	Definitions
41.2(135H)	Application for license
41.3(135H)	Renewal application or change of ownership
41.4(135H)	Licenses for distinct parts
41.5(135H)	Variances
41.6(135H)	Notice to the department
41.7(135H)	Inspection of complaints
41.8(135H)	General requirement
41.9(135H)	Certification of need for services
41.10(135H)	Active treatment
41.11(135H)	Individual plan of care
41.12(135H)	Individual written plan of care
41.13(135H)	Plan of care team
41.14(135H)	Required discharge
41.15(135H)	Criminal behavior involving children
41.16(22,135H)	Confidential or open information
41.17(135H)	Additional provisions concerning physical restraint

CHAPTERS 42 to 49

Reserved

CHAPTER 50

HEALTH CARE FACILITIES ADMINISTRATION

50.1(10A)	Inspections
50.2(10A)	Definitions
50.3(135B,135C)	Licensing
50.4(135C)	Fines and citations
50.5(135C)	Denial, suspension or revocation
50.6(10A)	Formal hearing
50.7(10A,135C)	Additional notification
50.8(22,135B,135C)	Records
50.9(135C)	Criminal, dependent adult abuse, and child abuse record checks
50.10(135C)	Inspections, exit interviews, plans of correction, and revisits
50.11(135C)	Complaint and self-reported incident investigation procedure
50.12(135C)	Requirements for service
50.13(135C)	Inspectors' conflicts of interest

CHAPTER 51

HOSPITALS

51.1(135B)	Definitions
51.2(135B)	Classification, compliance and license
51.3(135B)	Quality improvement program
51.4(135B)	Long-term acute care hospital located within a general hospital
51.5(135B)	Medical staff
51.6(135B)	Patient rights and responsibilities
51.7(135B)	Abuse
51.8(135B)	Organ, tissue and eye procurement
51.9(135B)	Nursing services
51.10 and 51.11	Reserved
51.12(135B)	Records and reports
51.13	Reserved

51.14(135B)	Pharmaceutical service
51.15(135B)	Orders other than medication
51.16(135B)	Radiological services
51.17	Reserved
51.18(135B)	Laboratory service
51.19	Reserved
51.20(135B)	Food and nutrition services
51.21	Reserved
51.22(135B)	Equipment for patient care
51.23	Reserved
51.24(135B)	Infection control
51.25	Reserved
51.26(135B)	Surgical services
51.27	Reserved
51.28(135B)	Anesthesia services
51.29	Reserved
51.30(135B)	Emergency services
51.31	Reserved
51.32(135B)	Obstetric and neonatal services
51.33	Reserved
51.34(135B)	Pediatric services
51.35	Reserved
51.36(135B)	Psychiatric services
51.37	Reserved
51.38(135B)	Long-term care service
51.39(135B)	Penalty and enforcement
51.40	Reserved
51.41(135B)	Criminal, dependent adult abuse, and child abuse record checks
51.42 to 51.49	Reserved
51.50(135B)	Minimum standards for construction
51.51 and 51.52	Reserved
51.53(135B)	Critical access hospitals

CHAPTER 52

DEPENDENT ADULT ABUSE IN FACILITIES AND PROGRAMS

52.1(235E)	Definitions
52.2(235E)	Persons who must report dependent adult abuse and the reporting procedure for those persons
52.3(235E)	Reports and registry of dependent adult abuse
52.4(235E)	Financial institution employees and reporting suspected financial exploitation
52.5(235E)	Evaluation of report
52.6(235E)	Separation of victim and alleged abuser
52.7(235E)	Interviews, examination of evidence, and investigation of dependent adult abuse allegations
52.8(235E)	Notification to subsequent employers

CHAPTER 53

HOSPICE LICENSE STANDARDS

53.1(135J)	Definitions
53.2(135J)	License
53.3(135J)	Patient rights
53.4(135J)	Governing body

53.5(135J)	Quality assurance and utilization review
53.6(135J)	Attending physician services
53.7(135J)	Medical director
53.8(135J)	Interdisciplinary team (IDT)
53.9(135J)	Nursing services
53.10	Reserved
53.11(135J)	Coordinator of patient care
53.12(135J)	Social services
53.13(135J)	Counseling services
53.14(135J)	Volunteer services
53.15(135J)	Spiritual counseling
53.16(135J)	Optional services
53.17(135J)	Contracted services
53.18(135J)	Short-term hospital services
53.19(135J)	Bereavement services
53.20(135J)	Records

CHAPTER 54

GOVERNOR'S AWARD FOR QUALITY CARE

54.1(135C)	Purpose
54.2(135C)	Definitions
54.3(135C)	Nomination
54.4(135C)	Applicant eligibility
54.5(135C)	Nomination information
54.6(135C)	Evaluation
54.7(135C)	Selection of finalists
54.8(135C)	Certificate of recognition

CHAPTER 55

Reserved

CHAPTER 56

FINING AND CITATIONS

56.1(135C)	Authority for citations
56.2(135C)	Classification of violations—classes
56.3(135C)	Fines
56.4(135C)	Time for compliance
56.5(135C)	Failure to correct a violation within the time specified—penalty
56.6(135C)	Treble and double fines
56.7(135C)	Notation of classes of violations
56.8(135C)	Notation for more than one class of violation
56.9(135C)	Factors determining selection of class of violation
56.10(135C)	Factors determining imposition of citation and fine
56.11(135C)	Class I violation not specified in the rules
56.12(135C)	Class I violation as a result of multiple lesser violations
56.13(135C)	Form of citations
56.14(135C)	Licensee's response to a citation
56.15(135C)	Informal conference
56.16(135C)	Procedure for facility after informal conference
56.17(135C)	Formal contest

CHAPTER 57
RESIDENTIAL CARE FACILITIES

57.1(135C)	Definitions
57.2(135C,17A)	Waiver or variance
57.3(135C)	Application for licensure
57.4(135C)	Issuance of license
57.5(135C)	Licenses for distinct parts
57.6(135C)	Special classifications
57.7(135C)	General requirements
57.8(135C)	Certified volunteer long-term care ombudsman program
57.9(135C)	Required notifications to the department
57.10(135C)	Administrator
57.11(135C)	Personnel
57.12(135C)	General policies
57.13(135C)	Admission, transfer and discharge
57.14(135C)	Involuntary discharge or transfer
57.15(135C)	Residency agreement
57.16(135C)	Medical examinations
57.17(135C)	Records
57.18(135C)	Resident care and personal services
57.19(135C)	Drugs
57.20(135C)	Dental services
57.21(135C)	Dietary
57.22(135C)	Orientation and service plan
57.23(135C)	Resident activities program
57.24(135C)	Residents' rights
57.25(135C)	Dignity preserved
57.26(135C)	Communications
57.27(135C)	Resident activities
57.28(135C)	Resident property
57.29(135C)	Financial affairs—management
57.30(135C)	Resident work
57.31(135C)	Family—shared rooms
57.32(135C)	Resident abuse prohibited
57.33(135C)	Crisis intervention
57.34(135C)	Safety
57.35(135C)	Housekeeping
57.36(135C)	Maintenance
57.37(135C)	Laundry
57.38(135C)	Garbage and waste disposal
57.39(135C)	Supplies
57.40(135C)	Buildings, furnishings, and equipment
57.41(135C)	Family and employee accommodations
57.42(135C)	Animals
57.43(135C)	Another business or activity in a facility
57.44(135C)	Respite care services

CHAPTER 58
NURSING FACILITIES

58.1(135C)	Definitions
58.2(135C)	Variances
58.3(135C)	Application for licensure

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)

- 58.55(135C) Another business or activity in a facility
- 58.56(135C) Respite care services
- 58.57(135C) Training of inspectors

CHAPTER 59
TUBERCULOSIS (TB) SCREENING

- 59.1(135B,135C) Purpose
- 59.2(135B,135C) Definitions
- 59.3(135B,135C) TB risk assessment
- 59.4(135B,135C) Health care facility or hospital risk classification
- 59.5(135B,135C) Baseline TB screening procedures for health care facilities and hospitals
- 59.6(135B,135C) Serial TB screening procedures for health care facilities and hospitals
- 59.7(135B,135C) Screening of HCWs who transfer to other health care facilities or hospitals
- 59.8(135B,135C) Baseline TB screening procedures for residents of health care facilities
- 59.9(135B,135C) Serial TB screening procedures for residents of health care facilities
- 59.10(135B,135C) Performance of screening and testing

CHAPTER 60
MINIMUM PHYSICAL STANDARDS
FOR RESIDENTIAL CARE FACILITIES

- 60.1(135C) Definitions
- 60.2(135C) Variances
- 60.3(135C) General requirements
- 60.4(135C) Typical construction
- 60.5(135C) Supervised care unit
- 60.6(135C) Support area
- 60.7(135C) Service area
- 60.8(135C) Administration and staff area
- 60.9(135C) Definition of public area
- 60.10(135C) Elevator requirements
- 60.11(135C) Mechanical requirements
- 60.12(135C) Electrical requirement
- 60.13(135C) Codes and standards

CHAPTER 61
MINIMUM PHYSICAL STANDARDS FOR NURSING FACILITIES

- 61.1(135C) Definitions
- 61.2(135C) General requirements
- 61.3(135C) Submission of construction documents
- 61.4(135C) Variances
- 61.5(135C) Additional notification requirements
- 61.6(135C) Construction requirements
- 61.7(135C) Nursing care unit
- 61.8(135C) Dietetic and other service areas
- 61.9(135C) Specialized unit or facility for persons with chronic confusion or a dementing illness (CCDI unit or facility)

CHAPTER 62
RESIDENTIAL CARE FACILITIES FOR PERSONS WITH MENTAL ILLNESS (RCFs/PMI)

- 62.1(135C) Applicability
- 62.2(135C) Definitions
- 62.3(135C) Personnel

- 62.4(135C) Admission criteria
- 62.5(135C) Evaluation services

CHAPTER 63

RESIDENTIAL CARE FACILITY—THREE- TO FIVE-BED SPECIALIZED LICENSE

- 63.1(135C) Definitions
- 63.2(135C,17A) Waiver or variance
- 63.3(135C) Application for licensure
- 63.4(135C) Issuance of license
- 63.5(135C) General requirements
- 63.6(135C) Required notifications to the department
- 63.7(135C) Administrator
- 63.8(135C) Personnel
- 63.9(135C) General policies
- 63.10(135C) Admission, transfer and discharge
- 63.11(135C) Involuntary discharge or transfer
- 63.12(135C) Residency agreement
- 63.13(135C) Medical examinations
- 63.14(135C) Records
- 63.15(135C) Resident care and personal services
- 63.16(135C) Drugs
- 63.17(135C) Dental services
- 63.18(135C) Dietary
- 63.19(135C) Orientation and service plan
- 63.20(135C) Resident activities program
- 63.21(135C) Residents' rights
- 63.22(135C) Dignity preserved
- 63.23(135C) Communications
- 63.24(135C) Resident property
- 63.25(135C) Financial affairs—management
- 63.26(135C) Resident work
- 63.27(135C) Resident abuse prohibited
- 63.28(135C) Crisis intervention
- 63.29(135C) Safety
- 63.30(135C) Housekeeping
- 63.31(135C) Maintenance
- 63.32(135C) Laundry
- 63.33(135C) Garbage and waste disposal
- 63.34(135C) Supplies
- 63.35(135C) Buildings, furnishings, and equipment
- 63.36(135C) Family and employee accommodations
- 63.37(135C) Animals

CHAPTER 64

INTERMEDIATE CARE FACILITIES FOR THE INTELLECTUALLY DISABLED

- 64.1 Reserved
- 64.2(135C) Variances
- 64.3(135C) Application for license
- 64.4(135C) General requirements
- 64.5(135C) Notifications required by the department
- 64.6(135C) Veteran eligibility

64.7(135C)	Licenses for distinct parts
64.8 to 64.16	Reserved
64.17(135C)	Contracts
64.18(135C)	Records
64.19 to 64.32	Reserved
64.33(135C)	Allegations of dependent adult abuse
64.34(135C)	Employee criminal record checks, child abuse checks and dependent adult abuse checks and employment of individuals who have committed a crime or have a founded abuse
64.35	Reserved
64.36(135C)	Involuntary discharge or transfer
64.37 to 64.59	Reserved
64.60(135C)	Federal regulations adopted—conditions of participation
64.61(135C)	Federal regulations adopted—rights
64.62(135C)	Another business or activity in a facility
64.63(135C)	Respite care services

CHAPTER 65

INTERMEDIATE CARE FACILITIES

FOR PERSONS WITH MENTAL ILLNESS (ICF/PMI)

65.1(135C)	Definitions
65.2(135C)	Application for license
65.3(135C)	Licenses for distinct parts
65.4(135C)	Variances
65.5(135C)	General requirements
65.6(135C)	Notification required by the department
65.7(135C)	Administrator
65.8(135C)	Administration
65.9(135C)	Personnel
65.10(135C)	General admission policies
65.11(135C)	Evaluation services
65.12(135C)	Individual program plan (IPP)
65.13(135C)	Activity program
65.14(135C)	Crisis intervention
65.15(135C)	Restraint or seclusion
65.16(135C)	Discharge or transfer
65.17(135C)	Medication management
65.18(135C)	Resident property and personal affairs
65.19(135C)	Financial affairs
65.20(135C)	Records
65.21(135C)	Health and safety
65.22(135C)	Nutrition
65.23(135C)	Physical facilities and maintenance
65.24	Reserved
65.25(135C)	Residents' rights in general
65.26(135C)	Incompetent residents
65.27(135C)	County care facilities
65.28(135C)	Violations
65.29(135C)	Another business or activity in a facility
65.30(135C)	Respite care services

CHAPTER 66
BOARDING HOMES

- 66.1(83GA,SF484) Definitions
- 66.2(83GA,SF484) Registration of boarding homes
- 66.3(83GA,SF484) Occupancy reports
- 66.4(83GA,SF484) Complaints
- 66.5(83GA,SF484) Investigations
- 66.6(83GA,SF484) Penalties
- 66.7(83GA,SF484) Public and confidential information

CHAPTER 67
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS,
AND ADULT DAY SERVICES

- 67.1(231B,231C,231D) Definitions
- 67.2(231B,231C,231D) Program policies and procedures, including those for incident reports
- 67.3(231B,231C,231D) Tenant rights
- 67.4(231B,231C,231D) Program notification to the department
- 67.5(231B,231C,231D) Medications
- 67.6(231B,231C,231D) Another business or activity located in a program
- 67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program
- 67.8(231B,231C,231D) All other waiver requests
- 67.9(231B,231C,231D) Staffing
- 67.10(17A,231B,231C,231D) Monitoring
- 67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure
- 67.12 Reserved
- 67.13(17A,231B,231C,231D,85GA,HF2365) Exit interview, final report, plan of correction
- 67.14(17A,231B,231C,231D,85GA,HF2365) Response to final report
- 67.15(17A,231B,231C,231D) Denial, suspension or revocation of a certificate
- 67.16(17A,231B,231C,231D) Conditional certification
- 67.17(17A,231B,231C,231D) Civil penalties
- 67.18(17A,231B,231C,231D) Judicial review
- 67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks
- 67.20(17A,231C,231D) Emergency removal of tenants
- 67.21(231C) Nursing assistant work credit
- 67.22(231B,231C,231D) Public or confidential information

CHAPTER 68
ELDER GROUP HOMES

- 68.1(231B) Definitions
- 68.2(231B) Program certification and posting requirements
- 68.3(231B) Certification—application process
- 68.4(231B) Certification—application content
- 68.5(231B) Initial certification process
- 68.6(231B) Expiration of program certification
- 68.7(231B) Recertification process
- 68.8(231B) Notification of recertification
- 68.9(231B) Listing of all certified programs
- 68.10(231B) Change of ownership—notification to the department
- 68.11(231B) Cessation of program operation
- 68.12(231B) Occupancy agreement
- 68.13(231B) Evaluation of tenant
- 68.14(231B) Criteria for admission and retention of tenants

68.15(231B)	Involuntary transfer from the program
68.16(231B)	Tenant documents
68.17(231B)	Service plans
68.18(231B)	Nurse review
68.19(231B)	Staffing
68.20(231B)	Managed risk policy and managed risk consensus agreements
68.21(231B)	Transportation
68.22(231B)	Identification of veteran's benefit eligibility
68.23(231B)	Resident advocate committees
68.24(231B)	Life safety—emergency policies and procedures and structural safety requirements
68.25(231B)	Structural standards
68.26(231B)	Landlord and tenant Act

CHAPTER 69 ASSISTED LIVING PROGRAMS

69.1(231C)	Definitions
69.2(231C)	Program certification
69.3(231C)	Certification of a nonaccredited program—application process
69.4(231C)	Nonaccredited program—application content
69.5(231C)	Initial certification process for a nonaccredited program
69.6(231C)	Expiration of the certification of a nonaccredited program
69.7(231C)	Recertification process for a nonaccredited program
69.8(231C)	Notification of recertification for a nonaccredited program
69.9(231C)	Certification or recertification of an accredited program—application process
69.10(231C)	Certification or recertification of an accredited program—application content
69.11(231C)	Initial certification process for an accredited program
69.12(231C)	Recertification process for an accredited program
69.13(231C)	Listing of all certified programs
69.14(231C)	Recognized accrediting entity
69.15(231C)	Requirements for an accredited program
69.16(231C)	Maintenance of program accreditation
69.17(231C)	Change of ownership—notification to the department
69.18(231C)	Plan reviews of a building for a new program
69.19(231C)	Plan review prior to the remodeling of a building for a certified program
69.20(231C)	Cessation of program operation
69.21(231C)	Occupancy agreement
69.22(231C)	Evaluation of tenant
69.23(231C)	Criteria for admission and retention of tenants
69.24(231C)	Involuntary transfer from the program
69.25(231C)	Tenant documents
69.26(231C)	Service plans
69.27(231C)	Nurse review
69.28(231C)	Food service
69.29(231C)	Staffing
69.30(231C)	Dementia-specific education for program personnel
69.31(231C)	Managed risk policy and managed risk consensus agreements
69.32(231C)	Life safety—emergency policies and procedures and structural safety requirements
69.33(231C)	Transportation
69.34(231C)	Activities
69.35(231C)	Structural requirements
69.36(231C)	Dwelling units in dementia-specific programs
69.37(231C)	Landlord and tenant Act

- 69.38(83GA,SF203) Identification of veteran's benefit eligibility
 69.39(231C) Respite care services

CHAPTER 70
 ADULT DAY SERVICES

- 70.1(231D) Definitions
 70.2(231D) Program certification
 70.3(231D) Certification of a nonaccredited program—application process
 70.4(231D) Nonaccredited program—application content
 70.5(231D) Initial certification process for a nonaccredited program
 70.6(231D) Expiration of the certification of a nonaccredited program
 70.7(231D) Recertification process for a nonaccredited program
 70.8(231D) Notification of recertification for a nonaccredited program
 70.9(231D) Certification or recertification of an accredited program—application process
 70.10(231D) Certification or recertification of an accredited program—application content
 70.11(231D) Initial certification process for an accredited program
 70.12(231D) Recertification process for an accredited program
 70.13(231D) Listing of all certified programs
 70.14(231D) Recognized accrediting entity
 70.15(231D) Requirements for an accredited program
 70.16(231D) Maintenance of program accreditation
 70.17(231D) Change of ownership—notification to the department
 70.18(231D) Plan reviews of a building for a new program
 70.19(231D) Plan review prior to the remodeling of a building for a certified program
 70.20(231D) Cessation of program operation
 70.21(231D) Contractual agreement
 70.22(231D) Evaluation of participant
 70.23(231D) Criteria for admission and retention of participants
 70.24(231D) Involuntary discharge from the program
 70.25(231D) Participant documents
 70.26(231D) Service plans
 70.27(231D) Nurse review
 70.28(231D) Food service
 70.29(231D) Staffing
 70.30(231D) Dementia-specific education for program personnel
 70.31(231D) Managed risk policy and managed risk consensus agreements
 70.32(231D) Life safety—emergency policies and procedures and structural safety requirements
 70.33(231D) Transportation
 70.34(231D) Activities
 70.35(231D) Structural requirements
 70.36(231D) Identification of veteran's benefit eligibility

CHAPTER 71
 SUBACUTE MENTAL HEALTH CARE FACILITIES

- 71.1(135G) Purpose—subacute mental health services
 71.2(135G) Definitions
 71.3(135G) Application for licensure
 71.4(135G) Licenses for distinct parts
 71.5(135G) Variances
 71.6(135G) Provisional license
 71.7(135G) General requirements
 71.8(135G) Required notifications to the department

71.9(135G)	Reports of dependent adult abuse
71.10(135G)	Administrator
71.11(135G)	Administration
71.12(135G)	Personnel
71.13(135G)	Admission, transfer, and discharge
71.14(135G)	Treatment plan
71.15(135G)	Crisis intervention
71.16(135G)	Seclusion and restraint
71.17(135G)	Medication management
71.18(135G)	Dietary
71.19(135G)	Buildings, furnishings, and equipment
71.20(135G)	Records
71.21(135G)	Residents' rights in general
71.22(135G)	Health and safety

CHAPTER 72

ECONOMIC FRAUD CONTROL BUREAU

72.1(10A)	Definitions
72.2(10A)	Economic fraud control bureau (EFCB)
72.3(10A)	Types of investigations
72.4(10A)	Referrals
72.5(10A)	Investigation procedures
72.6(10A)	EBT trafficking or misuse investigations
72.7(10A)	Findings
72.8(10A)	Confidentiality

CHAPTER 73

MEDICAID FRAUD CONTROL UNIT

73.1(10A)	Definitions
73.2(10A)	Investigative authority
73.3(10A)	Referrals
73.4(10A)	Investigations
73.5(10A)	Access to records
73.6(10A)	Subpoenas
73.7(10A)	Investigation results
73.8(10A)	Confidentiality

CHAPTER 74

Reserved

CHAPTER 75

DIVESTITURE UNIT

75.1(10A)	Definitions
75.2(10A)	Referral process
75.3(10A)	Referral review
75.4(10A)	Investigation
75.5(10A)	Organizing information
75.6(10A)	Computation of debt
75.7(10A)	Issuing notices
75.8(10A)	Conducting informal conferences
75.9(10A)	Failure to timely request hearing
75.10(10A)	District court hearing

- 75.11(10A) Filing and docketing of the order
75.12(10A,22) Confidentiality

CHAPTERS 76 to 89

Reserved

CHAPTER 90

PUBLIC ASSISTANCE DEBT RECOVERY UNIT

- 90.1(10A) Definitions
90.2(10A) Recovery process
90.3(10A) Records
90.4(10A) Review
90.5(10A) Debt repayment
90.6(10A) Further collection action
90.7(10A) Appeal rights
90.8(10A) Data processing systems matches
90.9(10A) Confidentiality

CHAPTERS 91 to 99

Reserved

*GAMES OF SKILL, CHANCE, BINGO
AND RAFFLES*

CHAPTER 100

GENERAL PROVISIONS FOR SOCIAL AND CHARITABLE GAMBLING

- 100.1(99B) Definitions
100.2(99B) Licensure
100.3(99B) License application
100.4(99B) Additional requirements for licensure
100.5(99B) Returned checks
100.6(99B) Payment systems
100.7(99B) Participation—game of skill, game of chance or raffle
100.8(99B) Posted rules—games other than bingo and raffles
100.9(99B) Posted rules—bingo
100.10(99B) Rules—raffles
100.11(99B) Prizes
100.12(99B) Games of chance—prohibited games
100.13(99B) Records
100.14(99B) Reports
100.15(10A,17A,99B) Appeal rights
100.16(99B) Raffles
100.17(99B) Expenses
100.18(99B) Net receipts
100.19(99B) Licensure of manufacturers and distributors of bingo equipment and supplies and electronic raffle systems
100.20(99B) Bingo supplies and equipment
100.21(99B) Electronic raffles
100.22(99B) Social gambling

CHAPTER 101

AMUSEMENT CONCESSIONS

- 101.1(99B) License requirements
101.2(99B) Prizes

- 101.3(99B) Conducting games
- 101.4(99B) Posted rules

CHAPTER 102
Reserved

CHAPTER 103
BINGO

- 103.1(99B) Definitions
- 103.2(99B) License
- 103.3(99B) Bingo occasion
- 103.4(99B) Game of bingo
- 103.5(99B) State rules and rules established by the licensee
- 103.6(99B) Prizes
- 103.7(99B) Workers
- 103.8(99B) Expenses
- 103.9(99B) Location
- 103.10 Reserved
- 103.11(10A,725) Advertising
- 103.12(10A,99B) Equipment
- 103.13(99B) Records
- 103.14(99B) Bingo checking account
- 103.15(10A,99B) Bingo savings account and bingo change fund
- 103.16(99B) Annual gambling reports
- 103.17(10A,99B) Inspections and audits
- 103.18(99B) Electronic bingo
- 103.19(99B) Bingo at a fair or community festival

CHAPTER 104
GENERAL PROVISIONS FOR ALL AMUSEMENT DEVICES

- 104.1(10A,99B) Definitions
- 104.2(99B) Device restrictions
- 104.3(99B) Prohibited games/devices
- 104.4(99B) Prizes
- 104.5(99B) Registration
- 104.6(99B) Violations
- 104.7(99B,17A) Declaratory orders

CHAPTER 105
REGISTERED AMUSEMENT DEVICES

- 105.1(10A,99B) Definitions
- 105.2(99B) Registered amusement device restrictions
- 105.3(99B) Prohibited registered amusement devices
- 105.4(99B) Prizes
- 105.5(99B) Registration by a manufacturer, distributor, or an owner that operates for profit
- 105.6(99B) Registration of registered amusement devices
- 105.7(99B) Violations
- 105.8(10A,99B) Appeal rights
- 105.9(10A,99B) Procedure for denial, revocation, or suspension of a registration
- 105.10(99B) Annual verification of device location
- 105.11(99B) Criteria for approval or denial of a registration
- 105.12(10A,99B) Suspension or revocation of a registration

CHAPTER 106

CARD GAME TOURNAMENTS BY VETERANS ORGANIZATIONS

- 106.1(99B) Definitions
- 106.2(99B) Licensing
- 106.3(99B) Card game tournament
- 106.4(99B) Records

CHAPTER 8
LICENSING ACTION FOR NONPAYMENT OF CHILD SUPPORT AND PROHIBITION
OF LICENSING ACTION FOR STUDENT LOAN DEFAULT/NONCOMPLIANCE WITH
AGREEMENT FOR PAYMENT OF OBLIGATION

481—8.1(252J) Certificates of noncompliance. The department shall suspend, revoke, or deny the issuance or renewal of a license upon the receipt of a certificate of noncompliance from the child support recovery unit of the department of human services according to the procedures in Iowa Code chapter 252J. In addition to the procedures set forth in Iowa Code chapter 252J, the rules in this chapter shall apply.

8.1(1) The notice required by Iowa Code section 252J.8 shall be served upon the applicant or licensee by restricted certified mail, return receipt requested, or personal service in accordance with R.C.P. 56.1. Alternatively, the applicant or licensee may accept service personally or through authorized counsel.

8.1(2) The effective date of the revocation or suspension of a license, or denial of the issuance or renewal of a license as specified in the notice required by Iowa Code section 252J.8, shall be 60 days following service of the notice upon the applicant or licensee.

8.1(3) The department director or designee of the director is authorized to prepare and serve the notice as required by Iowa Code section 252J.8 upon the applicant or licensee.

8.1(4) Licensees and license applicants shall keep the department informed of all court actions, and all child support recovery unit actions taken under or in connection with Iowa Code chapter 252J, and shall provide the department copies, within seven days of filing or issuance, of all applications filed with the district court pursuant to Iowa Code section 252J.9, all court orders entered in such actions, and withdrawals of certificates of noncompliance by the child support recovery unit.

8.1(5) All department fees for license applications, license renewal or reinstatement must be paid by licensees or applicants before a license will be issued, renewed or reinstated after the department has denied the issuance or renewal of a license, or has suspended or revoked a license pursuant to Iowa Code chapter 252J.

8.1(6) A licensee or applicant may file an application with the district court within 30 days of service of a department notice pursuant to Iowa Code sections 252J.8 and 252J.9.

a. The filing of the application shall stay the department action until the department receives a court order lifting the stay, dismissing the action, or otherwise directing the department to proceed.

b. For purposes of determining the effective date of the revocation or suspension, or denial of the issuance or renewal of a license, the department shall count the number of days before the action was filed and the number of days after the action was disposed of by the court.

8.1(7) The department shall notify the applicant or licensee in writing through regular first-class mail, or such other means as the department deems appropriate in the circumstances, within ten days of the effective date of the suspension or revocation of a license or the denial of the issuance or renewal of a license, and shall similarly notify the applicant or licensee when the license is issued, renewed, or reinstated following the department's receipt of a withdrawal of the certificate of noncompliance.

This rule is intended to implement Iowa Code chapter 252J.
[ARC 5187C, IAB 9/23/20, effective 10/28/20]

481—8.2(272C) Licensing actions against individuals who default or are delinquent on student loan debt or on a related service obligation prohibited. The department shall not deny the issuance or renewal of a license or suspend or revoke a license to a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

This rule is intended to implement Iowa Code section 272C.4.
[ARC 5187C, IAB 9/23/20, effective 10/28/20]

481—8.3(261) Suspension or revocation of a license. Rescinded ARC 5187C, IAB 9/23/20, effective 10/28/20.

[Filed emergency 11/30/95—published 12/20/95, effective 11/30/95]

[Filed 8/4/00, Notice 6/28/00—published 8/23/00, effective 9/29/00]

[Filed ARC 5187C (Notice ARC 5106C, IAB 7/29/20), IAB 9/23/20, effective 10/28/20]

CHAPTER 7
LOCAL EMERGENCY MANAGEMENT

[Prior to 4/18/90, Public Defense Department[650], Ch 7]

[Prior to 5/12/93, Disaster Services Division[607], Ch 7]

605—7.1(29C) Scope and purpose. These rules apply to each local emergency management commission as provided for in Iowa Code section 29C.9. These rules are intended to establish standards for emergency management and to provide local emergency management commissions with the criteria to assess and measure their capability to mitigate against, prepare for, respond to, and recover from emergencies or disasters.

605—7.2(29C) Definitions. For purposes of this chapter, the following definitions will apply:

“*Commission*” means a local emergency management commission or joint emergency management commission.

“*Local emergency management agency*” means a countywide, joint county-municipal agency organized to administer this chapter under the authority of a commission.

“*Shall*” indicates a mandatory requirement.

“*Should*” indicates a recommendation or that which is advised but not required.

[ARC 0129C, IAB 5/30/12, effective 7/4/12]

605—7.3(29C) Local emergency management commission.

7.3(1) The county board of supervisors, city councils, and sheriff in each county shall cooperate with the homeland security and emergency management department to establish a local emergency management commission to carry out the provisions of Iowa Code chapter 29C.

a. The local commission shall be named the (county name) county emergency management commission.

b. The commission shall be comprised of the following members:

(1) A member of the county board of supervisors.

(2) The county sheriff.

(3) The mayor from each city within the county.

c. The commission is a municipality as defined in Iowa Code section 670.1.

d. A commission member may designate an alternate to represent the designated entity. For any activity relating to Iowa Code section 29C.17, subsection 2, or Iowa Code chapter 24, participation shall only be by a commission member or a designated alternate that is an elected official for the same designated entity.

7.3(2) Local commission bylaws. The commission shall develop bylaws to specify, at a minimum, the following information:

a. The name of the commission.

b. The list of members.

c. The date for the commencement of operations.

d. The commission’s mission.

e. The commission’s powers and duties.

f. The manner for financing the commission and its activities and maintaining a budget therefor.

g. The manner for acquiring, holding and disposing of property.

h. The manner for electing or appointing officers and the terms of office.

i. The manner by which members may vote.

j. The manner for appointing, hiring, disciplining and terminating employees.

k. The rules for conducting meetings of the commission.

l. Any other necessary and proper rules or procedures.

The bylaws, as adopted, shall be signed by each member of the commission. The commission shall record the signed bylaws with the county recorder and shall forward a copy of the bylaws to the director of the homeland security and emergency management department.

7.3(3) Commission business. Commission business shall be conducted in compliance with Iowa Code chapter 21, "Official Meetings Open to Public," and Iowa Code chapter 22, "Examination of Public Records."

7.3(4) The commission shall have the following minimum duties and responsibilities:

a. Administration and finance.

(1) Establish and maintain a local emergency management agency responsible for the local emergency management program. The primary responsibility of this agency is to develop and maintain a comprehensive emergency management capability in cooperation with other governmental agencies, volunteer organizations, and private sector organizations. The name of this agency shall be the (county name) county emergency management agency.

(2) Determine the mission of the agency and its program.

(3) Develop and adopt a budget in accordance with the provisions of Iowa Code chapter 24 and Iowa Code section 29C.17 in support of the commission and its programs. The commission shall be the fiscal authority and the chairperson or vice chairperson shall be the certifying official for the budget.

(4) Appoint an emergency management coordinator who meets the qualifications established in subrule 7.4(3).

(5) Develop and adopt policies defining the rights and liabilities of commission employees, emergency workers and volunteers.

(6) Provide direction for the delivery of the emergency management services of planning, administration, coordination, training, exercising, and support for local governments and their departments.

(7) Coordinate emergency management activities and services among county and city governments and the private sector agencies under the jurisdiction of the commission.

b. Hazard identification, risk assessment, and capability assessment.

(1) The commission should continually identify credible hazards that may affect their jurisdiction, the likelihood of occurrence, and the vulnerability of the jurisdiction to such hazards. Hazards to be considered should include natural, technological, and human-caused.

(2) The commission should conduct an analysis to determine the consequences and impact of identified hazards on the health and safety of the public, the health and safety of responders, property and infrastructure, critical and essential facilities, public services, the environment, the economy of the jurisdiction, and government operations and obligations.

(3) The hazard analysis should include identification of vital personnel, systems, operations, equipment, and facilities at risk.

(4) The commission should identify mitigation and preparedness considerations based upon the hazard analysis.

(5) A comprehensive assessment of the emergency management program elements should be conducted periodically to determine the operational capability and readiness of the jurisdiction to address the identified hazards and risks.

c. Resource management.

(1) The commission should develop a method to effectively identify, acquire, distribute, account for, and utilize resources essential to emergency functions.

(2) The commission shall utilize, to the maximum extent practicable, the services, equipment, supplies and facilities of the political subdivisions that are members of the commission.

(3) The commission should identify resource shortfalls and develop the steps and procedures necessary to overcome such shortfalls.

(4) The commission shall, in collaboration with other public and private agencies within this state, develop written mutual aid agreements. Such agreements shall provide reciprocal disaster services and recovery aid and assistance in case of disaster too great to be dealt with by the jurisdiction unassisted. Mutual aid agreements shall be in compliance with the appropriate requirements contained in Iowa Code chapter 28E.

d. Planning.

(1) The commission shall develop a comprehensive emergency plan that is capabilities-based, multihazard and multifunctional in nature. The plan shall conform to the Comprehensive Preparedness Guide 101 as established by the Federal Emergency Management Agency.

(2) Plans shall contain the following common elements:

1. Identification of the functional roles and responsibilities of internal and external agencies, organizations, departments, and individuals during mitigation, preparedness, response and recovery.

2. Establishment and identification of lines of authority for those agencies, organizations, departments, and individuals.

(3) Plans shall be regularly reviewed and amended as appropriate in accordance with a five-year schedule established by the commission, which shall include, at a minimum, a complete review, and amendment as appropriate, at a minimum of every five years. However, a review, and amendment as appropriate, of the hazardous materials portion and of a minimum of 20 percent of the remaining annexes or portions of the plan shall be conducted on a yearly basis. The complete operations plan must be reviewed entirely, and amended as appropriate, every five years. A copy of the portions of the plan that are reviewed, regardless of amendment, must be certified and submitted to the department for approval by August 1 of each year.

(4) To be certified, the plan must be adopted by the members of the commission and attested to by the chairperson and the local emergency management coordinator on a signature document as specified by the department.

(5) In addition to the standards heretofore established in paragraph 7.3(4) "d," the operations plan shall include provisions for damage assessment.

(6) Hazardous materials plans shall meet the minimum requirements of federal law, 42 U.S.C. §11003.

(7) Counties designated as risk or host counties for a nuclear facility emergency planning zone shall meet the standards and requirements as published by the United States Nuclear Regulatory Commission and the Federal Emergency Management Agency in NUREG-0654, FEMA-REP-1, Rev. 1, March 1987.

(8) Commissions participating in or conducting exercises or experiencing real disaster incidents which require after-action and corrective action reports have 180 days from the date of the publication of the corrective action report to incorporate the corrective actions, as appropriate, into the commission's plans.

(9) Within 60 calendar days from the receipt of the plan, the department shall review plans or portions of plans submitted by a commission for approval. The department shall notify the local emergency management agency in writing of the approval or nonapproval of the plan. If the plan is not approved, the department shall state the specific standard or standards that are not being met and offer guidance on how the plan may be brought into compliance.

(10) A comprehensive emergency plan shall not be considered approved by the homeland security and emergency management department as required in Iowa Code subsection 29C.9(8) unless such plan adheres to and meets the minimum standards as established in paragraph 7.3(4) "d."

(11) Iowa Code section 29C.6 provides that state participation in funding financial assistance in a presidentially declared disaster is contingent upon the commission's having on file a state-approved, comprehensive emergency plan as provided in Iowa Code section 29C.9(8).

(12) Iowa Code section 29C.7 as enacted by 2020 Iowa Acts, Senate File 2188, provides that state participation in funding financial assistance in a non-presidentially declared disaster is contingent upon the commission's having on file a state-approved, comprehensive emergency plan as provided in Iowa Code section 29C.9(8).

e. Direction, control and coordination.

(1) The commission shall execute and enforce the orders or rules made by the governor, or under the governor's authority.

(2) The commission shall establish and maintain the capability to effectively direct, control and coordinate emergency and disaster response and recovery efforts.

(3) The commission shall establish a means of interfacing on-scene management with direction and control personnel and facilities.

(4) The commission should actively support use of the Incident Command System (ICS) model by all emergency and disaster response agencies within the jurisdiction.

f. Damage assessment.

(1) The commission shall develop and maintain a damage assessment capability consistent with local, state and federal requirements and shall designate individuals responsible for the function of damage assessment.

(2) Individuals identified by the commission to perform the function of damage assessment shall be trained through a course of instruction approved by the department.

g. Communications and warning.

(1) The commission should identify a means of disseminating a warning to the public, key officials, emergency response personnel and those other persons within the jurisdiction that may be potentially affected.

(2) The commission should identify the primary and secondary means of communications to support direction, control, and coordination of emergency management activities.

h. Operations and procedures. The commission should encourage public and private agencies, which have defined responsibilities in the comprehensive emergency plan, to develop standard operating procedures, policies, and directives in support of the plan.

i. Training.

(1) The commission shall require the local emergency management coordinator to meet the minimum training requirements as established by the division and identified in subrule 7.4(4).

(2) The commission should, in conjunction with the local emergency management coordinator, arrange for and actively support ongoing emergency management related training for local public officials, emergency responders, volunteers, and support staff.

(3) Persons responsible for emergency plan development or implementation should receive training specific to, or related to, hazards identified in the local hazard analysis.

(4) The commission should encourage individuals, other than the emergency management coordinator, with emergency management responsibilities as defined in the comprehensive emergency plan, to complete, within two years of appointment, training consistent with their emergency management responsibilities.

(5) The commission should encourage all individuals with emergency management responsibilities to maintain current and adequate training consistent with their responsibilities.

j. Exercises.

(1) The commission shall ensure that exercise activities are conducted annually in accordance with local, state and federal requirements.

(2) Exercise activities should follow a progressive five-year plan that is designed to meet the needs of the jurisdiction.

(3) Local entities assigned to an exercise should actively participate and support the role of the entity in the exercise.

(4) Local entities assigned to an exercise should actively participate in the design, development, implementation, and evaluation of the exercise activity.

k. Public education and information.

(1) The commission should designate the individual or individuals who are responsible for public education and information functions.

(2) The commission should ensure a public information capability, to include:

1. Designated public information personnel trained to meet local requirements.
2. A system of receiving and disseminating emergency public information.
3. A method to develop, coordinate, and authorize the release of information.
4. The capability to communicate with functional needs populations.

(3) The commission should actively support the development of capabilities to electronically collect, compile, report, receive, and transmit emergency public information.

7.3(5) Two or more commissions. Two or more commissions may, upon review by the director and with the approval of their respective boards of supervisors, cities, and sheriffs, enter into agreements

pursuant to Iowa Code chapter 28E for the joint coordination and administration of emergency management services throughout the multicounty area.

[ARC 0129C, IAB 5/30/12, effective 7/4/12; ARC 0336C, IAB 9/19/12, effective 10/24/12; ARC 2326C, IAB 12/23/15, effective 1/27/16; ARC 5186C, IAB 9/23/20, effective 10/28/20]

605—7.4(29C) Local emergency management coordinator.

7.4(1) Each commission shall appoint a local emergency management coordinator who shall serve at the pleasure of the commission. The commission shall delegate to the emergency management coordinator the authority to fulfill the commission's and coordinator's duties as provided in Iowa Code sections 29C.9 and 29C.10, as further described in subrule 7.3(4), and as otherwise assigned and authorized by the commission.

7.4(2) Political activity.

a. A member of a commission shall not be appointed as the local emergency management coordinator.

b. An individual serving in a full-time or part-time governmental position incompatible with the position of coordinator shall not be appointed as the emergency management coordinator.

c. Any employee of an organization for emergency management shall not:

(1) During working hours or when performing official duties or when using public equipment or at any time on public property, take part in any way in soliciting any contribution for any political party or any person seeking political office.

(2) Seek or attempt to use any political endorsement in connection with any appointment to a position created under this rule.

(3) Use any official authority or influence for the purpose of interfering with an election or affecting the results of an election.

7.4(3) Local emergency management coordinator qualifications. Each person appointed after July 1, 1990, as a local emergency management coordinator shall meet the following requirements with regard to education, abilities, experience, knowledge and skills:

a. Demonstrate a knowledge of local, state, and federal laws and regulations pertaining to emergency management.

b. Demonstrate an understanding of communications systems, frequencies, and equipment capabilities.

c. Demonstrate a knowledge of basic accounting principles and practices.

d. Express oneself clearly and concisely, both orally and in writing.

e. Establish and maintain effective working relationships with employees, public officials, and the general public.

f. Prepare accurate reports.

g. Write plans, direct the use of resources, and coordinate emergency operations under extraordinary circumstances.

h. Exercise good judgment in evaluating situations and making decisions.

i. Coordinate with agencies at all levels of government.

j. Have graduated from an accredited four-year college or university and have two years of responsible experience in emergency management, public or business administration, public relations, military preparedness or related work; or have an equivalent combination of experience and education, substituting 30 semester hours of graduate study for each year of the required work experience to a maximum of two years; or have an equivalent combination of experience and education, substituting one year of experience in the aforementioned areas for each year of college to a maximum of four years; or be an employee with current continuous experience in the state classified service that includes the equivalent of 18 months of full-time experience as an emergency management operations officer; or be an employee with current continuous experience in the state classified service that includes the equivalent of 36 months of full-time experience as a local emergency management assistant.

7.4(4) Local emergency management coordinator continuing education requirements. Each local emergency management coordinator shall meet the following educational development requirements.

The director may extend the time frame for meeting these continuing education requirements upon request from the commission.

a. Within two years of appointment as a local emergency management coordinator, the person must complete a set of study courses prescribed by the director and developed in consultation with the Iowa Emergency Management Association. The listing of courses shall be maintained on the department's website.

b. Within two years of appointment as a local emergency management coordinator, the person must complete the professional development series of courses as prescribed by the Federal Emergency Management Agency.

c. Upon completion of the requirements established in paragraphs "a" and "b" of this subrule, a person must complete annually a minimum of 24 hours of state-approved emergency management training. Since completion of the annual training will follow the federal fiscal year, October 1 to September 30, the requirement to complete 24 hours of annual training will commence on the next October 1.

d. The local emergency management coordinator must document completion of courses by submitting a copy of the certificate of completion, a letter indicating satisfactory completion, or other appropriate documentation.

e. The Iowa homeland security and emergency management department, in consultation with the Iowa Emergency Management Association, may substitute courses when deemed appropriate.

f. An emergency management coordinator who has met the baseline requirements prior to October 1, 2006, will not be required to take any of the study courses prescribed by the director in accordance with paragraph "a" to reestablish the person's baseline.

[ARC 8116B, IAB 9/9/09, effective 10/14/09; ARC 9332B, IAB 1/12/11, effective 2/16/11; ARC 0129C, IAB 5/30/12, effective 7/4/12; ARC 2326C, IAB 12/23/15, effective 1/27/16; ARC 2618C, IAB 7/6/16, effective 8/10/16; ARC 2804C, IAB 11/9/16, effective 12/14/16]

605—7.5(29C) Commission personnel.

7.5(1) Personnel for the commission, including the coordinator, operations officers, and emergency management assistants, shall be considered as employees of that commission.

7.5(2) The commission shall determine the personnel policies of the agency to include holidays, rate of pay, sick leave, vacation, and health benefits. The commission may adopt existing county or city policies in lieu of writing the commission's own policies.

[ARC 0129C, IAB 5/30/12, effective 7/4/12]

605—7.6(29C) Damage assessment and financial assistance for disaster recovery. Disaster-related expenditures and damages incurred by local governments, private nonprofit entities, individuals, and businesses may be reimbursable and covered under certain state and federal disaster assistance programs. Preliminary damage assessments shall be provided to the homeland security and emergency management department prior to the governor's making a determination that the magnitude and impact are sufficient to warrant a request for a presidential disaster declaration.

7.6(1) *Local preliminary damage assessment and impact statement.* The local emergency management coordinator shall be responsible for the coordination and collection of damage assessment and impact statement information immediately following a disaster that affects the jurisdiction.

7.6(2) *Damage assessment guidance and forms to be provided.* The homeland security and emergency management department will provide guidance regarding the methodologies to be used in collecting damage assessment and impact statement information and shall provide the forms and format by which this information shall be recorded.

7.6(3) *Joint preliminary damage assessment.* Once the governor has determined that a request for a presidential disaster declaration is appropriate, joint preliminary damage assessment teams, consisting of local, state, and federal inspectors, will assess the uninsured damages and costs incurred or to be incurred in responding to and recovering from the disaster. All affected city, municipality, or county governments shall be required to provide assistance to the joint preliminary damage assessment teams for conducting damage assessments. The jurisdiction may be required to develop maps to show the damaged

areas and to compile lists of names and telephone numbers of individuals, businesses, private nonprofit entities, and governmental agencies sustaining disaster response and recovery costs or damages. This joint preliminary damage assessment may be required before the request for presidential declaration is formally transmitted to the Federal Emergency Management Agency.

7.6(4) *Public assistance and hazard mitigation briefing.* In the event that a presidential disaster declaration is received, affected jurisdictions and eligible private nonprofit entities should be prepared to attend a public assistance and hazard mitigation briefing to acquire the information and documents necessary to make their formal applications for public and hazard mitigation assistance. Failure to comply with the deadlines for making application for public and mitigation assistance as established in 44 CFR Part 206 and the Stafford Act (PL 923-288) may jeopardize or eliminate the jurisdiction's or private nonprofit entity's ability to receive assistance.

7.6(5) *Forfeiture of assistance funding.* Failure to provide timely and accurate damage assessment and impact statement information may jeopardize or eliminate an applicant's ability to receive federal and state disaster assistance funds that may otherwise be available.

State participation in funding of disaster financial assistance in a presidentially declared disaster shall be contingent upon the commission's having on file a state-approved, comprehensive emergency plan which meets the standards as provided in paragraph 7.3(4) "d."

[ARC 0129C, IAB 5/30/12, effective 7/4/12; ARC 2326C, IAB 12/23/15, effective 1/27/16]

605—7.7(29C) Emergency management performance grant (EMPG) program. Emergency management is a joint responsibility of the federal government, the states, and their political subdivisions. "Emergency management" means all those activities and measures designed or undertaken to mitigate against, prepare for, respond to, or recover from the effects of a human-caused, technological, or natural hazard. The purpose of the emergency management performance grant program is to provide the necessary assistance to commissions to ensure that a comprehensive emergency system exists for all hazards.

7.7(1) *Eligibility.* Commissions may be eligible for funding under the state and emergency management performance grant program by meeting the requirements, conditions, duties and responsibilities for commissions and local emergency management coordinators established in rules 605—7.3(29C) and 605—7.4(29C). In addition, the commission shall ensure that the coordinator works an average of 20 hours per week or more toward the emergency management effort. Commissions formed under subrule 7.5(5) shall ensure that the coordinator works an average of 40 hours per week toward the emergency management effort.

7.7(2) *Application for funding.* Commissions may apply for funding under the emergency management performance grant program by entering into an agreement with the department and by completing the necessary application and forms, as published and distributed yearly to each commission by the department.

7.7(3) *Allocation and distribution of funds.*

a. The department shall allocate funds to eligible commissions within 45 days of receipt of notice from the federal Department of Homeland Security, Preparedness Directorate, Office of Grants and Training, that such funds are available. The homeland security and emergency management department shall use a formula for the allocation of funds based upon the number of eligible applicants, the part-time or full-time status of the coordinator, 50 percent equal-share base, and 50 percent population base. The total allocation of funds for an applicant may not exceed the lesser of \$39,000 or the amount requested by the applicant.

b. The formula shall be applied in the following manner: The pass-through amount is divided equally between an equal-share base and a population base.

(1) The amount of total equal-share base dollars is divided by the total number of EMPG counties to establish a per-county average. For counties with part-time coordinators, the per-county average is reduced by 50 percent to determine the part-time county allocation. The total baseline dollar amount, minus the cumulative total dollars already allocated to part-time counties, is then divided by the total number of counties with full-time coordinators to determine the full-time county allocation.

(2) The population base amount for each county is determined by adding the populations of all counties together; then each county's population is divided by that total population to determine a percentage. The total population base dollars are then multiplied by a county's percentage to determine that county's share of the population dollars.

c. Funds will be reimbursed to commissions on a federal fiscal year, quarterly basis; and such reimbursement will be based on eligible claims made against the commission's allocation. In no case will the allocation or reimbursement of funds be greater than one-half of the total cost of eligible emergency management related expenses.

7.7(4) Compliance. The director may withhold or recover emergency management performance grant funds from any commission for its failure or its coordinator's failure to meet any of the following conditions:

- a. Appoint a qualified coordinator.
- b. Comply with continuing education requirements.
- c. Adopt a comprehensive emergency plan that meets current standards.
- d. Determine the mission of its agency.
- e. Show continuing progress in fulfilling the commission's duties and obligations.
- f. Conduct commission business according to the guidelines and rules established in this chapter.
- g. Enter into and file a cooperative agreement with the department by the stipulated filing date.
- h. Abide by state and federal regulations governing the proper disbursement and accountability for federal funds, equal employment opportunity and merit system standards.
- i. Accomplish work specified in one or more program areas, as agreed upon in the cooperative agreement, or applicable state or federal rule or statute.
- j. Provide the required matching financial contribution.
- k. Expend funds for authorized purposes or in accordance with applicable laws, regulations, terms and conditions.
- l. Respond to, or cooperate with, state efforts to determine the extent and nature of compliance with the cooperative agreement.

7.7(5) Serious nonperformance problems. If a commission cannot demonstrate achievement of agreed-upon work products, the department is empowered to withhold reimbursement or to recover funds from the commission. Corrective action procedures are designed to focus the commission's attention on nonperformance problems and to bring about compliance with the cooperative agreement. Corrective action procedures, which could lead to sanction, may be enacted as soon as the director becomes aware of serious nonperformance or noncompliance. This realization may arise from staff visits or other contacts with the local emergency management agency or commission, from indications in the commission's or coordinator's quarterly report that indicate a significant shortfall from planned accomplishments, or from the commission's or coordinator's failure to report. Financial sanctions are to be applied only after corrective action remedies fail to result in accomplishment of agreed-upon work product.

7.7(6) Corrective actions.

a. *Informal corrective action.* As a first and basic step to correcting nonperformance, a designated member of the homeland security and emergency management department staff will visit, call or write the local emergency management coordinator to determine the reason for nonperformance and seek an agreeable resolution.

b. *Formal corrective action.* On those occasions when there is considerable discrepancy between agreed-upon and actual performance and response to informal corrective action is not sufficient or agreeable, the department will take the following steps:

(1) Homeland security and emergency management department staff will review the scope of work, as agreed to in the cooperative agreement, to determine the extent of nonperformance. To focus attention on the total nonperformance issue, all instances of nonperformance will be addressed together in a single correspondence to the commission.

(2) The director will prepare a letter to the commission which will contain, at a minimum, the following information:

1. The reasons why the department believes the commission may be in noncompliance, including the specified provisions in question.
2. A description of the efforts made by the department to resolve the matter and the reasons these efforts were unsuccessful.
3. A declaration of the commission's commitment to accomplishing the work agreed upon and specified in the comprehensive cooperative agreement and its importance to the emergency management capability of the local jurisdiction.
4. A description of the exact actions or alternative actions required of the commission to bring the problem to an agreed resolution.
5. A statement that this letter constitutes the final no-penalty effort to achieve a resolution and that financial sanctions provided for in these rules will be undertaken if a satisfactory response is not received by the division within 30 days.

7.7(7) Financial sanctions. If the corrective actions heretofore described fail to produce a satisfactory resolution to cases of serious nonperformance, the director may invoke the following financial sanction procedures:

a. Send a Notice of Intention to Withhold Payment to the chairperson of the commission. This notice shall also contain notice of a reasonable time and place for a hearing, should the commission request a hearing before the director.

b. Any request by a commission for a hearing must be made in writing, to the department, within 15 days of receipt of the Notice of Intention to Withhold Payment.

c. Any hearing under the Notice of Intention to Withhold Payment shall be held before the director. However, the director may designate an administrative law judge to take evidence and certify to the director the entire record, including findings and recommended actions.

d. The commission shall be given full opportunity to present its position orally and in writing.

e. If, after a hearing, the director finds sufficient evidence that the commission has violated established rules and regulations or the terms and conditions of the cooperative agreement, the director may withhold such contributions and payments as may be considered advisable, until the failure to expend funds in accordance with said rules, regulations, terms and conditions has been corrected or the director is satisfied that there will no longer be any such failure.

f. If upon the expiration of the 15-day period stated for a hearing, a hearing has not been requested, the director may issue the findings and take appropriate action as described in paragraph 7.7(7) "e."

g. If the director finds there is serious nonperformance by the commission or its coordinator and issues an order to withhold payments to the commission as described in this rule, the commission shall not receive funds under the emergency management performance grant program for the remainder of the federal fiscal year in which the order is issued and one additional year or until such time that all issues of nonperformance have been agreeably addressed by the department and the commission.

h. Any emergency management performance grant program funds withheld or recovered by the division as a result of this process shall be reallocated at the end of the federal fiscal year to the remaining participating commissions.

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◊ Two or more ARCs

PROFESSIONAL LICENSURE DIVISION[645]

Created within the Department of Public Health[641] by 1986 Iowa Acts, chapter 1245.
Prior to 7/29/87, for Chs. 20 to 22 see Health Department[470] Chs. 152 to 154.

CHAPTERS 1 to 3

Reserved

CHAPTER 4

BOARD ADMINISTRATIVE PROCESSES

- 4.1(17A) Definitions
- 4.2(17A) Purpose of board
- 4.3(17A,147,272C) Organization of board and proceedings
- 4.4(17A) Official communications
- 4.5(17A) Office hours
- 4.6(21) Public meetings
- 4.7(147) Licensure by reciprocal agreement
- 4.8(147) Duplicate certificate or wallet card
- 4.9(147) Reissued certificate or wallet card
- 4.10(17A,147,272C) License denial
- 4.11(272C) Audit of continuing education
- 4.12(272C,83GA,SF2325) Automatic exemption
- 4.13(272C) Grounds for disciplinary action
- 4.14(272C) Continuing education exemption for disability or illness
- 4.15(147,272C) Order for physical, mental, or clinical competency examination or alcohol or drug screening
- 4.16(252J,272D) Noncompliance rules regarding child support and nonpayment of state debt

CHAPTER 5

FEES

- 5.1(147,152D) Athletic training license fees
- 5.2(147,158) Barbering license fees
- 5.3(147,154D) Behavioral science license fees
- 5.4(151) Chiropractic license fees
- 5.5(147,157) Cosmetology arts and sciences license fees
- 5.6(147,152A) Dietetics license fees
- 5.7(147,154A) Hearing aid specialists license fees
- 5.8(147) Massage therapy license fees
- 5.9(147,156) Mortuary science license fees
- 5.10(147,155) Nursing home administrators license fees
- 5.11(147,148B) Occupational therapy license fees
- 5.12(147,154) Optometry license fees
- 5.13(147,148A) Physical therapy license fees
- 5.14(148C) Physician assistants license fees
- 5.15(147,148F,149) Podiatry license fees
- 5.16(147,154B) Psychology license fees
- 5.17(147,152B) Respiratory care license fees
- 5.18(147,154E) Sign language interpreters and transliterators license fees
- 5.19(147,154C) Social work license fees
- 5.20(147) Speech pathology and audiology license fees

CHAPTER 6
PETITIONS FOR RULE MAKING

- 6.1(17A) Petition for rule making
6.2(17A) Inquiries

CHAPTER 7
AGENCY PROCEDURE FOR RULE MAKING

- 7.1(17A) Adoption by reference

CHAPTER 8
DECLARATORY ORDERS
(Uniform Rules)

- 8.1(17A) Petition for declaratory order
8.2(17A) Notice of petition
8.3(17A) Intervention
8.5(17A) Inquiries

CHAPTER 9
COMPLAINTS AND INVESTIGATIONS

- 9.1(272C) Complaints
9.2(272C) Report of malpractice claims or actions or disciplinary actions
9.3(272C) Report of acts or omissions
9.4(272C) Investigation of complaints or reports
9.5(17A,272C) Issuance of investigatory subpoenas
9.6(272C) Peer review committees
9.7(17A) Appearance

CHAPTER 10
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

- 10.1(17A,22) Definitions
10.3(17A,22) Requests for access to records
10.5(17A,22) Request for treatment of a record as a confidential record and its withholding from examination
10.6(17A,22) Procedures by which additions, dissents, or objections may be entered into certain records
10.9(17A,22) Disclosures without the consent of the subject
10.10(17A,22) Routine use
10.11(17A,22) Consensual disclosure of confidential records
10.12(17A,22) Release to subject
10.13(17A,22) Availability of records
10.14(17A,22) Personally identifiable information
10.15(22) Other groups of records routinely available for public inspection
10.16(17A,22) Applicability

CHAPTER 11
CONTESTED CASES

- 11.1(17A) Scope and applicability
11.2(17A) Definitions
11.3(17A) Time requirements
11.4(17A) Probable cause
11.5(17A) Legal review
11.6(17A) Statement of charges and notice of hearing
11.7(17A,272C) Legal representation

11.8(17A,272C)	Presiding officer in a disciplinary contested case
11.9(17A)	Presiding officer in a nondisciplinary contested case
11.10(17A)	Disqualification
11.11(17A)	Consolidation—severance
11.12(17A)	Answer
11.13(17A)	Service and filing
11.14(17A)	Discovery
11.15(17A,272C)	Issuance of subpoenas in a contested case
11.16(17A)	Motions
11.17(17A)	Prehearing conferences
11.18(17A)	Continuances
11.19(17A,272C)	Hearing procedures
11.20(17A)	Evidence
11.21(17A)	Default
11.22(17A)	Ex parte communication
11.23(17A)	Recording costs
11.24(17A)	Interlocutory appeals
11.25(17A)	Applications for rehearing
11.26(17A)	Stays of agency actions
11.27(17A)	No factual dispute contested cases
11.28(17A)	Emergency adjudicative proceedings
11.29(17A)	Appeal
11.30(272C)	Publication of decisions
11.31(272C)	Reinstatement
11.32(17A,272C)	License denial

CHAPTER 12
INFORMAL SETTLEMENT

12.1(17A,272C)	Informal settlement
----------------	---------------------

CHAPTER 13
DISCIPLINE

13.1(272C)	Method of discipline
13.2(272C)	Discretion of board
13.3(272C)	Conduct of persons attending meetings

CHAPTERS 14 and 15
Reserved

CHAPTER 16
IMPAIRED PRACTITIONER REVIEW COMMITTEE

16.1(272C)	Definitions
16.2(272C)	Purpose
16.3(272C)	Composition of the committee
16.4(272C)	Organization of the committee
16.5(272)	Eligibility
16.6(272C)	Meetings
16.7(272C)	Terms of participation
16.8(272C)	Noncompliance
16.9(272C)	Practice restrictions
16.10(272C)	Limitations
16.11(272C)	Confidentiality

CHAPTER 17
MATERIALS FOR BOARD REVIEW

17.1(147) Materials for board review

CHAPTER 18
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

18.1(17A,147,272C) Definitions
18.2(17A,147,272C) Scope of chapter
18.3(17A,147,272C) Applicability of chapter
18.4(17A,147,272C) Criteria for waiver or variance
18.5(17A,147,272C) Filing of petition
18.6(17A,147,272C) Content of petition
18.7(17A,147,272C) Additional information
18.8(17A,147,272C) Notice
18.9(17A,147,272C) Hearing procedures
18.10(17A,147,272C) Ruling
18.11(17A,147,272C) Public availability
18.12(17A,147,272C) Summary reports
18.13(17A,147,272C) Cancellation of a waiver
18.14(17A,147,272C) Violations
18.15(17A,147,272C) Defense
18.16(17A,147,272C) Judicial review

CHAPTER 19
Reserved

CHAPTER 20
MILITARY SERVICE, VETERAN RECIPROCITY, AND SPOUSES OF ACTIVE DUTY SERVICE
MEMBERS

20.1(272C) Definitions
20.2(272C) Military education, training, and service credit
20.3(272C) Veteran and active duty military spouse reciprocity

BARBERS

CHAPTER 21
LICENSURE

21.1(158) Definitions
21.2(158) Requirements for licensure
21.3(158) Examination requirements for barbers and barber instructors
21.4 Reserved
21.5(158) Licensure by endorsement
21.6 Reserved
21.7(158) Temporary permits to practice barbering
21.8(158) Demonstrator's permit
21.9(158) License renewal
21.10 Reserved
21.11(158) Requirements for a barbershop license
21.12(158) Barbershop license renewal
21.13 to 21.15 Reserved
21.16(17A,147,272C) License reactivation
21.17(17A,147,272C) Reactivation of a barbershop license
21.18(17A,147,272C) License reinstatement

CHAPTER 22

INFECTION CONTROL FOR BARBERSHOPS AND BARBER SCHOOLS

22.1(158)	Definitions
22.2(158)	Infection control rules and inspection report
22.3(147)	Display requirements for barbershops
22.4(158)	Responsibilities of barbershop owner and supervisor
22.5(158)	Building standards
22.6(158)	Barbershops in residential buildings
22.7(158)	Barbershops adjacent to other businesses
22.8(142D,158)	Smoking
22.9(158)	Personal cleanliness
22.10(158)	Universal protocols
22.11(158)	Minimum equipment and supplies
22.12(158)	Disinfection and sterilizing instruments and equipment
22.13	Reserved
22.14(158)	Porous instruments and supplies that cannot be disinfected
22.15(158)	Semisolids, dusters, and styptics
22.16(158)	Blood exposure procedures
22.17(158)	Prohibited hazardous substances and use of products
22.18(158)	Proper protection of neck
22.19(158)	Proper laundering and storage
22.20(158)	Pets
22.21(158)	Records

CHAPTER 23

BARBER SCHOOLS

23.1(158)	Definitions
23.2(158)	Licensing for barber schools
23.3(158)	School license renewal
23.4(272C)	Inactive school license
23.5	Reserved
23.6(158)	Physical requirements for barber schools
23.7(158)	Minimum equipment requirements
23.8(158)	Course of study requirements
23.9(158)	Instructors
23.10(158)	Students
23.11(158)	Attendance requirements
23.12(158)	Graduate of a barber school
23.13(147)	Records requirements
23.14(158)	Public notice
23.15(158)	Apprenticeship
23.16(158)	Mentoring program

CHAPTER 24

CONTINUING EDUCATION FOR BARBERS

24.1(158)	Definitions
24.2(158)	Continuing education requirements
24.3(158,272C)	Standards

CHAPTER 25
DISCIPLINE FOR BARBERS, BARBER INSTRUCTORS,
BARBERSHOPS AND BARBER SCHOOLS

- 25.1(158) Definitions
25.2(272C) Grounds for discipline
25.3(158,272C) Method of discipline
25.4(272C) Discretion of board

CHAPTERS 26 to 30
Reserved

BEHAVIORAL SCIENTISTS

CHAPTER 31
LICENSURE OF MARITAL AND FAMILY THERAPISTS,
MENTAL HEALTH COUNSELORS, BEHAVIOR ANALYSTS, AND ASSISTANT BEHAVIOR
ANALYSTS

- 31.1(154D) Definitions
31.2(154D) Requirements for permanent and temporary licensure as a mental health counselor or marriage and family therapist
31.3(154D) Examination requirements for mental health counselors and marital and family therapists
31.4(154D) Educational qualifications for marital and family therapists
31.5(154D) Clinical experience requirements for marital and family therapists
31.6(154D) Educational qualifications for mental health counselors
31.7(154D) Clinical experience requirements for mental health counselors
31.8(154D) Licensure by endorsement for mental health counselors and marital and family therapists
31.9(147) Licensure of behavior analysts and assistant behavior analysts
31.10(147) License renewal for mental health counselors and marriage and family therapists
31.11(272C) Initial licensing, reactivation, and license renewal for behavior analysts and assistant behavior analysts
31.12(147) Licensee record keeping
31.13 to 31.15 Reserved
31.16(17A,147,272C) License reactivation for mental health counselors and marital and family therapists
31.17(17A,147,272C) License reinstatement
31.18(154D) Marital and family therapy and mental health counselor services subject to regulation
31.19(154D) Temporary licensees

CHAPTER 32
CONTINUING EDUCATION FOR MARITAL AND
FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS

- 32.1(272C) Definitions
32.2(272C) Continuing education requirements
32.3(154D,272C) Standards

CHAPTER 33
DISCIPLINE FOR MARITAL AND FAMILY THERAPISTS,
MENTAL HEALTH COUNSELORS, BEHAVIOR ANALYSTS, AND ASSISTANT BEHAVIOR
ANALYSTS

- 33.1(154D) Definitions
33.2(154D,272C) Grounds for discipline

- 33.3(147,272C) Method of discipline
33.4(272C) Discretion of board

CHAPTERS 34 to 40

Reserved

CHIROPRACTIC

CHAPTER 41

LICENSURE OF CHIROPRACTIC PHYSICIANS

- 41.1(151) Definitions
41.2(151) Requirements for licensure
41.3(151) Examination requirements
41.4(151) Educational qualifications
41.5(151) Temporary certificate
41.6(151) Licensure by endorsement
41.7 Reserved
41.8(151) License renewal
41.9 to 41.13 Reserved
41.14(17A,147,272C) License reactivation
41.15(17A,147,272C) License reinstatement

CHAPTER 42

COLLEGES FOR CHIROPRACTIC PHYSICIANS

- 42.1(151) Definitions
42.2(151) Board-approved chiropractic colleges
42.3(151) Practice by chiropractic interns and chiropractic residents
42.4(151) Approved chiropractic preceptorship program
42.5(151) Approved chiropractic physician preceptors
42.6(151) Termination of preceptorship

CHAPTER 43

PRACTICE OF CHIROPRACTIC PHYSICIANS

- 43.1(151) Definitions
43.2(147,272C) Principles of chiropractic ethics
43.3(151,514F) Utilization and cost control review
43.4(151) Chiropractic insurance consultant
43.5(151) Acupuncture
43.6 Reserved
43.7(151) Adjunctive procedures
43.8(151) Physical examination
43.9(151) Gonad shielding
43.10(151) Record keeping
43.11(151) Billing procedures
43.12(151) Chiropractic assistants

CHAPTER 44

CONTINUING EDUCATION FOR CHIROPRACTIC PHYSICIANS

- 44.1(151) Definitions
44.2(272C) Continuing education requirements
44.3(151,272C) Standards

CHAPTER 45
DISCIPLINE FOR CHIROPRACTIC PHYSICIANS

45.1(151)	Definitions
45.2(151,272C)	Grounds for discipline
45.3(147,272C)	Method of discipline
45.4(272C)	Discretion of board

CHAPTERS 46 to 59
Reserved

COSMETOLOGISTS

CHAPTER 60
LICENSURE OF COSMETOLOGISTS, ELECTROLOGISTS, ESTHETICIANS,
MANICURISTS, NAIL TECHNOLOGISTS, AND INSTRUCTORS
OF COSMETOLOGY ARTS AND SCIENCES

60.1(157)	Definitions
60.2(157)	Requirements for licensure
60.3(157)	Criteria for licensure in specific practice disciplines
60.4(157)	Practice-specific training requirements
60.5(157)	Licensure restrictions relating to practice
60.6(157)	Consent form requirements
60.7(157)	Licensure by endorsement
60.8(157)	License renewal
60.9 to 60.16	Reserved
60.17(17A,147,272C)	License reactivation
60.18(17A,147,272C)	License reinstatement

CHAPTER 61
LICENSURE OF SALONS AND SCHOOLS
OF COSMETOLOGY ARTS AND SCIENCES

61.1(157)	Definitions
61.2(157)	Salon licensing
61.3(157)	Salon license renewal
61.4(272C)	Inactive salon license
61.5(157)	Display requirements for salons
61.6(147)	Duplicate certificate or wallet card for salons
61.7(157)	Licensure for schools of cosmetology arts and sciences
61.8(157)	School license renewal
61.9(272C)	Inactive school license
61.10(157)	Display requirements for schools
61.11	Reserved
61.12(157)	Physical requirements for schools of cosmetology arts and sciences
61.13(157)	Minimum equipment requirements
61.14(157)	Course of study requirements
61.15(157)	Instructors
61.16(157)	Student instructors
61.17(157)	Students
61.18(157)	Attendance requirements
61.19(157)	Accelerated learning
61.20(157)	Mentoring program
61.21(157)	Graduate of a school of cosmetology arts and sciences
61.22(157)	Records requirements

- 61.23(157) Classrooms used for other educational purposes
 61.24(157) Public notice

CHAPTER 62

Reserved

CHAPTER 63

INFECTION CONTROL FOR SALONS AND SCHOOLS OF COSMETOLOGY ARTS AND SCIENCES

- 63.1(157) Definitions
 63.2(157) Infection control rules and inspection report
 63.3(157) Responsibilities of salon owners
 63.4(157) Responsibilities of licensees
 63.5(157) Joint responsibility
 63.6(157) Building standards
 63.7(157) Salons in residential buildings
 63.8(157) Salons adjacent to other businesses
 63.9(157) Smoking
 63.10(157) Personal cleanliness
 63.11(157) Universal precautions
 63.12(157) Blood exposure procedures
 63.13(157) Disinfecting and sterilizing instruments and equipment
 63.14(157) Porous instruments and supplies that cannot be disinfected
 63.15 Reserved
 63.16(157) Infection control methods for creams, cosmetics and applicators
 63.17 Reserved
 63.18(157) Prohibited hazardous substances and use of products and equipment
 63.19(157) Proper protection of neck
 63.20(157) Proper laundering and storage
 63.21(157) Pets
 63.22(157) General maintenance
 63.23(157) Records
 63.24(157) Salons and schools providing electrology or esthetics
 63.25(157) Cleaning and disinfecting circulating and noncirculating tubs, bowls, and spas
 63.26(157) Paraffin wax

CHAPTER 64

CONTINUING EDUCATION FOR COSMETOLOGY ARTS AND SCIENCES

- 64.1(157) Definitions
 64.2(157) Continuing education requirements
 64.3(157,272C) Standards

CHAPTER 65

DISCIPLINE FOR COSMETOLOGY ARTS AND SCIENCES LICENSEES, INSTRUCTORS, SALONS, AND SCHOOLS

- 65.1(157,272C) Definitions
 65.2(157,272C) Grounds for discipline
 65.3(157,272C) Method of discipline
 65.4(272C) Discretion of board
 65.5(157) Civil penalties against nonlicensees

CHAPTERS 66 to 80

Reserved

*DIETITIANS*CHAPTER 81
LICENSURE OF DIETITIANS

81.1(152A)	Definitions
81.2(152A)	Nutrition care
81.3	Reserved
81.4(152A)	Requirements for licensure
81.5(152A)	Educational qualifications
81.6(152A)	Supervised experience
81.7(152A)	Licensure by endorsement
81.8	Reserved
81.9(152A)	License renewal
81.10 to 81.14	Reserved
81.15(17A,147,272C)	License reactivation
81.16(17A,147,272C)	License reinstatement

CHAPTER 82
CONTINUING EDUCATION FOR DIETITIANS

82.1(152A)	Definitions
82.2(152A)	Continuing education requirements
82.3(152A,272C)	Standards

CHAPTER 83
DISCIPLINE FOR DIETITIANS

83.1(152A)	Definitions
83.2(152A,272C)	Grounds for discipline
83.3(152A,272C)	Method of discipline
83.4(272C)	Discretion of board

CHAPTERS 84 to 99
Reserved*FUNERAL DIRECTORS*CHAPTER 100
PRACTICE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS,
AND CREMATION ESTABLISHMENTS

100.1(156)	Definitions
100.2(156)	Funeral director duties
100.3(156)	Permanent identification tag
100.4(142,156)	Removal and transfer of human remains
100.5(135,144)	Burial transit permits
100.6(156)	Preparation and embalming activities
100.7(156)	Arranging and directing funeral and memorial ceremonies
100.8(142,156)	Unclaimed human remains for scientific use
100.9(144)	Disinterments
100.10(156)	Cremation of human remains
100.11(156)	Records to be retained by a funeral establishment

CHAPTER 101
LICENSURE OF FUNERAL DIRECTORS, FUNERAL ESTABLISHMENTS, AND
CREMATION ESTABLISHMENTS

- 101.1(156) Definitions
- 101.2(156) Requirements for licensure
- 101.3(147,156) Internship and preceptorship
- 101.4(156) Student practicum
- 101.5(156) Funeral establishment license or cremation establishment license
- 101.6(156) Licensure by endorsement
- 101.7(156) Renewal of funeral director license
- 101.8(272C) Renewal of a funeral establishment license or a cremation establishment license
- 101.9(272C) Inactive funeral establishment license or cremation establishment license
- 101.10(17A,147,272C) Reinstatement of a funeral establishment license or a cremation establishment license
- 101.11(17A,147,272C) License reactivation
- 101.12(17A,147,272C) Reinstatement of a funeral director license

CHAPTER 102
CONTINUING EDUCATION FOR FUNERAL DIRECTORS

- 102.1(272C) Definitions
- 102.2(272C) Continuing education requirements
- 102.3(156,272C) Standards
- 102.4 Reserved
- 102.5(83GA,SF2325) Automatic exemption

CHAPTER 103
DISCIPLINARY PROCEEDINGS

- 103.1(156) Definitions
- 103.2(17A,147,156,272C) Disciplinary authority
- 103.3(17A,147,156,272C) Grounds for discipline against funeral directors
- 103.4(17A,147,156,272C) Grounds for discipline against funeral establishments and cremation establishments
- 103.5(17A,147,156,272C) Method of discipline
- 103.6(17A,147,156,272C) Board discretion in imposing disciplinary sanctions
- 103.7 Reserved
- 103.8(17A,147,156,272C) Informal discussion

CHAPTER 104
ENFORCEMENT PROCEEDINGS AGAINST NONLICENSEES

- 104.1(156) Civil penalties against nonlicensees
- 104.2(156) Unlawful practices
- 104.3(156) Investigations
- 104.4(156) Subpoenas
- 104.5(156) Notice of intent to impose civil penalties
- 104.6(156) Requests for hearings
- 104.7(156) Factors to consider
- 104.8(156) Enforcement options

CHAPTERS 105 to 120
Reserved

HEARING AID SPECIALISTS

CHAPTER 121

LICENSURE OF HEARING AID SPECIALISTS

121.1(154A)	Definitions
121.2(154A)	Temporary permits
121.3(154A)	Supervision requirements
121.4(154A)	Requirements for initial licensure
121.5(154A)	Examination requirements
121.6(154A)	Licensure by endorsement
121.7	Reserved
121.8(154A)	Display of license
121.9(154A)	License renewal
121.10 to 121.13	Reserved
121.14(17A,147,272C)	License reactivation
121.15(17A,147,272C)	License reinstatement

CHAPTER 122

CONTINUING EDUCATION FOR HEARING AID SPECIALISTS

122.1(154A)	Definitions
122.2(154A)	Continuing education requirements
122.3(154A,272C)	Standards

CHAPTER 123

PRACTICE OF HEARING AID DISPENSING

123.1(154A)	Definitions
123.2(154A)	Requirements prior to sale of a hearing aid
123.3(154A)	Requirements for sales receipt
123.4(154A)	Requirements for record keeping

CHAPTER 124

DISCIPLINE FOR HEARING AID SPECIALISTS

124.1(154A,272C)	Definitions
124.2(154A,272C)	Grounds for discipline
124.3(154A,272C)	Method of discipline
124.4(272C)	Discretion of board

CHAPTERS 125 to 130

Reserved

MASSAGE THERAPISTS

CHAPTER 131

LICENSURE OF MASSAGE THERAPISTS

131.1(152C)	Definitions
131.2(152C)	Requirements for licensure
131.3(152C)	Educational qualifications
131.4(152C)	Examination requirements
131.5(152C)	Temporary licensure of a licensee from another state
131.6(152C)	Licensure by endorsement
131.7	Reserved
131.8(152C)	License renewal
131.9 to 131.13	Reserved

- 131.14(17A,147,272C) License reactivation
- 131.15(17A,147,272C) License reinstatement

CHAPTER 132

MESSAGE THERAPY EDUCATION CURRICULUM

- 132.1(152C) Definitions
- 132.2(152C) Application for approval of massage therapy education curriculum
- 132.3(152C) Curriculum requirements
- 132.4(152C) Student clinical practicum standards
- 132.5(152C) School certificate or diploma
- 132.6(152C) School records retention
- 132.7(152C) Massage school curriculum compliance
- 132.8(152C) Denial or withdrawal of approval

CHAPTER 133

CONTINUING EDUCATION FOR MESSAGE THERAPISTS

- 133.1(152C) Definitions
- 133.2(152C) Continuing education requirements
- 133.3(152C,272C) Continuing education criteria

CHAPTER 134

DISCIPLINE FOR MESSAGE THERAPISTS

- 134.1(152C) Definitions
- 134.2(152C,272C) Grounds for discipline
- 134.3(147,272C) Method of discipline
- 134.4(272C) Discretion of board
- 134.5(152C) Civil penalties

CHAPTERS 135 to 140

Reserved

NURSING HOME ADMINISTRATORS

CHAPTER 141

LICENSURE OF NURSING HOME ADMINISTRATORS

- 141.1(155) Definitions
- 141.2(155) Requirements for licensure
- 141.3(147,155) Examination requirements
- 141.4(155) Educational qualifications
- 141.5(155) Practicum experience
- 141.6(155) Provisional license
- 141.7(155) Licensure by endorsement
- 141.8(147,155) Licensure by reciprocal agreement
- 141.9(147,155) License renewal
- 141.10 to 141.14 Reserved
- 141.15(17A,147,272C) License reactivation
- 141.16(17A,147,272C) License reinstatement

CHAPTER 142

Reserved

CHAPTER 143

CONTINUING EDUCATION FOR NURSING HOME ADMINISTRATION

- 143.1(272C) Definitions
- 143.2(272C) Continuing education requirements

- 143.3(155,272C) Standards
- 143.4(155,272C) Audit of continuing education report
- 143.5(155,272C) Automatic exemption
- 143.6(272C) Continuing education exemption for disability or illness
- 143.7(155,272C) Grounds for disciplinary action

CHAPTER 144

DISCIPLINE FOR NURSING HOME ADMINISTRATORS

- 144.1(155) Definitions
- 144.2(155,272C) Grounds for discipline
- 144.3(155,272C) Method of discipline
- 144.4(272C) Discretion of board
- 144.5(155) Order for mental, physical, or clinical competency examination or alcohol or drug screening

CHAPTERS 145 to 179

Reserved

OPTOMETRISTS

CHAPTER 180

LICENSURE OF OPTOMETRISTS

- 180.1(154) Definitions
- 180.2(154) Requirements for licensure
- 180.3(154) Licensure by endorsement
- 180.4 Reserved
- 180.5(154) License renewal
- 180.6 to 180.10 Reserved
- 180.11(17A,147,272C) License reactivation
- 180.12(17A,147,272C) License reinstatement

CHAPTER 181

CONTINUING EDUCATION FOR OPTOMETRISTS

- 181.1(154) Definitions
- 181.2(154) Continuing education requirements
- 181.3(154,272C) Standards

CHAPTER 182

PRACTICE OF OPTOMETRISTS

- 182.1(154) Code of ethics
- 182.2(154,272C) Record keeping
- 182.3(154) Furnishing prescriptions
- 182.4(155A) Prescription drug orders

CHAPTER 183

DISCIPLINE FOR OPTOMETRISTS

- 183.1(154) Definitions
- 183.2(154,272C) Grounds for discipline
- 183.3(147,272C) Method of discipline
- 183.4(272C) Discretion of board

CHAPTERS 184 to 199

Reserved

PHYSICAL AND OCCUPATIONAL THERAPISTS

CHAPTER 200

LICENSURE OF PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

200.1(147)	Definitions
200.2(147)	Requirements for licensure
200.3(147)	Physical therapy compact
200.4(147)	Examination requirements for physical therapists and physical therapist assistants
200.5(147)	Educational qualifications
200.6(147)	Delegation by a supervising physical therapist
200.7(147)	Licensure by endorsement
200.8	Reserved
200.9(147)	License renewal
200.10 to 200.14	Reserved
200.15(17A,147,272C)	License reactivation
200.16(17A,147,272C)	License reinstatement

CHAPTER 201

PRACTICE OF PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

201.1(148A,272C)	Code of ethics for physical therapists and physical therapist assistants
201.2(147)	Record keeping
201.3(147)	Telehealth visits

CHAPTER 202

DISCIPLINE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS

202.1(148A)	Definitions
202.2(272C)	Grounds for discipline
202.3(147,272C)	Method of discipline
202.4(272C)	Discretion of board

CHAPTER 203

CONTINUING EDUCATION FOR PHYSICAL THERAPISTS
AND PHYSICAL THERAPIST ASSISTANTS

203.1(272C)	Definitions
203.2(148A)	Continuing education requirements
203.3(148A,272C)	Standards

CHAPTERS 204 and 205

Reserved

CHAPTER 206

LICENSURE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

206.1(147)	Definitions
206.2(147)	Requirements for licensure
206.3(147)	Limited permit to practice pending licensure
206.4	Reserved
206.5(147)	Practice of occupational therapy limited permit holders
206.6(147)	Examination requirements
206.7(147)	Educational qualifications
206.8(148B)	Supervision requirements
206.9(147)	Licensure by endorsement
206.10(147)	License renewal

- 206.11(17A,147,272C) License reactivation
- 206.12(17A,147,272C) License reinstatement

CHAPTER 207

CONTINUING EDUCATION FOR OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 207.1(148B) Definitions
- 207.2(272C) Continuing education requirements
- 207.3(148B,272C) Standards

CHAPTER 208

PRACTICE OF OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 208.1(148B,272C) Code of ethics for occupational therapists and occupational therapy assistants
- 208.2(147) Record keeping
- 208.3(147) Telehealth visits

CHAPTER 209

DISCIPLINE FOR OCCUPATIONAL THERAPISTS
AND OCCUPATIONAL THERAPY ASSISTANTS

- 209.1(148B) Definitions
- 209.2(272C) Grounds for discipline
- 209.3(147,272C) Method of discipline
- 209.4(272C) Discretion of board

CHAPTERS 210 to 219

Reserved

PODIATRISTS

CHAPTER 220

LICENSURE OF PODIATRISTS

- 220.1(149) Definitions
- 220.2(149) Requirements for licensure
- 220.3(149) Written examinations
- 220.4(149) Educational qualifications
- 220.5(149) Title designations
- 220.6(147,149) Temporary license
- 220.7(149) Licensure by endorsement
- 220.8 Reserved
- 220.9(149) License renewal
- 220.10 to 220.14 Reserved
- 220.15(17A,147,272C) License reactivation
- 220.16(17A,147,272C) License reinstatement

CHAPTER 221

LICENSURE OF ORTHOTISTS, PROSTHETISTS, AND PEDORTHISTS

- 221.1(148F) Definitions
- 221.2(148F) Transition period
- 221.3(148F) Requirements for licensure
- 221.4(148F) Written examinations
- 221.5(148F) Educational qualifications
- 221.6(148F) Licensure by endorsement
- 221.7(148F) License renewal

- 221.8(17A,147,272C) License reactivation
- 221.9(17A,147,272C) License reinstatement

CHAPTER 222

CONTINUING EDUCATION FOR PODIATRISTS

- 222.1(149,272C) Definitions
- 222.2(149,272C) Continuing education requirements
- 222.3(149,272C) Standards

CHAPTER 223

PRACTICE OF PODIATRY

- 223.1(149) Definitions
- 223.2(149) Requirements for administering conscious sedation
- 223.3(139A) Preventing HIV and HBV transmission
- 223.4(149) Unlicensed graduate of a podiatric college
- 223.5(149) Prescribing opioids

CHAPTER 224

DISCIPLINE FOR PODIATRISTS, ORTHOTISTS, PROSTHETISTS, AND PEDORTHISTS

- 224.1(148F,149) Definitions
- 224.2(148F,149,272C) Grounds for discipline
- 224.3(147,272C) Method of discipline
- 224.4(272C) Discretion of board
- 224.5 Reserved
- 224.6(148F,149,272C) Indiscriminately prescribing, administering or dispensing any drug for other than a lawful purpose

CHAPTER 225

CONTINUING EDUCATION FOR ORTHOTISTS, PROSTHETISTS, AND PEDORTHISTS

- 225.1(148F) Definitions
- 225.2(148F,272C) Continuing education requirements
- 225.3(148F,272C) Standards
- 225.4(148F,272C) Audit of continuing education report

CHAPTERS 226 to 239

Reserved

PSYCHOLOGISTS

CHAPTER 240

LICENSURE OF PSYCHOLOGISTS

- 240.1(154B) Definitions
- 240.2(154B) Requirements for licensure
- 240.3(154B) Educational qualifications
- 240.4(154B) Examination requirements
- 240.5(154B) Title designations
- 240.6(154B) Supervised professional experience
- 240.7(154B) Certified health service provider in psychology
- 240.8(154B) Exemption to licensure
- 240.9(154B) Psychologists' supervision of unlicensed persons in a practice setting
- 240.10(147) Licensure by endorsement
- 240.11(147) Licensure by reciprocal agreement
- 240.12(85GA,ch1043) Requirements for provisional licensure
- 240.13(147) License renewal

- 240.14(17A,147,272C) License reactivation
- 240.15(17A,147,272C) License reinstatement

CHAPTER 241

CONTINUING EDUCATION FOR PSYCHOLOGISTS

- 241.1(272C) Definitions
- 241.2(272C) Continuing education requirements
- 241.3(154B,272C) Standards

CHAPTER 242

DISCIPLINE FOR PSYCHOLOGISTS

- 242.1(154B) Definitions
- 242.2(147,272C) Grounds for discipline
- 242.3(147,272C) Method of discipline
- 242.4(272C) Discretion of board

CHAPTER 243

Reserved

CHAPTER 244

PRESCRIBING PSYCHOLOGISTS

- 244.1(148,154B) Definitions—joint rule
- 244.2(154B) Conditional prescription certificate
- 244.3(148,154B) Educational requirements for conditional prescription certificate—joint rule
- 244.4(148,154B) Supervised practice as a conditional prescribing psychologist—joint rule
- 244.5(154B) Prescription certificate
- 244.6(148,154B) Prescribing—joint rule
- 244.7(148,154B) Consultation with primary care physicians—joint rule
- 244.8(148,154B) Collaborative practice—joint rule
- 244.9(154B) Grounds for discipline
- 244.10(154B) List of psychologists
- 244.11(148,154B) Complaints—joint rule
- 244.12(148,154B) Joint waiver or variance—joint rule
- 244.13(148,154B) Amendment—joint rule

CHAPTERS 245 to 260

Reserved

RESPIRATORY CARE PRACTITIONERS

CHAPTER 261

LICENSURE OF RESPIRATORY CARE PRACTITIONERS, POLYSOMNOGRAPHIC TECHNOLOGISTS, AND RESPIRATORY CARE AND POLYSOMNOGRAPHY PRACTITIONERS

- 261.1(148G,152B) Definitions
- 261.2(148G,152B) General requirements for licensure
- 261.3(152B) Additional requirements for respiratory care practitioner licensure
- 261.4(148G,152B) Additional requirements for polysomnographic technologist licensure
- 261.5(148G,152B) Requirements for dual licensure
- 261.6 and 261.7 Reserved
- 261.8(148G,152B) License renewal
- 261.9 to 261.13 Reserved
- 261.14(17A,147,272C) License reactivation
- 261.15(17A,147,272C) License reinstatement

CHAPTER 262
CONTINUING EDUCATION FOR RESPIRATORY CARE PRACTITIONERS AND
POLYSOMNOGRAPHIC TECHNOLOGISTS

- 262.1(148G,152B,272C) Definitions
- 262.2(148G,152B,272C) Continuing education requirements
- 262.3(148G,152B,272C) Standards
- 262.4 Reserved
- 262.5(148G,152B,272C) Automatic exemption
- 262.6(148G,152B,272C) Grounds for disciplinary action
- 262.7(148G,152B,272C) Continuing education exemption for disability or illness

CHAPTER 263
DISCIPLINE FOR RESPIRATORY CARE PRACTITIONERS AND
POLYSOMNOGRAPHIC TECHNOLOGISTS

- 263.1(148G,152B) Definitions
- 263.2(148G,152B,272C) Grounds for discipline
- 263.3(147,272C) Method of discipline
- 263.4(272C) Discretion of board

CHAPTER 264
Reserved

CHAPTER 265
PRACTICE OF RESPIRATORY CARE PRACTITIONERS AND
POLYSOMNOGRAPHIC TECHNOLOGISTS

- 265.1(148G,152B,272C) Definitions
- 265.2(148G,152B,272C) Code of ethics
- 265.3(152B,272C) Intravenous administration
- 265.4(152B,272C) Setup and delivery of respiratory care equipment
- 265.5(152B,272C) Respiratory care as a practice
- 265.6(148G,272C) Practice of polysomnography
- 265.7(148G,152B,272C) Students
- 265.8(148G,272C) Location of polysomnography services

CHAPTERS 266 to 279
Reserved

SOCIAL WORKERS

CHAPTER 280
LICENSURE OF SOCIAL WORKERS

- 280.1(154C) Definitions
- 280.2(154C) Social work services subject to regulation
- 280.3(154C) Requirements for licensure
- 280.4(154C) Written examination
- 280.5(154C) Educational qualifications
- 280.6(154C) Period of supervised professional practice for LISW
- 280.7(154C) Licensure by endorsement
- 280.8 Reserved
- 280.9(154C) License renewal
- 280.10 to 280.13 Reserved
- 280.14(17A,147,272C) License reactivation
- 280.15(17A,147,272C) License reinstatement

CHAPTER 281

CONTINUING EDUCATION FOR SOCIAL WORKERS

- 281.1(154C) Definitions
- 281.2(154C) Continuing education requirements
- 281.3(154C,272C) Standards

CHAPTER 282

PRACTICE OF SOCIAL WORKERS

- 282.1(154C) Definitions
- 282.2(154C) Rules of conduct

CHAPTER 283

DISCIPLINE FOR SOCIAL WORKERS

- 283.1(154B) Definitions
- 283.2(272C) Grounds for discipline
- 283.3(147,272C) Method of discipline
- 283.4(272C) Discretion of board

CHAPTERS 284 to 299

Reserved

SPEECH PATHOLOGISTS AND AUDIOLOGISTS

CHAPTER 300

LICENSURE OF SPEECH PATHOLOGISTS AND AUDIOLOGISTS

- 300.1(147) Definitions
- 300.2(147) Speech pathology and audiology services subject to regulation
- 300.3(147) Requirements for licensure
- 300.4(147) Educational qualifications
- 300.5(147) Examination requirements
- 300.6(147) Temporary clinical license
- 300.7(147) Temporary permit
- 300.8(147) Use of assistants
- 300.9(147) Licensure by endorsement
- 300.10 Reserved
- 300.11(147) License renewal
- 300.12(17A,147,272C) Board meetings
- 300.13 to 300.16 Reserved
- 300.17(17A,147,272C) License reactivation
- 300.18(17A,147,272C) License reinstatement

CHAPTERS 301 and 302

Reserved

CHAPTER 303

CONTINUING EDUCATION FOR SPEECH PATHOLOGISTS
AND AUDIOLOGISTS

- 303.1(147) Definitions
- 303.2(147) Continuing education requirements
- 303.3(147,272C) Standards

CHAPTER 304

DISCIPLINE FOR SPEECH PATHOLOGISTS AND AUDIOLOGISTS

- 304.1(147) Definitions
- 304.2(272C) Grounds for discipline

- 304.3(272C) Method of discipline
- 304.4(272C) Discretion of board

CHAPTERS 305 to 325

Reserved

PHYSICIAN ASSISTANTS

CHAPTER 326

LICENSURE OF PHYSICIAN ASSISTANTS

- 326.1(148C) Definitions
- 326.2(148C) Requirements for licensure
- 326.3(148C) Temporary licensure
- 326.4(148C) Licensure by endorsement
- 326.5 Reserved
- 326.6(148C) Examination requirements
- 326.7(148C) Educational qualifications
- 326.8(148C) Supervision requirements
- 326.9(148C) License renewal
- 326.10 to 326.14 Reserved
- 326.15(148C,88GA,ch1020) Use of title
- 326.16(148C) Address change
- 326.17(148C) Student physician assistant
- 326.18(148C) Recognition of an approved program
- 326.19(17A,147,272C) License reactivation
- 326.20(17A,147,272C) License reinstatement

CHAPTER 327

PRACTICE OF PHYSICIAN ASSISTANTS

- 327.1(148C,88GA,ch1020) Duties
- 327.2(148C) Prohibition
- 327.3 Reserved
- 327.4(148C,88GA,ch1020) Remote medical site
- 327.5(147,88GA,ch1020) Identification as a physician assistant
- 327.6(147) Prescription requirements
- 327.7(147) Supplying—requirements for containers, labeling, and records
- 327.8(148C) Sharing information

CHAPTER 328

CONTINUING EDUCATION FOR PHYSICIAN ASSISTANTS

- 328.1(148C) Definitions
- 328.2(148C) Continuing education requirements
- 328.3(148C,272C) Standards

CHAPTER 329

DISCIPLINE FOR PHYSICIAN ASSISTANTS

- 329.1(148C) Definitions
- 329.2(148C,272C) Grounds for discipline
- 329.3(147,272C) Method of discipline
- 329.4(272C) Discretion of board

CHAPTERS 330 to 350

Reserved

*ATHLETIC TRAINERS*CHAPTER 351
LICENSURE OF ATHLETIC TRAINERS

351.1(152D)	Definitions
351.2(152D)	Requirements for licensure
351.3(152D)	Educational qualifications
351.4(152D)	Examination requirements
351.5(152D)	Documentation of physician direction
351.6(152D)	Athletic training plan for direct service
351.7(152D)	Licensure by endorsement
351.8	Reserved
351.9(147)	License renewal
351.10(272C)	Exemptions for inactive practitioners
351.11 and 351.12	Reserved
351.13(272C)	Lapsed licenses
351.14	Reserved
351.15(17A,147,272C)	License reactivation
351.16(17A,147,272C)	License reinstatement

CHAPTER 352

CONTINUING EDUCATION FOR ATHLETIC TRAINERS

352.1(272C)	Definitions
352.2(152D)	Continuing education requirements
352.3(152D,272C)	Standards
352.4(152D,272C)	Audit of continuing education report
352.5 and 352.6	Reserved
352.7(152D,272C)	Continuing education waiver for active practitioners
352.8(152D,272C)	Continuing education exemption for inactive practitioners
352.9	Reserved
352.10(152D,272C)	Reinstatement of inactive practitioners
352.11(272C)	Hearings

CHAPTER 353

DISCIPLINE FOR ATHLETIC TRAINERS

353.1(152D)	Definitions
353.2(152D,272C)	Grounds for discipline
353.3(152D,272C)	Method of discipline
353.4(272C)	Discretion of board

CHAPTERS 354 to 360

Reserved

SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

CHAPTER 361

LICENSURE OF SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

361.1(154E)	Definitions
361.2(154E)	Requirements for licensure
361.3(154E)	Requirements for temporary license
361.4(154E)	Licensure by endorsement
361.5(154E)	License renewal
361.6 to 361.8	Reserved

- 361.9(17A,147,272C) License reactivation
- 361.10(17A,147,272C) License reinstatement

CHAPTER 362

CONTINUING EDUCATION FOR SIGN LANGUAGE INTERPRETERS AND
TRANSLITERATORS

- 362.1(154E,272C) Definitions
- 362.2(154E,272C) Continuing education requirements
- 362.3(154E,272C) Standards

CHAPTER 363

DISCIPLINE FOR SIGN LANGUAGE INTERPRETERS AND TRANSLITERATORS

- 363.1(154E) Definitions
- 363.2(154E,272C) Grounds for discipline
- 363.3(147,272C) Method of discipline
- 363.4(272C) Discretion of board

CHAPTER 4
BOARD ADMINISTRATIVE PROCESSES

645—4.1(17A) Definitions.

“Board” means the professional licensing board of any of the following: athletic training, barbering, behavioral science, chiropractic, cosmetology arts and sciences, dietetics, hearing aid specialists, massage therapy, mortuary science, nursing home administrators, optometry, physical and occupational therapy, physician assistants, podiatry, psychology, respiratory care, sign language interpreters and transliterators, social work, and speech pathology and audiology.

“Board office” means the office of the administrative staff of each professional licensing board.

“Department” means the department of public health.

“Disciplinary proceeding” means any proceeding under the authority of each board pursuant to which licensee discipline may be imposed.

“License” means a license to practice the specific practice governed by one of the boards defined in this chapter.

“Licensee” means a person licensed to practice the specific practice governed by one of the boards defined in this chapter.

“Overpayment” means payment in excess of the required fee. Overpayment of less than \$10 received by the board shall not be refunded.

[ARC 2151C, IAB 9/16/15, effective 10/21/15]

645—4.2(17A) Purpose of board. The purpose of each professional licensing board is to administer and enforce the provisions of Iowa Code chapters 17A, 21, 147, 272C and the practice-specific provisions in Iowa Code chapters 148A, 148B, 148C, 149, 151, 152A, 152B, 152C, 152D, 154, 154A, 154B, 154C, 154D, 154E, 155, 156, 157 and 158 applicable to each board. The mission of each professional licensing board is to protect the public health, safety and welfare by licensing qualified individuals who provide services to consumers and by fair and consistent enforcement of the statutes and rules of each board. Responsibilities of each professional licensing board include, but are not limited to:

4.2(1) Licensing qualified applicants by examination, renewal, endorsement, and reciprocity.

4.2(2) Developing and administering a program of continuing education to ensure the continued competency of individuals licensed by the board.

4.2(3) Imposing discipline on licensees as provided by statute or rule.

645—4.3(17A,147,272C) Organization of board and proceedings.

4.3(1) Each professional licensing board is composed of members appointed by the governor and confirmed by the senate as defined in Iowa Code chapter 147.

4.3(2) Each board shall elect a chairperson and vice chairperson from its membership at the first meeting after April 30 of each year.

4.3(3) Each board shall hold at least one meeting annually.

4.3(4) A majority of the members of each board shall constitute a quorum.

4.3(5) Board meetings shall be governed in accordance with Iowa Code chapter 21.

4.3(6) The professional licensure division shall furnish each board with the necessary facilities and employees to perform the duties required by this chapter and shall be reimbursed for all costs incurred from funds collected from licensure-related fees.

4.3(7) Each professional licensing board has the authority to:

a. Develop and implement continuing education rules to ensure the continued competency of individuals licensed by the board.

b. Establish fees.

c. Establish committees of the board, the members of which shall be appointed by the board chairperson and shall not constitute a quorum of the board. The board chairperson shall appoint committee chairpersons.

d. Hold a closed session if the board votes to do so in a public roll-call vote with an affirmative vote of at least two-thirds if the total board is present or a unanimous vote if fewer are present. The board will recognize the appropriate statute allowing for a closed session when voting to go into closed session. The board shall keep minutes of all discussion, persons present, and action occurring at a closed session and shall tape-record the proceedings. The records shall be stored securely in the board office and shall not be made available for public inspection.

e. Investigate alleged violations of statutes or rules that relate to the practice of licensees upon receipt of a complaint or upon the board's own initiation. The investigation will be based on information or evidence received by the board.

f. Initiate and impose licensee discipline.

g. Monitor licenses that are restricted by a board order.

h. Establish and register peer reviewers.

i. Refer complaints to one or more registered peer reviewers for investigation and review. The peer reviewers will review cases and recommend appropriate action. However, the referral of any matter shall not relieve the board of any of its duties and shall not divest the board of any authority or jurisdiction.

j. Perform any other functions authorized by a provision of law.

[ARC 7586B, IAB 2/25/09, effective 4/1/09; ARC 9768B, IAB 10/5/11, effective 11/9/11]

645—4.4(17A) Official communications.

4.4(1) All official communications, including submissions and requests, may be addressed to the specific professional licensing board, Professional Licensure Division, Fifth Floor, Lucas State Office Building, Des Moines, Iowa 50319-0075.

4.4(2) Notice of change of address. Each licensee shall notify the board of a change of the licensee's current mailing address within 30 days after the change of address occurs.

4.4(3) Notice of change of name. Each licensee shall notify the board in writing of a change of name within 30 days after changing the name.

645—4.5(17A) Office hours. The board office is open for public business from 8 a.m. to 4:30 p.m., Monday through Friday of each week, except holidays.

645—4.6(21) Public meetings. Members of the public may be present during board meetings unless the board votes to hold a closed session. Dates and location of board meetings may be obtained from the board's website (www.idph.iowa.gov/licensure) or directly from the board office.

4.6(1) At every regularly scheduled board meeting, time will be designated for public comment. No more than ten minutes will be allotted for public comment at any one time unless the chairperson indicates otherwise.

4.6(2) Persons who have not asked to address the board during the public comment period may raise their hands to be recognized by the chairperson. Acknowledgment and an opportunity to speak will be at the discretion of the chairperson.

4.6(3) The person presiding at a meeting of the board may exclude a person from an open meeting for behavior that obstructs the meeting.

4.6(4) Cameras and recording devices may be used at open meetings, provided the cameras or recording devices do not obstruct the meeting. If the user of a camera or recording device obstructs the meeting by the use of such device, the person presiding at the meeting may request the user to discontinue use of the camera or device.

645—4.7(147) Licensure by reciprocal agreement. The board may enter into a reciprocal agreement with the District of Columbia or any state, territory, province or foreign country with equal or similar requirements for licensure of the specific professional board. The applicant shall take the examination required by the board.

645—4.8(147) Duplicate certificate or wallet card.

4.8(1) A duplicate wallet card or duplicate certificate shall be required if the current wallet card or certificate is lost, stolen or destroyed. A duplicate wallet card or a duplicate certificate shall be issued only under such circumstances.

4.8(2) A duplicate wallet card or duplicate certificate shall be issued upon receipt of the completed application for duplicate license and payment of the fee as specified in 645—Chapter 5.

4.8(3) If the board receives a completed application for a duplicate license stating that the wallet card or certificate was not received within 60 days after being mailed by the board, no fee shall be required for issuing the duplicate wallet card or duplicate certificate.

645—4.9(147) Reissued certificate or wallet card. The board shall reissue a certificate or current wallet card upon receipt of a written request from the licensee, return of the original document and payment of the fee as specified in 645—Chapter 5.

645—4.10(17A,147,272C) License denial.

4.10(1) When the board denies an applicant licensure, the board shall notify the applicant of the denial in writing by certified mail, return receipt requested, or in the manner of service of an original notice, and shall cite the reasons for which the application was denied.

4.10(2) An applicant who has been denied licensure by the board may appeal the denial and request a hearing on the issues related to the licensure denial by serving a written notice of appeal and request for hearing upon the board by certified mail, return receipt requested, not more than 30 days following the date of mailing of the notification of licensure denial to the applicant. The request for hearing shall specifically describe the facts to be contested and determined at the hearing.

4.10(3) If an applicant who has been denied licensure by the board appeals the licensure denial and requests a hearing pursuant to this rule, the hearing and subsequent procedures shall be held pursuant to the process outlined in Iowa Code chapters 17A and 272C and 645—Chapter 11.

645—4.11(272C) Audit of continuing education. The board may select licensees for audit following license renewal.

4.11(1) Licensees shall provide information to the board for auditing purposes as follows:

a. The licensee shall provide an individual certificate of completion issued to the licensee or evidence of successful completion of the course from the course sponsor. These documents must contain the course date, title, contact hours, sponsor and licensee's name.

b. Information identified in paragraph 4.11(1) "a" must be submitted within 30 days after the date on the letter of notification of the audit. Extension of time may be granted on an individual basis.

4.11(2) For auditing purposes, all licensees must retain the information identified in paragraph 4.11(1) "a" for two years after the biennium has ended.

4.11(3) If the submitted materials are incomplete or unsatisfactory, the licensee may be given the opportunity to submit make-up credit to cover the deficit found through the audit. The deadline for receipt of the documentation for this make-up credit is 90 days from the date of mailing of the notice of deficit to the address of record at the board office. The license shall be re-audited following the next renewal period when make-up credit has been accepted.

4.11(4) Failure to notify the board of a current mailing address will not absolve the licensee from meeting the audit requirement.

[ARC 9171B, IAB 11/3/10, effective 12/8/10]

645—4.12(272C,83GA,SF2325) Automatic exemption.

4.12(1) A licensee shall be exempt from the continuing education requirement during the license biennium when the licensee:

- a.* Served honorably on active duty in the military service; or
- b.* Resided in another state or district having continuing education requirements for the profession and met all requirements of that state or district for practice therein; or
- c.* Was a government employee working in the licensee's specialty and assigned to duty outside the United States; or

d. Was absent from the state but engaged in active practice under circumstances which are approved by the board.

4.12(2) Automatic exemptions for a funeral director are identified in rule 645—102.5(83GA,SF2325).

[ARC 9239B, IAB 11/17/10, effective 12/22/10; ARC 5189C, IAB 9/23/20, effective 10/28/20]

645—4.13(272C) Grounds for disciplinary action. The board may take formal disciplinary action on the following grounds:

1. Failure to cooperate with a board audit.
2. Failure to meet the continuing education requirement for licensure.
3. Falsification of information on the license renewal form.
4. Falsification of continuing education information.

645—4.14(272C) Continuing education exemption for disability or illness. A licensee who has had a physical or mental disability or illness during the license period may apply for an exemption. An exemption provides for an extension of time or exemption from some or all of the continuing education requirements. An applicant shall submit a completed application form approved by the board for an exemption. The application form is available upon request from the board office. The application requires the signature of a licensed health care professional who can attest to the existence of a disability or illness during the license period. If the application is from a licensee who is the primary caregiver for a relative who is ill or disabled and needs care from that primary caregiver, the physician shall verify the licensee's status as the primary caregiver. A licensee who applies for an exemption shall be notified of the decision regarding the application. A licensee who obtains approval shall retain a copy of the exemption to be presented to the board upon request.

4.14(1) The board may grant an extension of time to fulfill the continuing education requirement.

4.14(2) The board may grant an exemption from the continuing education requirement for any period of time not to exceed two calendar years. If the physical or mental disability or illness for which an extension or exemption was granted continues beyond the period initially approved by the board, the licensee must reapply for a continuance of the extension or exemption.

4.14(3) The board may, as a condition of any extension or exemption granted, require the licensee to make up a portion of the continuing education requirement in the manner determined by the board.

645—4.15(147,272C) Order for physical, mental, or clinical competency examination or alcohol or drug screening. A licensee who is licensed by the board is, as a condition of licensure, under a duty to submit to a physical, mental, or clinical competency examination, including alcohol or drug screening, within a time specified by order of the board. Such examination may be ordered upon a showing of probable cause and shall be at the licensee's expense.

4.15(1) Content of order. A board order for a physical, mental, or clinical competency examination shall include the following items:

- a. A description of the type of examination to which the licensee must submit.
- b. The name and address of the examiner or of the evaluation or treatment facility that the board has identified to perform the examination on the licensee.
- c. The time period in which the licensee must schedule the required examination.
- d. The amount of time the licensee has to complete the examination.
- e. A requirement that the licensee sign necessary releases for the board to communicate with the examiner or the evaluation or treatment facility.
- f. A requirement that the licensee cause a report of the examination results to be provided to the board within a specified period of time.
- g. A requirement that the licensee communicate with the board regarding the status of the examination.
- h. A concise statement of the facts relied on by the board to order the evaluation.

4.15(2) Alternatives. Following issuance of the examination order, the licensee may request additional time to schedule or complete the examination or may request that the board approve an alternative examiner or treatment facility. The board in its sole discretion shall determine whether to grant such a request.

4.15(3) Objection to order. A licensee who is the subject of a board order and who objects to the order may file a request for hearing. The request for hearing must be filed within 30 days of the date of the examination order, and the request for hearing shall specifically identify the factual and legal issues upon which the licensee bases the objection. A licensee who fails to timely file a request for hearing to object to an examination order waives any future objection to the examination order in the event formal disciplinary charges are filed for failure to comply with the examination order or on any other grounds. The hearing shall be considered a contested case proceeding and shall be governed by the provisions of 645—Chapter 11. On judicial review of a board decision in a contested case involving an objection to an examination order, the case will be captioned in the name of Jane Doe or John Doe to maintain the licensee's confidentiality.

4.15(4) Closed hearing. Any hearing on an objection to the examination order shall be closed pursuant to Iowa Code section 272C.6(1).

4.15(5) Order and reports confidential. An examination order, and any subsequent examination reports issued in the course of a board investigation, are confidential investigative information pursuant to Iowa Code section 272C.6(4). However, all investigative information regarding the examination order shall be provided to the licensee in the event the licensee files an objection, under subrule 4.15(3), in order to allow the licensee an opportunity to prepare for hearing.

4.15(6) Admissibility. In the event the licensee submits to evaluation and subsequent proceedings are held before the board, all objections shall be waived as to the admissibility of the examining physicians' or health care providers' testimony or examination reports on the grounds that they constitute privileged communication. The medical testimony or examination reports shall not be used against the licensee in any proceeding other than one relating to licensee discipline by the board.

4.15(7) Failure to submit. Failure of a licensee to submit to a board-ordered physical, mental, or clinical competency examination or to submit to alcohol or drug screening constitutes a violation of the rules of the board and is grounds for disciplinary action.

[ARC 7586B, IAB 2/25/09, effective 4/1/09]

645—4.16(252J,272D) Noncompliance rules regarding child support and nonpayment of state debt.

4.16(1) Child support noncompliance. The board hereby adopts by reference 641—Chapter 192, "Child Support Noncompliance," Iowa Administrative Code.

4.16(2) Sanctions for default or delinquency on student loan debt or service obligation prohibited. The board shall not suspend or revoke the license or certification of a person who is in default or is delinquent on repayment or a service obligation under federal or state postsecondary educational loans or public or private services-conditional postsecondary tuition assistance solely on the basis of such default or delinquency.

4.16(3) Nonpayment of state debt. The board hereby adopts by reference 641—Chapter 194, "Nonpayment of State Debt," Iowa Administrative Code.

[ARC 8706B, IAB 4/21/10, effective 5/26/10; ARC 5189C, IAB 9/23/20, effective 10/28/20]

These rules are intended to implement Iowa Code chapters 17A, 21, 147, 252J, 272C and 272D.

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[Filed ARC 5189C (Notice ARC 4963C, IAB 3/11/20), IAB 9/23/20, effective 10/28/20]

NURSING BOARD[655]

[Prior to 8/26/87, see Nursing, Board of[590], renamed Nursing Board[655] under the “umbrella” of Public Health Department by 1986 Iowa Acts, ch 1245]

CHAPTER 1 ADMINISTRATIVE AND REGULATORY AUTHORITY

- 1.1(17A,147,152) Definitions for purposes of nursing board
- 1.2(17A,147,152) Severability
- 1.3(17A,147,152) Description and organization of the board
- 1.4(147,152,272C) Newsletter

CHAPTER 2 NURSING EDUCATION PROGRAMS

- 2.1(152) Definitions
- 2.2(152) Programs eligible for board approval
- 2.3(152) Application for interim approval of a nursing program
- 2.4(152) Approval and reapproval procedures
- 2.5(152) Provisional approval
- 2.6(152) Denial or withdrawal of board approval
- 2.7(152) Closure of an approved program
- 2.8(152) Organization and administration of the program
- 2.9(152) Resources of the controlling institution
- 2.10(152) Curriculum
- 2.11(152) Faculty
- 2.12(152) Program responsibilities
- 2.13(152) Student criminal history checks
- 2.14(152) Clinical facilities
- 2.15(152) Preceptorship
- 2.16(152) Results of graduates who take the licensure examination for the first time
- 2.17(152) Reports to the board

CHAPTER 3 LICENSURE TO PRACTICE—REGISTERED NURSE/LICENSED PRACTICAL NURSE

- 3.1(17A,147,152,272C) Definitions
- 3.2(17A,147,152,272C) Mandatory licensure
- 3.3(17A,147,152,272C) Licensure qualifications for registered nurse and licensed practical nurse
- 3.4(17A,147,152,272C) Licensure by examination
- 3.5(17A,147,152,272C) Licensure by endorsement
- 3.6(17A,147,152,272C) Applicants educated in a foreign country or in a U.S. territory that is not a member of NCSBN
- 3.7(17A,147,152,272C) License cycle
- 3.8(17A,147,152,272C) Verification
- 3.9(17A,272C) License denial
- 3.10(152) Nurse refresher course

CHAPTER 4 DISCIPLINE

- 4.1(17A,147,152,272C) Board authority
- 4.2(17A,147,152,272C) Complaints and investigations
- 4.3(17A,147,152,272C) Issuance of investigatory subpoenas
- 4.4(17A,147,152,272C) Board action
- 4.5(17A,147,152,272C) Peer review committee
- 4.6(17A,147,152,272C) Grounds for discipline

- 4.7(17A,147,152,272C) Sanctions
- 4.8(17A,147,152,272C) Voluntary surrender
- 4.9(17A,147,152,272C) Prohibited grounds for discipline

CHAPTER 5
CONTINUING EDUCATION

- 5.1(272C) Definitions
- 5.2(272C) Continuing education—licensees
- 5.3(272C) Continuing education—providers

CHAPTER 6
NURSING PRACTICE FOR
REGISTERED NURSES/LICENSED PRACTICAL NURSES

- 6.1(152) Definitions
- 6.2(152) Minimum standards of nursing practice for registered nurses
- 6.3(152) Minimum standards of practice for licensed practical nurses
- 6.4(152) Additional acts which may be performed by registered nurses
- 6.5(152) Additional acts which may be performed by licensed practical nurses
- 6.6(152) Specific nursing practice for licensed practical nurses
- 6.7(152) Specific nursing practice for registered nurses

CHAPTER 7
ADVANCED REGISTERED NURSE PRACTITIONERS

- 7.1(17A,124,147,152) Definitions
- 7.2(152) Requirements for licensure as an ARNP
- 7.3(17A,147,152) Application process
- 7.4(17A,147,152) Advanced nursing practice
- 7.5(17A,147,152) Standards of practice for treating patients
- 7.6(17A,124,147,152,272C) Standards of practice for controlled substances
- 7.7(124) Use of the prescription monitoring program
- 7.8(152) Prescribing epinephrine auto-injectors in the name of a facility

CHAPTER 8
PETITIONS FOR RULE MAKING
(Uniform Rules)

- 8.1(17A) Petition for rule making
- 8.3(17A) Inquiries

CHAPTER 9
DECLARATORY ORDERS
(Uniform Rules)

- 9.1(17A) Petition for declaratory order
- 9.2(17A) Notice of petition
- 9.3(17A) Intervention
- 9.4(17A) Briefs
- 9.5(17A) Inquiries
- 9.6(17A) Service and filing of petitions and other papers
- 9.7(17A) Consideration
- 9.8(17A) Action on petition
- 9.9(17A) Refusal to issue order
- 9.12(17A) Effect of a declaratory order

CHAPTER 10
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

- 10.3(17A) Public rule-making docket
- 10.4(17A) Notice of proposed rule making
- 10.5(17A) Public participation
- 10.6(17A) Regulatory analysis
- 10.10(17A) Exemptions from public rule-making procedures
- 10.11(17A) Concise statement of reasons
- 10.12(17A) Contents, style, and form of rule
- 10.13(17A) Agency rule-making record

CHAPTER 11
EXAMINATION OF PUBLIC RECORDS

- 11.1(17A,22,147,152,272C) Definitions
- 11.2(17A,22,147,152,272C) Public information and inspection of records
- 11.3(17A,22,147,152,272C) Personally identifiable information
- 11.4(17A,22,147,152,272C) Notice to suppliers of information
- 11.5(17A,22,147,152,272C) Rosters

CHAPTER 12
REGISTERED NURSE CERTIFYING ORGANIZATIONS/
UTILIZATION AND COST CONTROL REVIEW

- 12.1(509,514,514B,514F) Purpose
- 12.2(509,514,514B,514F) Definition
- 12.3(509,514,514B) National certifying organizations
- 12.4(514F) Utilization and cost control review (U.C.C.R.) committee
- 12.5(514F) Selection and composition of the U.C.C.R. committee
- 12.6(514F) Scope of review
- 12.7(514F) Procedures for utilization and cost control review

CHAPTER 13
DISCIPLINARY HEARING COSTS

- 13.1(152,272C) Disciplinary hearings—fees and costs

CHAPTER 14
FAIR INFORMATION PRACTICES
(Uniform Rules)

- 14.1(17A,22) Definitions
- 14.3(17A,22) Requests for access to records
- 14.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
- 14.7(17A,22) Consent to disclosure by the subject of a confidential record
- 14.8(17A,22) Notice to suppliers of information

CHAPTER 15
WAIVER AND VARIANCE RULES

- 15.1(147,ExecOrd8,78GA,ch1176) Definition
- 15.2(147,ExecOrd8,78GA,ch1176) Scope of chapter
- 15.3(147,ExecOrd8,78GA,ch1176) Applicability of chapter
- 15.4(147,ExecOrd8,78GA,ch1176) Criteria for waiver or variance
- 15.5(147,ExecOrd8,78GA,ch1176) Filing of petition
- 15.6(147,ExecOrd8,78GA,ch1176) Content of petition
- 15.7(147,ExecOrd8,78GA,ch1176) Additional information

- 15.8(147,ExecOrd8,78GA,ch1176) Notice
- 15.9(147,ExecOrd8,78GA,ch1176) Hearing procedures
- 15.10(147,ExecOrd8,78GA,ch1176) Ruling
- 15.11(147,ExecOrd8,78GA,ch1176) Public availability
- 15.12(147,ExecOrd8,78GA,ch1176) Summary reports
- 15.13(147,ExecOrd8,78GA,ch1176) Cancellation of a waiver
- 15.14(147,ExecOrd8,78GA,ch1176) Violations
- 15.15(147,ExecOrd8,78GA,ch1176) Defense
- 15.16(147,ExecOrd8,78GA,ch1176) Judicial review

CHAPTER 16

Reserved

CHAPTER 17

NONPAYMENT OF CHILD SUPPORT OR STATE DEBT

DIVISION I

NONPAYMENT OF CHILD SUPPORT

- 17.1(252J) Definitions
- 17.2(252J) Denial of issuance or renewal of a license—nonpayment of child support
- 17.3(252J) Suspension or revocation of a license—nonpayment of child support

DIVISION II

NONPAYMENT OF STATE DEBT

- 17.4(272D) Definitions
- 17.5(272D) Denial of issuance or renewal of a license—nonpayment of state debt
- 17.6(272D) Suspension or revocation of a license—nonpayment of state debt

CHAPTER 18

MILITARY SERVICE AND VETERAN RECIPROCITY

- 18.1(272C) Definitions
- 18.2(272C) Military education, training, and service credit
- 18.3(272C) Veteran and active duty military spouse reciprocity

CHAPTER 19

IOWA NURSE ASSISTANCE PROGRAM

- 19.1(272C) Iowa nurse assistance program committee
- 19.2(272C) Definitions
- 19.3(272C) Organization of the committee
- 19.4(272C) Eligibility
- 19.5(272C) Terms of participation
- 19.6(272C) Referral to the board
- 19.7(272C) Confidentiality
- 19.8(28E) Authority for 28E agreements

CHAPTER 20

CONTESTED CASES

- 20.1(17A,272C) Scope and applicability
- 20.2(17A,272C) Definitions
- 20.3(17A,272C) Time requirements
- 20.4(17A,272C) Applicability of Iowa Rules of Civil Procedure
- 20.5(17A,272C) Combined statement of charges and settlement agreement
- 20.6(17A,272C) Notice of hearing
- 20.7(17A,272C) Statement of charges
- 20.8(13,272C) Legal representation

20.9(17A,272C)	Presiding officer in a disciplinary contested case
20.10(17A,272C)	Presiding officer in a nondisciplinary contested case
20.11(17A,272C)	Disqualification
20.12(17A,272C)	Waiver of procedures
20.13(17A,272C)	Telephone or electronic proceedings
20.14(17A,272C)	Consolidation—severance
20.15(17A,272C)	Appearance
20.16(17A,272C)	Answer
20.17(17A,272C)	Filing and service of documents
20.18(272C)	Investigative file
20.19(17A,272C)	Discovery
20.20(17A,272C)	Issuance of subpoenas in a contested case
20.21(17A,272C)	Motions
20.22(17A,272C)	Prehearing conferences
20.23(17A,272C)	Continuances
20.24(17A,272C)	Settlement agreements
20.25(17A,272C)	Hearing procedures in contested cases
20.26(17A,272C)	Evidence
20.27(17A,272C)	Default
20.28(17A,272C)	Ex parte communication
20.29(17A,272C)	Recording
20.30(17A,272C)	Proposed decisions
20.31(17A,272C)	Final decisions
20.32(17A,272C)	Applications for rehearing
20.33(17A,272C)	Stays of agency actions
20.34(17A,272C)	No factual dispute contested cases
20.35(17A,272C)	Emergency adjudicative proceedings
20.36(17A,147,272C)	Application for reinstatement
20.37(17A,22,272C)	Dissemination of public records
20.38(17A)	Judicial review

CHAPTER 19
IOWA NURSE ASSISTANCE PROGRAM

655—19.1(272C) Iowa nurse assistance program committee. Pursuant to the authority of Iowa Code section 272C.3(1)“k,” the board establishes the Iowa nurse assistance program committee (INAPC), formerly known as the licensee review committee, to implement the Iowa nurse assistance program (INAP). The purpose of the INAPC is to provide a program to support the evaluation and monitoring of licensees who are impaired as a result of any substance use disorder or any mental or physical health condition, while protecting the health, safety and welfare of the public.
[ARC 2204C, IAB 10/28/15, effective 12/2/15; ARC 5188C, IAB 9/23/20, effective 10/28/20]

655—19.2(272C) Definitions.

“*Board*” means the Iowa board of nursing.

“*Contract*” means the written document executed by an applicant or licensee and the INAPC after the INAPC receives a report from an approved treatment provider, which establishes the terms for participation in the INAP.

“*Impairment*” means an inability, or significant potential for inability, to practice with reasonable safety and skill as a result of a diagnosed substance use disorder or any diagnosed mental or physical health condition.

“*INAP*” or “*program*” means the Iowa nurse assistance program.

“*INAPC*” or “*committee*” means the Iowa nurse assistance program committee.

“*Initial agreement*” means the written document establishing the initial terms for participation in the INAP.

“*Participant*” means an applicant or licensee who does any of the following: self-reports an impairment to the program, is referred to the program by the board, signs an initial agreement with the committee, or signs a contract with the committee.

“*Recognized treatment provider*” means a licensed health care provider with board-approved expertise in substance use disorders or mental or physical health conditions.

“*Referral by the board*” means the board has determined, with or without having taken disciplinary action, that the applicant or licensee is an appropriate candidate for participation in the program.

“*Self-report*” means an applicant or licensee provides written notification to the committee that the applicant or licensee has been, is, or may be impaired. Information related to impairment or a potential impairment which is provided on a license application or renewal form may be considered a self-report.
[ARC 2204C, IAB 10/28/15, effective 12/2/15; ARC 5188C, IAB 9/23/20, effective 10/28/20]

655—19.3(272C) Organization of the committee. The board shall appoint the members of the INAPC.

19.3(1) Membership. The membership of the INAPC includes, but is not limited to:

- a. The executive director of the board or the director’s designee from the board’s staff;
- b. One board of nursing licensee who has maintained sobriety for a period of no less than two years following successful completion of a recovery program;
- c. One licensed health care provider with expertise in substance use disorders;
- d. One licensed provider with expertise in mental health; and
- e. One public member.

19.3(2) Officers. At the last meeting of each calendar year, the INAPC shall elect a chairperson and a vice chairperson, each of whom will begin serving a one-year term on January 1.

a. The chairperson is responsible for offering guidance and direction to staff between regularly scheduled committee meetings, including guidance and direction concerning negotiation and execution of initial agreements, contracts, and program descriptions and interim restrictions on practice, on behalf of the committee. The INAPC retains authority to review all interim decisions at its discretion.

b. The vice chairperson is responsible for providing guidance and direction to staff between regularly scheduled committee meetings if the chairperson is unavailable or unable to assist in a particular matter.

19.3(3) Terms. Committee members, except the executive director or designee, shall be appointed for three-year terms and shall serve for a maximum of three terms. Each term shall expire on December 31 of the third year of the term.

[ARC 2204C, IAB 10/28/15, effective 12/2/15]

655—19.4(272C) Eligibility.

19.4(1) Self-report. An applicant or a licensee shall provide a written self-report of an impairment or potential impairment directly to the program.

19.4(2) Board referral. The board may refer an applicant or licensee to the program if a complaint or investigation reveals an impairment or potential impairment and the board determines that the individual is an appropriate candidate for review by the INAPC. The board may refer a licensee to the program in a public disciplinary order or other public order.

19.4(3) Review by the INAPC. The INAPC will determine on a case-by-case basis whether an applicant or licensee who self-reports or is referred by the board is an appropriate candidate for participation in the program. Several factors may lead to the INAPC's determination that an applicant or licensee is ineligible to participate in the program, including but not limited to if the committee finds sufficient evidence that the applicant or licensee:

- a. Diverted drugs for distribution to third parties or for personal profit;
- b. Adulterated, misbranded, or otherwise tampered with drugs intended for a patient;
- c. Provided inaccurate, misleading, or fraudulent information or failed to fully cooperate with the INAPC;
- d. Participated in the program, or similar programs offered by other states, without success; or
- e. Fails to sign a contract when recommended by the INAPC.

19.4(4) Discretion. Eligibility to participate in the program is at the sole discretion of the INAPC. No person is entitled to participate in the program.

19.4(5) Authority and jurisdiction of the board over participants.

a. A participant's entrance into an initial agreement or contract with the INAPC does not divest the board of its authority or jurisdiction over the participant.

b. A participant's entrance into an initial agreement or contract with the INAPC specifically does not divest the board of its authority or jurisdiction to impose discipline against a participant who receives a criminal conviction or discipline from another state's licensing agency, regardless of whether the conduct resulting in the conviction or out-of-state discipline is related to the participant's impairment, and regardless of whether the conviction or out-of-state discipline occurred prior to or after the participant entered into the initial agreement or contract with the INAPC.

c. Participants may be eligible to continue participating in the program, subject to the INAPC's discretion, while being subject to investigation or discipline by the board for conduct unrelated to the participant's impairment.

[ARC 2204C, IAB 10/28/15, effective 12/2/15; ARC 5188C, IAB 9/23/20, effective 10/28/20]

655—19.5(272C) Terms of participation. A participant shall agree to comply with the INAP terms of participation established in the initial agreement and contract. Participants will be responsible for all expenses incurred to comply with the terms imposed by the program. Terms of participation specified in the contract shall include, but not be limited to:

19.5(1) Duration. The length of time a participant may participate in the program shall be determined by the INAPC in accordance with the following:

a. Participation in the program for participants impaired as a result of a substance use disorder is set at a minimum of three years. The INAPC may offer a contract with a shorter duration to a participant who can demonstrate successful participation in another state's nurse assistance program, who can document similar experience, or who, as a board referral, has successfully completed a portion of the monitoring period established in the board order.

b. Length of participation in the program for participants with impairments resulting from mental or physical conditions will vary depending upon the recommendations provided by an approved licensed health care professional and the determination of the INAPC following review of all relevant information.

19.5(2) Requirements. The INAPC shall establish terms designed to meet the specific needs of the participant. The committee shall determine the type of recovery, rehabilitation, or maintenance program required to treat the participant's impairment. The contract shall provide a detailed description of the goals of the program, the requirements for successful participation, and the participant's obligations therein. The committee may establish terms specific to a participant's impairment including, but not limited to: treatment, aftercare, worksite monitoring, chemical screening, further evaluations, structured recovery meetings, therapy, and medication management.

19.5(3) Practice restrictions. The INAPC may impose restrictions on the license to practice as a term of the initial agreement or contract until such time as the INAPC receives a report from an approved evaluator and the INAPC determines, based on all relevant information, that the participant is capable of practicing with reasonable skill and safety. As a condition of participation in the program, a licensee is required to agree to restricted practice in accordance with the terms specified in the initial agreement or contract. In the event the licensee refuses to agree to or comply with the practice restrictions, the committee shall refer the licensee to the board for appropriate action.

19.5(4) Noncompliance. Noncompliance is the failure to adhere to the terms of the initial agreement or contract. Participants shall promptly notify the INAPC of any instances of noncompliance, including relapse. Instances of noncompliance shall initially be reviewed by the INAP program coordinator. The INAP program coordinator may refer instances of noncompliance to the INAPC for further review of continued participation in the program. The INAPC may refer instances of noncompliance to the board for possible disciplinary action.

[ARC 2204C, IAB 10/28/15, effective 12/2/15]

655—19.6(272C) Referral to the board. If a participant is alleged to have violated a statute or board administrative rule, based on conduct that is unrelated to the participant's impairment, the INAPC shall refer the participant to the board for appropriate action.

[ARC 2204C, IAB 10/28/15, effective 12/2/15; ARC 5188C, IAB 9/23/20, effective 10/28/20]

655—19.7(272C) Confidentiality. Information in the possession of the board or the committee shall be subject to the confidentiality requirements of Iowa Code section 272C.6. Information about participants in the program shall not be disclosed except as provided in this rule.

19.7(1) The INAPC is authorized, pursuant to Iowa Code section 272C.6(4), to communicate information about a current or former INAP participant to the applicable regulatory authorities or impaired licensee programs in the state of Iowa and in any jurisdiction of the United States or foreign nations in which the participant is currently licensed or in which the participant seeks licensure. INAP participants must report their participation to the applicable nurse assistance program or licensing authority in any state in which the participant is currently licensed or in which the participant seeks licensure.

19.7(2) The INAPC is authorized to communicate information about an INAP participant to any person assisting in the participant's treatment, recovery, rehabilitation, monitoring, or maintenance for the duration of the contract.

19.7(3) The INAPC is authorized to communicate information about an INAP participant to the board in the event a participant does not comply with the terms of the contract as set forth in rule 655—19.5(272C). The INAPC may provide the board with a participant's INAP file in the event the participant does not comply with the terms of the contract and the INAPC refers the case to the board for the filing of formal disciplinary charges or other appropriate action. If the board initiates disciplinary action against a licensee for noncompliance with the terms of the contract, the board may include information about a licensee's participation in the INAP in the public disciplinary documents. The INAPC is also authorized to communicate information about a participant to the board in the event the participant is under investigation by the board.

19.7(4) The INAPC is authorized to communicate information about a current or former INAP participant to the board if reliable information held by the INAPC reasonably indicates a significant risk to the public exists. If the board initiates disciplinary action based upon this information, the board may

include in the public disciplinary documents information about a licensee's participation if necessary to address impairment issues related to the violations which are the subject of the disciplinary action.

[ARC 2204C, IAB 10/28/15, effective 12/2/15]

655—19.8(28E) Authority for 28E agreements. The INAPC may enter into 28E agreements with other health professional licensing boards to evaluate, assist, and monitor impaired licensees from other health professions who self-report and to report to those professional licensing boards regarding the compliance of individual licensees. In the event of noncompliance, the licensee may be referred to the appropriate licensing board for appropriate disciplinary action.

[ARC 2204C, IAB 10/28/15, effective 12/2/15]

These rules are intended to implement Iowa Code sections 272C.3(1) "k," 272C.6(4) and 28E.4.

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REVENUE DEPARTMENT[701]

Created by 1986 Iowa Acts, chapter 1245.

CHAPTERS 1 and 2

Reserved

CHAPTER 3

VOLUNTARY DISCLOSURE PROGRAM

3.1(421,422,423) Voluntary disclosure program

CHAPTER 4

MULTILEVEL MARKETER AGREEMENTS

4.1(421) Multilevel marketers—in general

CHAPTER 5

PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

(Uniform Rules)

5.1(17A,22) Definitions
 5.3(17A,22) Requests for access to records
 5.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
 5.9(17A,22) Disclosures without the consent of the subject
 5.10(17A,22) Routine use
 5.11(17A,22) Consensual disclosure of confidential records
 5.12(17A,22) Release to subject
 5.13(17A,22) Availability of records
 5.14(17A,22) Personally identifiable information
 5.15(17A,22) Other groups of records
 5.16(17A,22) Applicability

TITLE I

ADMINISTRATION

CHAPTER 6

ORGANIZATION, PUBLIC INSPECTION

6.1(17A) Establishment, organization, general course and method of operations, methods by which and location where the public may obtain information or make submissions or requests
 6.2(17A) Public inspection
 6.3(17A) Examination of records
 6.4(17A) Copies of proposed rules
 6.5(17A) Regulatory analysis procedures
 6.6(422) Retention of records and returns by the department
 6.7(68B) Consent to sell
 6.8(421) Tax return extension in disaster areas

CHAPTER 7

PRACTICE AND PROCEDURE BEFORE THE DEPARTMENT OF REVENUE

7.1(421,17A) Applicability and scope of rules
 7.2(421,17A) Definitions
 7.3(17A) Business hours
 7.4(17A) Computation of time, filing of documents
 7.5(17A) Form and style of papers
 7.6(17A) Persons authorized to represent themselves or others

7.7(17A)	Resolution of tax liability
7.8(17A)	Protest
7.9(17A)	Identifying details
7.10(17A)	Docket
7.11(17A)	Informal procedures and dismissals of protests
7.12(17A)	Answer
7.13(17A)	Subpoenas
7.14(17A)	Commencement of contested case proceedings
7.15(17A)	Discovery
7.16(17A)	Prehearing conference
7.17(17A)	Contested case proceedings
7.18(17A)	Interventions
7.19(17A)	Record and transcript
7.20(17A)	Application for rehearing
7.21(17A)	Service
7.22(17A)	Ex parte communications and disqualification
7.23(17A)	Licenses
7.24(17A)	Declaratory order—in general
7.25(17A)	Department procedure for rule making
7.26(17A)	Public inquiries on rule making and the rule-making records
7.27(17A)	Criticism of rules
7.28(17A)	Waiver or variance of certain department rules
7.29(17A)	Petition for rule making
7.30(9C,91C)	Procedure for nonlocal business entity bond forfeitures
7.31(421)	Abatement of unpaid tax
7.32(421)	Time and place of taxpayer interviews
7.33(421)	Mailing to the last-known address
7.34(421)	Power of attorney
7.35(421)	Taxpayer designation of tax type and period to which voluntary payments are to be applied
7.36(421)	Tax return preparers

CHAPTER 8

FORMS AND COMMUNICATIONS

8.1(17A,421)	Definitions
8.2(17A,421)	Department forms
8.3(17A,421)	Substitute forms
8.4(17A)	Description of forms
8.5(422)	Electronic filing of Iowa income tax returns

CHAPTER 9

FILING AND EXTENSION OF TAX LIENS AND CHARGING OFF UNCOLLECTIBLE TAX ACCOUNTS

9.1(422,423)	Definitions
9.2(422,423)	Lien attaches
9.3(422,423)	Purpose of filing
9.4(422,423)	Place of filing
9.5(422,423)	Time of filing
9.6(422,423)	Period of lien
9.7(422,423)	Fees

CHAPTER 10

INTEREST, PENALTY, EXCEPTIONS TO PENALTY, AND JEOPARDY ASSESSMENTS

10.1(421)	Definitions	
10.2(421)	Interest	
10.3(422,423,450,452A)	Interest on refunds and unpaid tax	
10.4(421)	Frivolous return penalty	
10.5(421)	Improper receipt of credit or refund	
		PENALTY FOR TAX PERIOD BEGINNING AFTER JANUARY 1, 1991
10.6(421)	Penalties	
10.7(421)	Waiver of penalty—definitions	
10.8(421)	Penalty exceptions	
10.9(421)	Notice of penalty exception for one late return in a three-year period	
10.10 to 10.19	Reserved	
		RETAIL SALES
10.20 to 10.29	Reserved	
		USE
10.30 to 10.39	Reserved	
		INDIVIDUAL INCOME
10.40 to 10.49	Reserved	
		WITHHOLDING
10.50 to 10.55	Reserved	
		CORPORATE
10.56 to 10.65	Reserved	
		FINANCIAL INSTITUTIONS
10.66 to 10.70	Reserved	
		MOTOR FUEL
10.71(452A)	Penalty and enforcement provisions	
10.72(452A)	Interest	
10.73 to 10.75	Reserved	
		CIGARETTES AND TOBACCO
10.76(453A)	Penalties	
10.77(453A)	Interest	
10.78	Reserved	
10.79(453A)	Request for statutory exception to penalty	
10.80 to 10.84	Reserved	
		INHERITANCE
10.85 to 10.89	Reserved	
		IOWA ESTATE
10.90 to 10.95	Reserved	
		GENERATION SKIPPING
10.96 to 10.100	Reserved	
		FIDUCIARY INCOME
10.101 to 10.109	Reserved	
		HOTEL AND MOTEL
10.110 to 10.114	Reserved	

ALL TAXES

- 10.115(421) Application of payments to penalty, interest, and then tax due for payments made on or after January 1, 1995, unless otherwise designated by the taxpayer

JEOPARDY ASSESSMENTS

- 10.116(422,453B) Jeopardy assessments
 10.117(422,453B) Procedure for posting bond
 10.118(422,453B) Time limits
 10.119(422,453B) Amount of bond
 10.120(422,453B) Posting of bond
 10.121(422,453B) Order
 10.122(422,453B) Director's order
 10.123(422,453B) Type of bond
 10.124(422,453B) Form of surety bond
 10.125(422,453B) Duration of the bond
 10.126(422,453B) Exoneration of the bond

TITLE II
EXCISECHAPTER 11
ADMINISTRATION

- 11.1(422,423) Definitions
 11.2(422,423) Statute of limitations
 11.3(422,423) Credentials and receipts
 11.4(422,423) Retailers required to keep records
 11.5(422,423) Audit of records
 11.6(422,423) Billings
 11.7(422,423) Collections
 11.8(422,423) No property exempt from distress and sale
 11.9(422,423) Information confidential
 11.10(423) Bonding procedure

CHAPTER 12

FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST

- 12.1(422) Returns and payment of tax
 12.2(422,423) Remittances
 12.3(422) Permits and negotiated rate agreements
 12.4(422) Nonpermit holders
 12.5(422,423) Regular permit holders responsible for collection of tax
 12.6(422,423) Sale of business
 12.7(422) Bankruptcy, insolvency or assignment for benefit of creditors
 12.8(422) Vending machines and other coin-operated devices
 12.9(422) Claim for refund of tax
 12.10(423) Audit limitation for certain services
 12.11 Reserved
 12.12(422) Extension of time for filing
 12.13(422) Determination of filing status
 12.14(422,423) Immediate successor liability for unpaid tax
 12.15(422,423) Officers and partners—personal liability for unpaid tax
 12.16(422) Show sponsor liability
 12.17(423) Purchaser liability for unpaid sales tax
 12.18(423) Biodiesel production refund

- 12.19(15) Sales and use tax refund for eligible businesses
 12.20(423) Collection, permit, and tax return exemption for certain out-of-state businesses

CHAPTER 13

PERMITS

- 13.1(422) Retail sales tax permit required
 13.2(422) Application for permit
 13.3(422) Permit not transferable—sale of business
 13.4(422) Permit—consolidated return optional
 13.5(422) Retailers operating a temporary business
 13.6(422) Reinstatement of canceled permit
 13.7(422) Reinstatement of revoked permit
 13.8(422) Withdrawal of permit
 13.9(422) Loss or destruction of permit
 13.10(422) Change of location
 13.11(422) Change of ownership
 13.12(422) Permit posting
 13.13(422) Trustees, receivers, executors and administrators
 13.14(422) Vending machines and other coin-operated devices
 13.15(422) Other amusements
 13.16(422) Substantially delinquent tax—denial of permit
 13.17(422) Substantially delinquent tax—revocation of permit

CHAPTER 14

COMPUTATION OF TAX

- 14.1(422) Tax not to be included in price
 14.2(422,423,77GA, ch1130) Retail bracket system for state sales and local option sales and service tax
 14.3(422,423) Taxation of transactions due to rate change

CHAPTER 15

DETERMINATION OF A SALE AND SALE PRICE

- 15.1(422) Conditional sales to be included in gross sales
 15.2(422,423) Repossessed goods
 15.3(422,423) Exemption certificates, direct pay permits, fuel used in processing, and beer and wine wholesalers
 15.4(422,423) Bad debts
 15.5(422,423) Recovery of bad debts by collection agency or attorney
 15.6(422,423) Discounts, rebates and coupons
 15.7 Reserved
 15.8(422,423) Returned merchandise
 15.9(422) Goods damaged in transit
 15.10(422) Consignment sales
 15.11(422,423) Leased departments
 15.12(422,423) Excise tax included in and excluded from gross receipts
 15.13(422,423) Freight, other transportation charges, and exclusions from the exemption applicable to these services
 15.14(422,423) Installation charges when tangible personal property is sold at retail
 15.15(422) Premiums and gifts
 15.16(422) Gift certificates
 15.17(422,423) Finance charge
 15.18(422,423) Coins and other currency exchanged at greater than face value

- 15.19(422,423) Trade-ins
- 15.20(422,423) Corporate mergers which do not involve taxable sales of tangible personal property or services

CHAPTER 16
TAXABLE SALES

- 16.1(422) Tax imposed
- 16.2(422) Used or secondhand tangible personal property
- 16.3(422,423) Tangible personal property used or consumed by the manufacturer thereof
- 16.4(422,423) Patterns, dies, jigs, tools, and manufacturing or printing aids
- 16.5(422,423) Explosives used in mines, quarries and elsewhere
- 16.6(422,423) Electrotypes, types, zinc etchings, halftones, stereotypes, color process plates and wood mounts
- 16.7 Reserved
- 16.8(422,423) Wholesalers and jobbers selling at retail
- 16.9(422,423) Materials and supplies sold to retail stores
- 16.10(422,423) Sales to certain corporations organized under federal statutes
- 16.11(422,423) Paper plates, paper cups, paper dishes, paper napkins, paper, wooden or plastic spoons and forks and straws
- 16.12(422) Tangible personal property purchased for resale but incidentally consumed by the purchaser
- 16.13(422) Property furnished without charge by employers to employees
- 16.14(422) Sales in interstate commerce—goods delivered into this state
- 16.15(422) Owners or operators of buildings
- 16.16(422,423) Tangible personal property made to order
- 16.17(422,423) Blacksmith and machine shops
- 16.18(422,423) Sales of signs at retail
- 16.19(422,423) Products sold by cooperatives to members or patrons
- 16.20(422,423) Municipal utilities, investor-owned utilities, or municipal or rural electrification cooperatives or associations
- 16.21(422,423) Sale of pets
- 16.22(422,423) Sales on layaway
- 16.23(422) Meal tickets, coupon books, and merchandise cards
- 16.24(422,423) Truckers engaged in retail business
- 16.25(422,423) Foreign truckers selling at retail in Iowa
- 16.26(422) Admissions to amusements, athletic events, commercial amusement enterprises, fairs, and games
- 16.27 and 16.28 Reserved
- 16.29(422) Rental of personal property in connection with the operation of amusements
- 16.30(422) Commercial amusement enterprises—companies or persons which contract to furnish show for fixed fee
- 16.31 Reserved
- 16.32(422) River steamboats
- 16.33(422) Pawnbrokers
- 16.34(422,423) Druggists and pharmacists
- 16.35(422,423) Memorial stones
- 16.36(422) Communication services furnished by hotel to its guests
- 16.37(422) Private clubs
- 16.38 Reserved
- 16.39(422) Athletic events
- 16.40(422,423) Iowa dental laboratories
- 16.41(422,423) Dental supply houses

16.42(422)	News distributors and magazine distributors
16.43(422,423)	Magazine subscriptions by independent dealers
16.44(422,423)	Sales by finance companies
16.45(422,423)	Sale of baling wire and baling twine
16.46(422,423)	Snowmobiles and motorboats
16.47(422)	Conditional sales contracts
16.48(422,423)	Carpeting and other floor coverings
16.49(422,423)	Bowling
16.50(422,423)	Various special problems relating to public utilities
16.51(423)	Sales of services treated as sales of tangible personal property

CHAPTER 17 EXEMPT SALES

17.1(422,423)	Gross receipts expended for educational, religious, and charitable purposes
17.2(422)	Fuel used in processing—when exempt
17.3(422,423)	Processing exemptions
17.4	Reserved
17.5(422,423)	Sales to the American Red Cross, the Coast Guard Auxiliary, Navy-Marine Corps Relief Society, and U.S.O
17.6(422,423)	Sales of vehicles subject to registration—new and used—by dealers
17.7(422,423)	Sales to certain federal corporations
17.8(422)	Sales in interstate commerce—goods transported or shipped from this state
17.9(422,423)	Sales of breeding livestock, fowl and certain other property used in agricultural production
17.10(422,423)	Materials used for seed inoculations
17.11(422,423)	Educational institution
17.12(422)	Coat or hat checkrooms
17.13(422,423)	Railroad rolling stock
17.14(422,423)	Chemicals, solvents, sorbents, or reagents used in processing
17.15(422,423)	Demurrage charges
17.16(422,423)	Sale of a draft horse
17.17(422,423)	Beverage container deposits
17.18(422,423)	Films, video tapes and other media, exempt rental and sale
17.19(422,423)	Gross receipts from the sale or rental of tangible personal property or from services performed, rendered, or furnished to certain nonprofit corporations exempt from tax
17.20(422)	Raffles
17.21(422)	Exempt sales of prizes
17.22(422,423)	Modular homes
17.23(422,423)	Sales to other states and their political subdivisions
17.24(422)	Nonprofit private museums
17.25(422,423)	Exempt sales by excursion boat licensees
17.26(422,423)	Bedding for agricultural livestock or fowl
17.27(422,423)	Statewide notification center service exemption
17.28(422,423)	State fair and fair societies
17.29(422,423)	Reciprocal shipment of wines
17.30(422,423)	Nonprofit organ procurement organizations
17.31(422,423)	Sale of electricity to water companies
17.32(422)	Food and beverages sold by certain organizations are exempt
17.33(422,423)	Sales of building materials, supplies and equipment to not-for-profit rural water districts
17.34(422,423)	Sales to hospices

17.35(422,423)	Sales of livestock ear tags
17.36(422,423)	Sale or rental of information services
17.37(422,423)	Temporary exemption from sales tax on certain utilities
17.38(422,423)	State sales tax phase-out on energies
17.39(422,423)	Art centers
17.40(422,423)	Community action agencies
17.41(422,423)	Legislative service bureau

CHAPTER 18

TAXABLE AND EXEMPT SALES DETERMINED BY METHOD
OF TRANSACTION OR USAGE

18.1(422,423)	Tangible personal property purchased from the United States government
18.2(422,423)	Sales of butane, propane and other like gases in cylinder drums, etc.
18.3(422,423)	Chemical compounds used to treat water
18.4(422)	Mortgages and trustees
18.5(422,423)	Sales to agencies or instrumentalities of federal, state, county and municipal government
18.6(422,423)	Relief agencies
18.7(422,423)	Containers, including packing cases, shipping cases, wrapping material and similar items
18.8(422)	Auctioneers
18.9(422)	Sales by farmers
18.10(422,423)	Florists
18.11(422,423)	Landscaping materials
18.12(422,423)	Hatcheries
18.13(422,423)	Sales by the state of Iowa, its agencies and instrumentalities
18.14(422,423)	Sales of livestock and poultry feeds
18.15(422,423)	Student fraternities and sororities
18.16(422,423)	Photographers and photostaters
18.17(422,423)	Gravel and stone
18.18(422,423)	Sale of ice
18.19(422,423)	Antiques, curios, old coins or collector's postage stamps
18.20(422,423)	Communication services
18.21(422,423)	Morticians or funeral directors
18.22(422,423)	Physicians, dentists, surgeons, ophthalmologists, oculists, optometrists, and opticians
18.23(422)	Veterinarians
18.24(422,423)	Hospitals, infirmaries and sanitariums
18.25(422,423)	Warranties and maintenance contracts
18.26(422)	Service charge and gratuity
18.27(422)	Advertising agencies, commercial artists, and designers
18.28(422,423)	Casual sales
18.29(422,423)	Processing, a definition of the word, its beginning and completion characterized with specific examples of processing
18.30(422)	Taxation of American Indians
18.31(422,423)	Tangible personal property purchased by one who is engaged in the performance of a service
18.32(422,423)	Sale, transfer or exchange of tangible personal property or taxable enumerated services between affiliated corporations
18.33(422,423)	Printers' and publishers' supplies exemption with retroactive effective date
18.34(422,423)	Automatic data processing
18.35(422,423)	Drainage tile

18.36(422,423)	True leases and purchases of tangible personal property by lessors
18.37(422,423)	Motor fuel, special fuel, aviation fuels and gasoline
18.38(422,423)	Urban transit systems
18.39(422,423)	Sales or services rendered, furnished, or performed by a county or city
18.40(422,423)	Renting of rooms
18.41(422,423)	Envelopes for advertising
18.42(422,423)	Newspapers, free newspapers and shoppers' guides
18.43(422,423)	Written contract
18.44(422,423)	Sale or rental of farm machinery and equipment
18.45(422,423)	Sale or rental of computers, industrial machinery and equipment; refund of and exemption from tax paid for periods prior to July 1, 1997
18.46(422,423)	Automotive fluids
18.47(422,423)	Maintenance or repair of fabric or clothing
18.48(422,423)	Sale or rental of farm machinery, equipment, replacement parts, and repairs used in livestock, dairy, or plant production
18.49(422,423)	Aircraft sales, rental, component parts, and services exemptions prior to, on, and after July 1, 1999
18.50(422,423)	Property used by a lending organization
18.51(422,423)	Sales to nonprofit legal aid organizations
18.52(422,423)	Irrigation equipment used in farming operations
18.53(422,423)	Sales to persons engaged in the consumer rental purchase business
18.54(422,423)	Sales of advertising material
18.55(422,423)	Drop shipment sales
18.56(422,423)	Wind energy conversion property
18.57(422,423)	Exemptions applicable to the production of flowering, ornamental, and vegetable plants
18.58(422,423)	Exempt sales or rentals of computers, industrial machinery and equipment, and exempt sales of fuel and electricity on and after July 1, 1997, but before July 1, 2016
18.59(422,423)	Exempt sales to nonprofit hospitals
18.60(422,423)	Exempt sales of gases used in the manufacturing process
18.61(422,423)	Exclusion from tax for property delivered by certain media

CHAPTER 19

SALES AND USE TAX ON CONSTRUCTION ACTIVITIES

19.1(422,423)	General information
19.2(422,423)	Contractors are consumers of building materials, supplies, and equipment by statute
19.3(422,423)	Sales of building materials, supplies, and equipment to contractors, subcontractors, builders or owners
19.4(422,423)	Contractors, subcontractors or builders who are retailers
19.5(422,423)	Building materials, supplies, and equipment used in the performance of construction contracts within and outside Iowa
19.6(422,423)	Prefabricated structures
19.7(422,423)	Types of construction contracts
19.8(422,423)	Machinery and equipment sales contracts with installation
19.9(422,423)	Construction contracts with equipment sales (mixed contracts)
19.10(422,423)	Distinguishing machinery and equipment from real property
19.11(422,423)	Tangible personal property which becomes structures
19.12(422,423)	Construction contracts with tax exempt entities
19.13(422,423)	Tax on enumerated services
19.14(422,423)	Transportation cost
19.15(422,423)	Start-up charges

19.16(422,423)	Liability of subcontractors
19.17(422,423)	Liability of sponsors
19.18(422,423)	Withholding
19.19(422,423)	Resale certificates
19.20(423)	Reporting for use tax

CHAPTER 20

FOODS FOR HUMAN CONSUMPTION, PRESCRIPTION DRUGS, INSULIN,
HYPODERMIC SYRINGES, DIABETIC TESTING MATERIALS, PROSTHETIC,
ORTHOTIC OR ORTHOPEDIC DEVICES

20.1(422,423)	Foods for human consumption
20.2(422,423)	Food coupon rules
20.3(422,423)	Nonparticipating retailer in the food coupon program
20.4(422,423)	Determination of eligible foods
20.5(422,423)	Meals and prepared food
20.6(422,423)	Vending machines
20.7(422,423)	Prescription drugs and devices
20.8(422,423)	Exempt sales of nonprescription medical devices, other than prosthetic devices
20.9(422,423)	Prosthetic, orthotic and orthopedic devices
20.10(422,423)	Sales and rentals covered by Medicaid and Medicare
20.11(422,423)	Reporting
20.12(422,423)	Exempt sales of clothing and footwear during two-day period in August

CHAPTERS 21 to 25

Reserved

TITLE III

SALES TAX ON SERVICES

CHAPTER 26

SALES AND USE TAX ON SERVICES

26.1(422)	Definition and scope
26.2(422)	Enumerated services exempt
26.3(422)	Alteration and garment repair
26.4(422)	Armored car
26.5(422)	Vehicle repair
26.6(422)	Battery, tire and allied
26.7(422)	Investment counseling
26.8(422)	Bank and financial institution service charges
26.9(422)	Barber and beauty
26.10(422)	Boat repair
26.11(422)	Car and vehicle wash and wax
26.12(422)	Carpentry
26.13(422)	Roof, shingle and glass repair
26.14(422)	Dance schools and dance studios
26.15(422)	Dry cleaning, pressing, dyeing and laundering
26.16(422)	Electrical and electronic repair and installation
26.17(423)	Photography and retouching
26.18(422,423)	Equipment and tangible personal property rental
26.19(422)	Excavating and grading
26.20(422)	Farm implement repair of all kinds
26.21(422)	Flying service
26.22(422)	Furniture, rug, upholstery, repair and cleaning
26.23(422)	Fur storage and repair

26.24(422)	Golf and country clubs and all commercial recreation
26.25(422)	House and building moving
26.26(422)	Household appliance, television and radio repair
26.27(422)	Jewelry and watch repair
26.28(422)	Machine operators
26.29(422)	Machine repair of all kinds
26.30(422)	Motor repair
26.31(422)	Motorcycle, scooter and bicycle repair
26.32(422)	Oilers and lubricators
26.33(422)	Office and business machine repair
26.34(422)	Painting, papering and interior decorating
26.35(422)	Parking facilities
26.36(422)	Pipe fitting and plumbing
26.37(422)	Wood preparation
26.38(422)	Private employment agency, executive search agency
26.39(422)	Printing and binding
26.40(422)	Sewing and stitching
26.41(422)	Shoe repair and shoeshine
26.42(422)	Storage warehousing, storage locker, and storage warehousing of raw agricultural products and household goods
26.43(422,423)	Telephone answering service
26.44(422)	Test laboratories
26.45(422)	Termite, bug, roach, and pest eradicators
26.46(422)	Tin and sheet metal repair
26.47(422)	Turkish baths, massage, and reducing salons
26.48(422)	Vulcanizing, recapping or retreading
26.49	Reserved
26.50(422)	Weighing
26.51(422)	Welding
26.52(422)	Well drilling
26.53(422)	Wrapping, packing and packaging of merchandise other than processed meat, fish, fowl and vegetables
26.54(422)	Wrecking service
26.55(422)	Wrecker and towing
26.56(422)	Cable and pay television
26.57(422)	Camera repair
26.58(422)	Campgrounds
26.59(422)	Gun repair
26.60(422)	Janitorial and building maintenance or cleaning
26.61(422)	Lawn care
26.62(422)	Landscaping
26.63(422)	Pet grooming
26.64(422)	Reflexology
26.65(422)	Tanning beds and tanning salons
26.66(422)	Tree trimming and removal
26.67(422)	Water conditioning and softening
26.68(422)	Motor vehicle, recreational vehicle and recreational boat rental
26.69(422)	Security and detective services
26.70	Reserved
26.71(422,423)	Solid waste collection and disposal services
26.72(422,423)	Sewage services
26.73	Reserved

26.74(422,423)	Aircraft rental
26.75(422,423)	Sign construction and installation
26.76(422,423)	Swimming pool cleaning and maintenance
26.77(422,423)	Taxidermy
26.78(422,423)	Mini-storage
26.79(422,423)	Dating services
26.80(422,423)	Personal transportation service
26.81(422)	Sales of bundled services contracts

CHAPTER 27

AUTOMOBILE RENTAL EXCISE TAX

27.1(423C)	Definitions and characterizations
27.2(423C)	Tax imposed upon rental of automobiles
27.3(423C)	Lessor's obligation to collect tax
27.4(423C)	Administration of tax

TITLE IV
USECHAPTER 28
DEFINITIONS

28.1(423)	Taxable use defined
28.2(423)	Processing of property defined
28.3(423)	Purchase price defined
28.4(423)	Retailer maintaining a place of business in this state defined

CHAPTER 29
CERTIFICATES

29.1(423)	Certificate of registration
29.2(423)	Cancellation of certificate of registration
29.3(423)	Certificates of resale, direct pay permits, or processing

CHAPTER 30
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST

30.1(423)	Liability for use tax and denial and revocation of permit
30.2(423)	Measure of use tax
30.3(421,423)	Consumer's use tax return
30.4(423)	Retailer's use tax return
30.5(423)	Collection requirements of registered retailers
30.6(423)	Bracket system to be used by registered vendors
30.7(423)	Sales tax or use tax paid to another state
30.8(423)	Registered retailers selling tangible personal property on a conditional sale contract basis
30.9(423)	Registered vendors repossessing goods sold on a conditional sale contract basis
30.10(423)	Penalties for late filing of a monthly tax deposit or use tax returns
30.11(423)	Claim for refund of use tax
30.12(423)	Extension of time for filing

CHAPTER 31
RECEIPTS SUBJECT TO USE TAX

31.1(423)	Transactions consummated outside this state
31.2(423)	Goods coming into this state
31.3(423)	Sales by federal government or agencies to consumers
31.4(423)	Sales for lease of vehicles subject to registration—taxation and exemptions

- 31.5(423) Motor vehicle use tax on long-term leases
- 31.6(423) Sales of aircraft subject to registration
- 31.7(423) Communication services

CHAPTER 32

RECEIPTS EXEMPT FROM USE TAX

- 32.1(423) Tangible personal property and taxable services subject to sales tax
- 32.2(423) Sales tax exemptions applicable to use tax
- 32.3(423) Mobile homes and manufactured housing
- 32.4(423) Exemption for vehicles used in interstate commerce
- 32.5(423) Exemption for transactions if sales tax paid
- 32.6(423) Exemption for ships, barges, and other waterborne vessels
- 32.7(423) Exemption for containers
- 32.8(423) Exemption for building materials used outside this state
- 32.9(423) Exemption for vehicles subject to registration
- 32.10(423) Exemption for vehicles operated under Iowa Code chapter 326
- 32.11(423) Exemption for vehicles purchased for rental or lease
- 32.12(423) Exemption for vehicles previously purchased for rental
- 32.13(423) Exempt use of aircraft on and after July 1, 1999
- 32.14(423) Exemption for tangible personal property brought into Iowa under Iowa Code section 29C.24

CHAPTER 33

RECEIPTS SUBJECT TO USE TAX DEPENDING ON METHOD OF TRANSACTION

- 33.1 Reserved
- 33.2(423) Federal manufacturer's or retailer's excise tax
- 33.3(423) Fuel consumed in creating power, heat or steam for processing or generating electric current
- 33.4(423) Repair of tangible personal property outside the state of Iowa
- 33.5(423) Taxation of American Indians
- 33.6(422,423) Exemption for property used in Iowa only in interstate commerce
- 33.7(423) Property used to manufacture certain vehicles to be leased
- 33.8(423) Out-of-state rental of vehicles subject to registration subsequently used in Iowa
- 33.9(423) Sales of mobile homes, manufactured housing, and related property and services
- 33.10(423) Tax imposed on the use of manufactured housing as tangible personal property and as real estate

CHAPTER 34

VEHICLES SUBJECT TO REGISTRATION

- 34.1(422,423) Definitions
- 34.2(423) County treasurer shall collect tax
- 34.3(423) Returned vehicles and tax refunded by manufacturers
- 34.4(423) Use tax collections required
- 34.5(423) Exemptions
- 34.6(423) Vehicles subject to registration received as gifts or prizes
- 34.7(423) Titling of used foreign vehicles by dealers
- 34.8(423) Dealer's retail sales tax returns
- 34.9(423) Affidavit forms
- 34.10(423) Exempt and taxable purchases of vehicles for taxable rental
- 34.11(423) Manufacturer's refund of use tax to a consumer, lessor, or lessee of a defective motor vehicle

- 34.12(423) Government payments for a motor vehicle which do not involve government purchases of the same
- 34.13(423) Transfers of vehicles resulting from corporate mergers and other types of corporate transfers
- 34.14(423) Refund of use tax paid on the purchase of a motor vehicle
- 34.15(423) Registration by manufacturers
- 34.16(423) Rebates
- 34.17(321,423) Repossession of a vehicle
- 34.18(423) Federal excise tax
- 34.19(423) Claiming an exemption from Iowa tax
- 34.20(423) Affidavit forms
- 34.21(423) Insurance companies

CHAPTERS 35 and 36

Reserved

CHAPTER 37

UNDERGROUND STORAGE TANK RULES INCORPORATED BY REFERENCE

- 37.1(424) Rules incorporated

TITLE V *INDIVIDUAL*

CHAPTER 38 ADMINISTRATION

- 38.1(422) Definitions
- 38.2(422) Statute of limitations
- 38.3(422) Retention of records
- 38.4(422) Authority for deductions
- 38.5(422) Jeopardy assessments
- 38.6(422) Information deemed confidential
- 38.7(422) Power of attorney
- 38.8(422) Delegations to audit and examine
- 38.9(422) Bonding procedure
- 38.10(422) Indexation
- 38.11(422) Appeals of notices of assessment and notices of denial of taxpayer's refund claims
- 38.12(422) Indexation of the optional standard deduction for inflation
- 38.13(422) Reciprocal tax agreements
- 38.14(422) Information returns for reporting income payments to the department of revenue
- 38.15(422) Relief of innocent spouse for substantial understatement of tax attributable to other spouse
- 38.16(422) Preparation of taxpayers' returns by department employees
- 38.17(422) Resident determination
- 38.18(422) Tax treatment of income repaid in current tax year which had been reported on prior Iowa individual income tax return

CHAPTER 39

FILING RETURN AND PAYMENT OF TAX

- 39.1(422) Who must file
- 39.2(422) Time and place for filing
- 39.3(422) Form for filing
- 39.4(422) Filing status
- 39.5(422) Payment of tax

39.6(422)	Minimum tax
39.7(422)	Tax on lump-sum distributions
39.8(422)	State income tax limited to taxpayer's net worth immediately before the distressed sale
39.9(422)	Special tax computation for all low-income taxpayers except single taxpayers
39.10(422)	Election to report excess income from sale or exchange of livestock due to drought in the next tax year
39.11(422)	Forgiveness of tax for an individual whose federal income tax was forgiven because the individual was killed outside the United States due to military or terroristic action
39.12(422)	Tax benefits for persons in the armed forces deployed outside the United States and for certain other persons serving in support of those forces
39.13	Reserved
39.14(422)	Tax benefits for persons serving in support of the Bosnia-Herzegovina hazardous duty area
39.15(422)	Special tax computation for taxpayers who are 65 years of age or older

CHAPTER 40

DETERMINATION OF NET INCOME

40.1(422)	Net income defined
40.2(422)	Interest and dividends from federal securities
40.3(422)	Interest and dividends from foreign securities and securities of state and other political subdivisions
40.4	Reserved
40.5(422)	Military pay
40.6(422)	Interest and dividend income
40.7(422)	Current year capital gains and losses
40.8(422)	Gains and losses on property acquired before January 1, 1934
40.9(422)	Work opportunity tax credit and alcohol and cellulosic biofuel fuels credit
40.10 and 40.11	Reserved
40.12(422)	Income from partnerships or limited liability companies
40.13(422)	Subchapter "S" income
40.14(422)	Contract sales
40.15(422)	Reporting of incomes by married taxpayers who file a joint federal return but elect to file separately for Iowa income tax purposes
40.16(422)	Income of nonresidents
40.17(422)	Income of part-year residents
40.18(422)	Net operating loss carrybacks and carryovers
40.19(422)	Casualty losses
40.20(422)	Adjustments to prior years
40.21(422)	Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
40.22(422)	Disability income exclusion
40.23(422)	Social security benefits
40.24(99E)	Lottery prizes
40.25 and 40.26	Reserved
40.27(422)	Incomes from distressed sales of qualifying taxpayers
40.28	Reserved
40.29(422)	Intangible drilling costs
40.30(422)	Percentage depletion
40.31(422)	Away-from-home expenses of state legislators

40.32(422)	Interest and dividends from regulated investment companies which are exempt from federal income tax
40.33	Reserved
40.34(422)	Exemption of restitution payments for persons of Japanese ancestry
40.35(422)	Exemption of Agent Orange settlement proceeds received by disabled veterans or beneficiaries of disabled veterans
40.36(422)	Exemption of interest earned on bonds issued to finance beginning farmer loan program
40.37(422)	Exemption of interest from bonds issued by the Iowa comprehensive petroleum underground storage tank fund board
40.38(422)	Capital gain deduction or exclusion for certain types of net capital gains
40.39(422)	Exemption of interest from bonds or notes issued to fund the 911 emergency telephone system
40.40(422)	Exemption of active-duty military pay of national guard personnel and armed forces reserve personnel received for services related to operation desert shield
40.41	Reserved
40.42(422)	Depreciation of speculative shell buildings
40.43(422)	Retroactive exemption for payments received for providing unskilled in-home health care services to a relative
40.44(422,541A)	Individual development accounts
40.45(422)	Exemption for distributions from pensions, annuities, individual retirement accounts, or deferred compensation plans received by nonresidents of Iowa
40.46(422)	Taxation of compensation of nonresident members of professional athletic teams
40.47(422)	Partial exclusion of pensions and other retirement benefits for disabled individuals, individuals who are 55 years of age or older, surviving spouses, and survivors
40.48(422)	Health insurance premiums deduction
40.49(422)	Employer social security credit for tips
40.50(422)	Computing state taxable amounts of pension benefits from state pension plans
40.51(422)	Exemption of active-duty military pay of national guard personnel and armed forces military reserve personnel for overseas services pursuant to military orders for peacekeeping in the Bosnia-Herzegovina area
40.52(422)	Mutual funds
40.53(422)	Deduction for contributions by taxpayers to the Iowa educational savings plan trust and addition to income for refunds of contributions previously deducted
40.54(422)	Roth individual retirement accounts
40.55(422)	Exemption of income payments for victims of the Holocaust and heirs of victims
40.56(422)	Taxation of income from the sale of obligations of the state of Iowa and its political subdivisions
40.57(422)	Installment sales by taxpayers using the accrual method of accounting
40.58(422)	Exclusion of distributions from retirement plans by national guard members and members of military reserve forces of the United States
40.59	Reserved
40.60(422)	Additional first-year depreciation allowance
40.61(422)	Exclusion of active duty pay of national guard members and armed forces military reserve members for service under orders for Operation Iraqi Freedom, Operation Noble Eagle, Operation Enduring Freedom or Operation New Dawn
40.62(422)	Deduction for overnight expenses not reimbursed for travel away from home of more than 100 miles for performance of service as a member of the national guard or armed forces military reserve
40.63(422)	Exclusion of income from military student loan repayments

40.64(422)	Exclusion of death gratuity payable to an eligible survivor of a member of the armed forces, including a member of a reserve component of the armed forces who has died while on active duty
40.65(422)	Section 179 expensing
40.66(422)	Deduction for certain unreimbursed expenses relating to a human organ transplant
40.67(422)	Deduction for alternative motor vehicles
40.68(422)	Injured veterans grant program
40.69(422)	Exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain
40.70(422)	Exclusion of income from sale, rental or furnishing of tangible personal property or services directly related to production of film, television or video projects
40.71(422)	Exclusion for certain victim compensation payments
40.72(422)	Exclusion of Vietnam Conflict veterans bonus
40.73(422)	Exclusion for health care benefits of nonqualified tax dependents
40.74(422)	Exclusion for AmeriCorps Segal Education Award
40.75(422)	Exclusion of certain amounts received from Iowa veterans trust fund
40.76(422)	Exemption of active duty pay for armed forces, armed forces military reserve, or the national guard
40.77(422)	Exclusion of biodiesel production refund
40.78(422)	Allowance of certain deductions for 2008 tax year
40.79(422)	Special filing provisions related to 2010 tax changes
40.80(422)	Exemption for military retirement pay
40.81(422)	Iowa ABLE savings plan trust
40.82(422,541B)	First-time homebuyer savings accounts
40.83(422)	Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020

CHAPTER 41

DETERMINATION OF TAXABLE INCOME

41.1(422)	Verification of deductions required
41.2(422)	Federal rulings and regulations
41.3(422)	Federal income tax deduction and federal refund
41.4(422)	Optional standard deduction
41.5(422)	Itemized deductions
41.6(422)	Itemized deductions—separate returns by spouses
41.7(422)	Itemized deductions—part-year residents
41.8(422)	Itemized deductions—nonresidents
41.9(422)	Annualizing income
41.10(422)	Income tax averaging
41.11(422)	Reduction in state itemized deductions for certain high-income taxpayers
41.12(422)	Deduction for home mortgage interest for taxpayers with mortgage interest credit
41.13(422)	Iowa income taxes and Iowa tax refund

CHAPTER 42

ADJUSTMENTS TO COMPUTED TAX AND TAX CREDITS

42.1(257,422)	School district surtax
42.2(422D)	Emergency medical services income surtax
42.3(422)	Exemption credits
42.4(422)	Tuition and textbook credit for expenses incurred for dependents attending grades kindergarten through 12 in Iowa
42.5(422)	Nonresident and part-year resident credit
42.6(422)	Out-of-state tax credits

42.7(422)	Out-of-state tax credit for minimum tax
42.8(422)	Withholding and estimated tax credits
42.9(422)	Motor fuel credit
42.10(422)	Alternative minimum tax credit for minimum tax paid in a prior tax year
42.11(15,422)	Research activities credit
42.12(422)	New jobs credit
42.13(422)	Earned income credit
42.14(15)	Investment tax credit—new jobs and income program and enterprise zone program
42.15(422)	Child and dependent care credit
42.16(422)	Franchise tax credit
42.17(15E)	Eligible housing business tax credit
42.18(422)	Assistive device tax credit
42.19(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014
42.20(422)	Ethanol blended gasoline tax credit
42.21(15E)	Eligible development business investment tax credit
42.22(15E,422)	Venture capital credits
42.23(15)	New capital investment program tax credits
42.24(15E,422)	Endow Iowa tax credit
42.25(422)	Soy-based cutting tool oil tax credit
42.26(15I,422)	Wage-benefits tax credit
42.27(422,476B)	Wind energy production tax credit
42.28(422,476C)	Renewable energy tax credit
42.29(15)	High quality job creation program
42.30(15E,422)	Economic development region revolving fund tax credit
42.31(422)	Early childhood development tax credit
42.32(422)	School tuition organization tax credit
42.33(422)	E-85 gasoline promotion tax credit
42.34(422)	Biodiesel blended fuel tax credit
42.35(422)	Soy-based transformer fluid tax credit
42.36(16,422)	Agricultural assets transfer tax credit and custom farming contract tax credit
42.37(15,422)	Film qualified expenditure tax credit
42.38(15,422)	Film investment tax credit
42.39(422)	Ethanol promotion tax credit
42.40(422)	Charitable conservation contribution tax credit
42.41(15,422)	Redevelopment tax credit
42.42(15)	High quality jobs program
42.43(16,422)	Disaster recovery housing project tax credit
42.44(422)	Deduction of credits
42.45(15)	Aggregate tax credit limit for certain economic development programs
42.46(422)	E-15 plus gasoline promotion tax credit
42.47(422)	Geothermal tax credits
42.48(422)	Solar energy system tax credit
42.49(422)	Volunteer fire fighter, volunteer emergency medical services personnel and reserve peace officer tax credit
42.50(422)	Taxpayers trust fund tax credit
42.51(422,85GA,SF452)	From farm to food donation tax credit
42.52(422)	Adoption tax credit
42.53(15)	Workforce housing tax incentives program
42.54(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects registered on or after July 1, 2014, and before August 15, 2016

- 42.55(404A,422) Historic preservation and cultural and entertainment district tax credit for projects registered on or after August 15, 2016
 42.56(15,422) Renewable chemical production tax credit program

CHAPTER 43
ASSESSMENTS AND REFUNDS

- 43.1(422) Notice of discrepancies
 43.2(422) Notice of assessment, supplemental assessments and refund adjustments
 43.3(422) Overpayments of tax
 43.4(68A,422,456A) Optional designations of funds by taxpayer
 43.5(422) Abatement of tax
 43.6 and 43.7 Reserved
 43.8(422) Livestock production credit refunds for corporate taxpayers and individual taxpayers

CHAPTER 44
PENALTY AND INTEREST

- 44.1(422) Penalty
 44.2(422) Computation of interest on unpaid tax
 44.3(422) Computation of interest on refunds resulting from net operating losses
 44.4(422) Computation of interest on overpayments

CHAPTER 45
PARTNERSHIPS

- 45.1(422) General rule
 45.2(422) Partnership returns
 45.3(422) Contents of partnership return
 45.4(422) Distribution and taxation of partnership income

CHAPTER 46
WITHHOLDING

- 46.1(422) Who must withhold
 46.2(422) Computation of amount withheld
 46.3(422) Forms, returns and reports
 46.4(422) Withholding on nonresidents
 46.5(422) Penalty and interest
 46.6(422) Withholding tax credit to workforce development fund
 46.7(422) ACE training program credits from withholding
 46.8(260E) New job tax credit from withholding
 46.9(15) Supplemental new jobs credit from withholding and alternative credit for housing assistance programs
 46.10(403) Targeted jobs withholding tax credit

CHAPTER 47
Reserved

CHAPTER 48
COMPOSITE RETURNS

- 48.1(422) Composite returns
 48.2(422) Definitions
 48.3(422) Filing requirements
 48.4 Reserved
 48.5(422) Composite return required by director
 48.6(422) Determination of composite Iowa income

- 48.7(422) Determination of composite Iowa tax
- 48.8(422) Estimated tax
- 48.9(422) Time and place for filing

CHAPTER 49

ESTIMATED INCOME TAX FOR INDIVIDUALS

- 49.1(422) Who must pay estimated income tax
- 49.2(422) Time for filing and payment of tax
- 49.3(422) Estimated tax for nonresidents
- 49.4(422) Special estimated tax periods
- 49.5(422) Reporting forms
- 49.6(422) Penalty—underpayment of estimated tax
- 49.7(422) Estimated tax carryforwards and how the carryforward amounts are affected under different circumstances

CHAPTER 50

APPORTIONMENT OF INCOME FOR RESIDENT SHAREHOLDERS OF S CORPORATIONS

- 50.1(422) Apportionment of income for resident shareholders of S corporations
- 50.2 Reserved
- 50.3(422) Distributions
- 50.4(422) Computation of net S corporation income
- 50.5(422) Computation of federal tax on S corporation income
- 50.6(422) Income allocable to Iowa
- 50.7(422) Credit for taxes paid to another state
- 50.8 and 50.9 Reserved
- 50.10(422) Example for tax periods beginning on or after January 1, 2002

TITLE VI *CORPORATION*

CHAPTER 51 ADMINISTRATION

- 51.1(422) Definitions
- 51.2(422) Statutes of limitation
- 51.3(422) Retention of records
- 51.4(422) Cancellation of authority to do business
- 51.5(422) Authority for deductions
- 51.6(422) Jeopardy assessments
- 51.7(422) Information confidential
- 51.8(422) Power of attorney
- 51.9(422) Delegation of authority to audit and examine

CHAPTER 52

FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST, AND TAX CREDITS

- 52.1(422) Who must file
- 52.2(422) Time and place for filing return
- 52.3(422) Form for filing
- 52.4(422) Payment of tax
- 52.5(422) Minimum tax
- 52.6(422) Motor fuel credit
- 52.7(422) Research activities credit
- 52.8(422) New jobs credit

52.9	Reserved
52.10(15)	New jobs and income program tax credits
52.11(422)	Refunds and overpayments
52.12(422)	Deduction of credits
52.13(422)	Livestock production credits
52.14(15E)	Enterprise zone tax credits
52.15(15E)	Eligible housing business tax credit
52.16(422)	Franchise tax credit
52.17(422)	Assistive device tax credit
52.18(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects with Part 2 applications approved and tax credits reserved prior to July 1, 2014
52.19(422)	Ethanol blended gasoline tax credit
52.20(15E)	Eligible development business investment tax credit
52.21(15E,422)	Venture capital credits
52.22(15)	New capital investment program tax credits
52.23(15E,422)	Endow Iowa tax credit
52.24(422)	Soy-based cutting tool oil tax credit
52.25(15I,422)	Wage-benefits tax credit
52.26(422,476B)	Wind energy production tax credit
52.27(422,476C)	Renewable energy tax credit
52.28(15)	High quality job creation program
52.29(15E,422)	Economic development region revolving fund tax credit
52.30(422)	E-85 gasoline promotion tax credit
52.31(422)	Biodiesel blended fuel tax credit
52.32(422)	Soy-based transformer fluid tax credit
52.33(16,422)	Agricultural assets transfer tax credit and custom farming contract tax credit
52.34(15,422)	Film qualified expenditure tax credit
52.35(15,422)	Film investment tax credit
52.36(422)	Ethanol promotion tax credit
52.37(422)	Charitable conservation contribution tax credit
52.38(422)	School tuition organization tax credit
52.39(15,422)	Redevelopment tax credit
52.40(15)	High quality jobs program
52.41(15)	Aggregate tax credit limit for certain economic development programs
52.42(16,422)	Disaster recovery housing project tax credit
52.43(422)	E-15 plus gasoline promotion tax credit
52.44(422)	Solar energy system tax credit
52.45(422,85GA,SF452)	From farm to food donation tax credit
52.46(15)	Workforce housing tax incentives program
52.47(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects registered on or after July 1, 2014, and before August 15, 2016
52.48(404A,422)	Historic preservation and cultural and entertainment district tax credit for projects registered on or after August 15, 2016
52.49(15,422)	Renewable chemical production tax credit program

CHAPTER 53

DETERMINATION OF NET INCOME

53.1(422)	Computation of net income for corporations
53.2(422)	Net operating loss carrybacks and carryovers
53.3(422)	Capital loss carryback
53.4(422)	Net operating and capital loss carrybacks and carryovers
53.5(422)	Interest and dividends from federal securities

- 53.6(422) Interest and dividends from foreign securities, and securities of state and their political subdivisions
- 53.7(422) Safe harbor leases
- 53.8(422) Additions to federal taxable income
- 53.9(422) Gains and losses on property acquired before January 1, 1934
- 53.10(422) Work opportunity tax credit and alcohol and cellulosic biofuel fuels credit
- 53.11(422) Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
- 53.12(422) Federal income tax deduction
- 53.13(422) Iowa income taxes and Iowa tax refund
- 53.14(422) Method of accounting, accounting period
- 53.15(422) Consolidated returns
- 53.16(422) Federal rulings and regulations
- 53.17(422) Depreciation of speculative shell buildings
- 53.18(422) Deduction of multipurpose vehicle registration fee
- 53.19(422) Deduction of foreign dividends
- 53.20(422) Employer social security credit for tips
- 53.21(422) Deductions related to the Iowa educational savings plan trust
- 53.22(422) Additional first-year depreciation allowance
- 53.23(422) Section 179 expensing
- 53.24(422) Exclusion of ordinary or capital gain income realized as a result of involuntary conversion of property due to eminent domain
- 53.25(422) Exclusion of income from sale, rental or furnishing of tangible personal property or services directly related to production of film, television, or video projects
- 53.26(422) Exclusion of biodiesel production refund
- 53.27(422) Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020

CHAPTER 54

ALLOCATION AND APPORTIONMENT

- 54.1(422) Basis of corporate tax
- 54.2(422) Allocation or apportionment of investment income
- 54.3(422) Application of related expense to allocable interest, dividends, rents and royalties—tax periods beginning on or after January 1, 1978
- 54.4(422) Net gains and losses from the sale of assets
- 54.5(422) Where income is derived from the manufacture or sale of tangible personal property
- 54.6(422) Apportionment of income derived from business other than the manufacture or sale of tangible personal property
- 54.7(422) Apportionment of income of transportation, communications, and certain public utilities corporations
- 54.8(422) Apportionment of income derived from more than one business activity carried on within a single corporate structure
- 54.9(422) Allocation and apportionment of income in special cases

CHAPTER 55

ASSESSMENTS, REFUNDS, APPEALS

- 55.1(422) Notice of discrepancies
- 55.2(422) Notice of assessment
- 55.3(422) Refund of overpaid tax
- 55.4(421) Abatement of tax
- 55.5(422) Protests

CHAPTER 56
ESTIMATED TAX FOR CORPORATIONS

56.1(422)	Who must pay estimated tax
56.2(422)	Time for filing and payment of tax
56.3(422)	Special estimate periods
56.4(422)	Reporting forms
56.5(422)	Penalties
56.6(422)	Overpayment of estimated tax

TITLE VII
FRANCHISE

CHAPTER 57
ADMINISTRATION

57.1(422)	Definitions
57.2(422)	Statutes of limitation
57.3(422)	Retention of records
57.4(422)	Authority for deductions
57.5(422)	Jeopardy assessments
57.6(422)	Information deemed confidential
57.7(422)	Power of attorney
57.8(422)	Delegation to audit and examine

CHAPTER 58
FILING RETURNS, PAYMENT OF TAX, PENALTY AND INTEREST,
AND TAX CREDITS

58.1(422)	Who must file
58.2(422)	Time and place for filing return
58.3(422)	Form for filing
58.4(422)	Payment of tax
58.5(422)	Minimum tax
58.6(422)	Refunds and overpayments
58.7(422)	Allocation of franchise tax revenues
58.8(15E)	Eligible housing business tax credit
58.9(15E)	Eligible development business investment tax credit
58.10(404A,422)	Historic preservation and cultural and entertainment district tax credit
58.11(15E,422)	Venture capital credits
58.12(15)	New capital investment program tax credits
58.13(15E,422)	Endow Iowa tax credit
58.14(15I,422)	Wage-benefits tax credit
58.15(422,476B)	Wind energy production tax credit
58.16(422,476C)	Renewable energy tax credit
58.17(15)	High quality job creation program
58.18(15E,422)	Economic development region revolving fund tax credit
58.19(15,422)	Film qualified expenditure tax credit
58.20(15,422)	Film investment tax credit
58.21(15)	High quality jobs program
58.22(422)	Solar energy system tax credit
58.23(15)	Workforce housing tax incentives program

CHAPTER 59
DETERMINATION OF NET INCOME

59.1(422)	Computation of net income for financial institutions
59.2(422)	Net operating loss carrybacks and carryovers

59.3(422)	Capital loss carryback
59.4(422)	Net operating and capital loss carrybacks and carryovers
59.5(422)	Interest and dividends from federal securities
59.6(422)	Interest and dividends from foreign securities and securities of states and other political subdivisions
59.7(422)	Safe harbor leases
59.8(422)	Additional deduction for wages paid or accrued for work done in Iowa by certain individuals
59.9(422)	Work opportunity tax credit
59.10(422)	Like-kind exchanges of personal property completed after December 31, 2017, but before tax periods beginning on or after January 1, 2020
59.11(422)	Gains and losses on property acquired before January 1, 1934
59.12(422)	Federal income tax deduction
59.13(422)	Iowa franchise taxes
59.14(422)	Method of accounting, accounting period
59.15(422)	Consolidated returns
59.16(422)	Federal rulings and regulations
59.17(15E,422)	Charitable contributions relating to the endow Iowa tax credit
59.18(422)	Depreciation of speculative shell buildings
59.19(422)	Deduction of multipurpose vehicle registration fee
59.20(422)	Disallowance of expenses to carry an investment subsidiary for tax years which begin on or after January 1, 1995
59.21(422)	S corporation and limited liability company financial institutions
59.22(422)	Deduction for contributions made to the endowment fund of the Iowa educational savings plan trust
59.23(422)	Additional first-year depreciation allowance
59.24(422)	Section 179 expensing

ALLOCATION AND APPORTIONMENT

59.25(422)	Basis of franchise tax
59.26(422)	Allocation and apportionment
59.27(422)	Net gains and losses from the sale of assets
59.28(422)	Apportionment factor
59.29(422)	Allocation and apportionment of income in special cases

CHAPTER 60

ASSESSMENTS, REFUNDS, APPEALS

60.1(422)	Notice of discrepancies
60.2(422)	Notice of assessment
60.3(422)	Refund of overpaid tax
60.4(421)	Abatement of tax
60.5(422)	Protests

CHAPTER 61

ESTIMATED TAX FOR FINANCIAL INSTITUTIONS

61.1(422)	Who must pay estimated tax
61.2(422)	Time for filing and payment of tax
61.3(422)	Special estimate periods
61.4(422)	Reporting forms
61.5(422)	Penalties
61.6(422)	Overpayment of estimated tax

CHAPTERS 62 to 66

Reserved

TITLE VIII
MOTOR FUEL

CHAPTER 67

ADMINISTRATION

67.1(452A)	Definitions
67.2(452A)	Statute of limitations, supplemental assessments and refund adjustments
67.3(452A)	Taxpayers required to keep records
67.4(452A)	Audit—costs
67.5(452A)	Estimate gallonage
67.6(452A)	Timely filing of returns, reports, remittances, applications, or requests
67.7(452A)	Extension of time to file
67.8(452A)	Penalty and interest
67.9(452A)	Penalty and enforcement provisions
67.10(452A)	Application of remittance
67.11(452A)	Reports, returns, records—variations
67.12(452A)	Form of invoice
67.13(452A)	Credit card invoices
67.14(452A)	Original invoice retained by purchaser—certified copy if lost
67.15(452A)	Taxes erroneously or illegally collected
67.16(452A)	Credentials and receipts
67.17(452A)	Information confidential
67.18(452A)	Delegation to audit and examine
67.19(452A)	Practice and procedure before the department of revenue
67.20(452A)	Time for filing protest
67.21(452A)	Bonding procedure
67.22(452A)	Tax refund offset
67.23(452A)	Supplier, restrictive supplier, importer, exporter, blender, dealer, or user licenses
67.24(452A)	Reinstatement of license canceled for cause
67.25(452A)	Fuel used in implements of husbandry
67.26(452A)	Excess tax collected
67.27(452A)	Retailer gallons report

CHAPTER 68

MOTOR FUEL AND UNDYED SPECIAL FUEL

68.1(452A)	Definitions
68.2(452A)	Tax rates—time tax attaches—responsible party
68.3(452A)	Exemption
68.4(452A)	Blended fuel taxation—nonterminal location
68.5(452A)	Tax returns—computations
68.6(452A)	Distribution allowance
68.7(452A)	Supplier credit—uncollectible account
68.8(452A)	Refunds
68.9(452A)	Claim for refund—payment of claim
68.10(452A)	Refund permit
68.11(452A)	Revocation of refund permit
68.12(452A)	Income tax credit in lieu of refund
68.13(452A)	Reduction of refund—sales and use tax
68.14(452A)	Terminal withdrawals—meters
68.15(452A)	Terminal and nonterminal storage facility reports and records

- 68.16(452A) Method of reporting taxable gallonage
- 68.17(452A) Transportation reports
- 68.18(452A) Bill of lading or manifest requirements
- 68.19(452A) Right of distributors and dealers to blend conventional blendstock for oxygenate blending, gasoline, or diesel fuel using a biofuel

CHAPTER 69

LIQUEFIED PETROLEUM GAS—

COMPRESSED NATURAL GAS—LIQUEFIED NATURAL GAS

- 69.1(452A) Definitions
- 69.2(452A) Tax rates—time tax attaches—responsible party—payment of the tax
- 69.3(452A) Penalty and interest
- 69.4(452A) Bonding procedure
- 69.5(452A) Persons authorized to place L.P.G., L.N.G., or C.N.G. in the fuel supply tank of a motor vehicle
- 69.6(452A) Requirements to be licensed
- 69.7(452A) Licensed metered pumps
- 69.8(452A) Single license for each location
- 69.9(452A) Dealer's and user's license nonassignable
- 69.10(452A) Separate storage—bulk sales—highway use
- 69.11(452A) Combined storage—bulk sales—highway sales or use
- 69.12(452A) Exemption certificates
- 69.13(452A) L.P.G. sold to the state of Iowa, its political subdivisions, contract carriers under contract with public schools to transport pupils or regional transit systems
- 69.14(452A) Refunds
- 69.15(452A) Notice of meter seal breakage
- 69.16(452A) Location of records—L.P.G. or C.N.G. users and dealers

TITLE IX
PROPERTY

CHAPTER 70

REPLACEMENT TAX AND STATEWIDE PROPERTY TAX

DIVISION I
REPLACEMENT TAX

- 70.1(437A) Who must file return
- 70.2(437A) Time and place for filing return
- 70.3(437A) Form for filing
- 70.4(437A) Payment of tax
- 70.5(437A) Statute of limitations
- 70.6(437A) Billings
- 70.7(437A) Refunds
- 70.8(437A) Abatement of tax
- 70.9(437A) Taxpayers required to keep records
- 70.10(437A) Credentials
- 70.11(437A) Audit of records
- 70.12(437A) Collections/reimbursements
- 70.13(437A) Information confidential

DIVISION II
STATEWIDE PROPERTY TAX

- 70.14(437A) Who must file return
- 70.15(437A) Time and place for filing return
- 70.16(437A) Form for filing

70.17(437A)	Payment of tax
70.18(437A)	Statute of limitations
70.19(437A)	Billings
70.20(437A)	Refunds
70.21(437A)	Abatement of tax
70.22(437A)	Taxpayers required to keep records
70.23(437A)	Credentials
70.24(437A)	Audit of records

CHAPTER 71

ASSESSMENT PRACTICES AND EQUALIZATION

71.1(405,427A,428,441,499B)	Classification of real estate
71.2(421,428,441)	Assessment and valuation of real estate
71.3(421,428,441)	Valuation of agricultural real estate
71.4(421,428,441)	Valuation of residential real estate
71.5(421,428,441)	Valuation of commercial real estate
71.6(421,428,441)	Valuation of industrial land and buildings
71.7(421,427A,428,441)	Valuation of industrial machinery
71.8(428,441)	Abstract of assessment
71.9(428,441)	Reconciliation report
71.10(421)	Assessment/sales ratio study
71.11(441)	Equalization of assessments by class of property
71.12(441)	Determination of aggregate actual values
71.13(441)	Tentative equalization notices
71.14(441)	Hearings before the department
71.15(441)	Final equalization order and appeals
71.16(441)	Alternative method of implementing equalization orders
71.17(441)	Special session of boards of review
71.18(441)	Judgment of assessors and local boards of review
71.19(441)	Conference boards
71.20(441)	Board of review
71.21(421,17A)	Property assessment appeal board
71.22(428,441)	Assessors
71.23(421,428,441)	Valuation of multiresidential real estate
71.24(421,428,441)	Valuation of dual classification property
71.25(441,443)	Omitted assessments
71.26(441)	Assessor compliance

CHAPTER 72

EXAMINATION AND CERTIFICATION OF ASSESSORS AND DEPUTY ASSESSORS

72.1(441)	Application for examination
72.2(441)	Examinations
72.3(441)	Eligibility requirements to take the examination
72.4(441)	Appraisal-related experience
72.5(441)	Regular certification
72.6(441)	Temporary certification
72.7	Reserved
72.8(441)	Deputy assessors—regular certification
72.9	Reserved
72.10(441)	Appointment of deputy assessors
72.11(441)	Special examinations
72.12(441)	Register of eligible candidates

- 72.13(441) Course of study for provisional appointees
- 72.14(441) Examining board
- 72.15(441) Appointment of assessor
- 72.16(441) Reappointment of assessor
- 72.17(441) Removal of assessor
- 72.18(421,441) Courses offered by the department of revenue

CHAPTER 73

PROPERTY TAX CREDIT AND RENT REIMBURSEMENT

- 73.1(425) Eligible claimants
- 73.2(425) Separate homesteads—husband and wife property tax credit
- 73.3(425) Dual claims
- 73.4(425) Multipurpose building
- 73.5(425) Multidwelling
- 73.6(425) Income
- 73.7(425) Joint tenancy
- 73.8(425) Amended claim
- 73.9(425) Simultaneous homesteads
- 73.10(425) Confidential information
- 73.11(425) Mobile, modular, and manufactured homes
- 73.12(425) Totally disabled
- 73.13(425) Nursing homes
- 73.14(425) Household
- 73.15(425) Homestead
- 73.16(425) Household income
- 73.17(425) Timely filing of claims
- 73.18(425) Separate homestead—husband and wife rent reimbursements
- 73.19(425) Gross rent/rent constituting property taxes paid
- 73.20(425) Leased land
- 73.21(425) Property: taxable status
- 73.22(425) Special assessments
- 73.23(425) Suspended, delinquent, or canceled taxes
- 73.24(425) Income: spouse
- 73.25(425) Common law marriage
- 73.26 Reserved
- 73.27(425) Special assessment credit
- 73.28(425) Credit applied
- 73.29(425) Deceased claimant
- 73.30(425) Audit of claim
- 73.31(425) Extension of time for filing a claim
- 73.32(425) Annual adjustment factor
- 73.33(425) Proration of claims
- 73.34(425) Unreasonable hardship

CHAPTER 74

MOBILE, MODULAR, AND MANUFACTURED HOME TAX

- 74.1(435) Definitions
- 74.2(435) Movement of home to another county
- 74.3(435) Sale of home
- 74.4(435) Reduced tax rate
- 74.5(435) Taxation—real estate
- 74.6(435) Taxation—square footage

- 74.7(435) Audit by department of revenue
- 74.8(435) Collection of tax

CHAPTER 75

PROPERTY TAX ADMINISTRATION

- 75.1(441) Tax year
- 75.2(445) Partial payment of tax
- 75.3(445) When delinquent
- 75.4(446) Payment of subsequent year taxes by purchaser
- 75.5(428,433,434,437,437A,438,85GA,SF451) Central assessment confidentiality
- 75.6(446) Tax sale
- 75.7(445) Refund of tax
- 75.8(614) Delinquent property taxes

CHAPTER 76

DETERMINATION OF VALUE OF RAILROAD COMPANIES

- 76.1(434) Definitions of terms
- 76.2(434) Filing of annual reports
- 76.3(434) Comparable sales
- 76.4(434) Stock and debt approach to unit value
- 76.5(434) Income capitalization approach to unit value
- 76.6(434) Cost approach to unit value
- 76.7(434) Correlation
- 76.8(434) Allocation of unit value to state
- 76.9(434) Exclusions

CHAPTER 77

DETERMINATION OF VALUE OF UTILITY COMPANIES

- 77.1(428,433,437,438) Definition of terms
- 77.2(428,433,437,438) Filing of annual reports
- 77.3(428,433,437,438) Comparable sales
- 77.4(428,433,437,438) Stock and debt approach to unit value
- 77.5(428,433,437,438) Income capitalization approach to unit value
- 77.6(428,433,437,438) Cost approach to unit value
- 77.7(428,433,437,438) Correlation
- 77.8(428,433,437,438) Allocation of unit value to state

CHAPTER 78

REPLACEMENT TAX AND STATEWIDE PROPERTY
TAX ON RATE-REGULATED WATER UTILITIES

REPLACEMENT TAX

- 78.1(437B) Who must file return
- 78.2(437B) Time and place for filing return
- 78.3(437B) Form for filing
- 78.4(437B) Payment of tax
- 78.5(437B) Statute of limitations
- 78.6(437B) Billings
- 78.7(437B) Refunds
- 78.8(437B) Abatement of tax
- 78.9(437B) Taxpayers required to keep records
- 78.10(437B) Credentials
- 78.11(437B) Audit of records
- 78.12(437B) Information confidential

STATEWIDE PROPERTY TAX

78.13(437B)	Who must file return
78.14(437B)	Time and place for filing return
78.15(437B)	Form for filing
78.16(437B)	Payment of tax
78.17(437B)	Statute of limitations
78.18(437B)	Billings
78.19(437B)	Refunds
78.20(437B)	Abatement of tax
78.21(437B)	Taxpayers required to keep records
78.22(437B)	Credentials
78.23(437B)	Audit of records

CHAPTER 79

REAL ESTATE TRANSFER TAX AND DECLARATIONS OF VALUE

79.1(428A)	Real estate transfer tax: Responsibility of county recorders
79.2(428A)	Taxable status of real estate transfers
79.3(428A)	Declarations of value: Responsibility of county recorders and city and county assessors
79.4(428A)	Certain transfers of agricultural realty
79.5(428A)	Form completion and filing requirements
79.6(428A)	Public access to declarations of value

CHAPTER 80

PROPERTY TAX CREDITS AND EXEMPTIONS

80.1(425)	Homestead tax credit
80.2(22,35,426A)	Military service tax exemption
80.3(427)	Pollution control and recycling property tax exemption
80.4(427)	Low-rent housing for the elderly and persons with disabilities
80.5(427)	Speculative shell buildings
80.6(427B)	Industrial property tax exemption
80.7(427B)	Assessment of computers and industrial machinery and equipment
80.8(404)	Urban revitalization partial exemption
80.9(427C,441)	Forest and fruit-tree reservations
80.10(427B)	Underground storage tanks
80.11(425A)	Family farm tax credit
80.12(427)	Methane gas conversion property
80.13(427B,476B)	Wind energy conversion property
80.14(427)	Mobile home park storm shelter
80.15(427)	Barn and one-room schoolhouse preservation
80.16(426)	Agricultural land tax credit
80.17(427)	Indian housing property
80.18(427)	Property used in value-added agricultural product operations
80.19(427)	Dwelling unit property within certain cities
80.20(427)	Nursing facilities
80.21(368)	Annexation of property by a city
80.22(427)	Port authority
80.23(427A)	Concrete batch plants and hot mix asphalt facilities
80.24(427)	Airport property
80.25(427A)	Car wash equipment
80.26(427)	Web search portal and data center business property
80.27(427)	Privately owned libraries and art galleries

80.28(404B)	Disaster revitalization area
80.29(427)	Geothermal heating and cooling systems installed on property classified as residential
80.30(426C)	Business property tax credit
80.31(427)	Broadband infrastructure
80.32(427,428,433,434,435,437,438)	Property aiding in disaster or emergency-related work
80.33 to 80.48	Reserved
80.49(441)	Commercial and industrial property tax replacement—county replacement claims
80.50(427,441)	Responsibility of local assessors
80.51(441)	Responsibility of local boards of review
80.52(427)	Responsibility of director of revenue
80.53(427)	Application for exemption
80.54(427)	Partial exemptions
80.55(427,441)	Taxable status of property
80.56(427)	Abatement of taxes

TITLE X
CIGARETTES AND TOBACCO

CHAPTER 81
ADMINISTRATION

81.1(453A)	Definitions
81.2(453A)	Credentials and receipts
81.3(453A)	Examination of records
81.4(453A)	Records
81.5(453A)	Form of invoice
81.6(453A)	Audit of records—cost, supplemental assessments and refund adjustments
81.7(453A)	Bonds
81.8(98)	Penalties
81.9(98)	Interest
81.10(98)	Waiver of penalty or interest
81.11(453A)	Appeal—practice and procedure before the department
81.12(453A)	Permit—license revocation
81.13(453A)	Permit applications and denials
81.14(453A)	Confidential information
81.15(98)	Request for waiver of penalty
81.16(453A)	Inventory tax

CHAPTER 82
CIGARETTE TAX AND REGULATION OF DELIVERY SALES OF ALTERNATIVE NICOTINE PRODUCTS OR VAPOR PRODUCTS

82.1(453A)	Permits required
82.2(453A)	Partial year permits—payment—refund—exchange
82.3(453A)	Bond requirements
82.4(453A)	Cigarette tax—attachment—exemption—exclusivity of tax
82.5(453A)	Cigarette tax stamps
82.6(453A)	Banks authorized to sell stamps—requirements—restrictions
82.7(453A)	Purchase of cigarette tax stamps—discount
82.8(453A)	Affixing stamps
82.9(453A)	Reports
82.10(453A)	Manufacturer's samples
82.11(453A)	Refund of tax—unused and destroyed stamps
82.12(453A)	Delivery sales of alternative nicotine products or vapor products

CHAPTER 83
TOBACCO TAX

83.1(453A)	Licenses
83.2(453A)	Distributor bond
83.3(453A)	Tax on tobacco products
83.4(453A)	Tax on little cigars
83.5(453A)	Distributor discount
83.6(453A)	Distributor returns
83.7(453A)	Consumer's return
83.8(453A)	Transporter's report
83.9(453A)	Free samples
83.10(453A)	Credits and refunds of taxes
83.11(453A)	Sales exempt from tax
83.12(81GA,HF339)	Retail permits required
83.13(81GA,HF339)	Permit issuance fee
83.14(81GA,HF339)	Refunds of permit fee
83.15(81GA,HF339)	Application for permit
83.16(81GA,HF339)	Records and reports
83.17(81GA,HF339)	Penalties

CHAPTER 84
UNFAIR CIGARETTE SALES

84.1(421B)	Definitions
84.2(421B)	Minimum price
84.3(421B)	Combination sales
84.4(421B)	Retail redemption of coupons
84.5(421B)	Exempt sales
84.6(421B)	Notification of manufacturer's price increase
84.7(421B)	Permit revocation

CHAPTER 85
TOBACCO MASTER SETTLEMENT AGREEMENT

DIVISION I
TOBACCO MASTER SETTLEMENT AGREEMENT

85.1(453C)	National uniform tobacco settlement
85.2(453C)	Definitions
85.3(453C)	Report required
85.4(453C)	Report information
85.5(453C)	Record-keeping requirement
85.6(453C)	Confidentiality
85.7 to 85.20	Reserved

DIVISION II
TOBACCO PRODUCT MANUFACTURERS' OBLIGATIONS AND PROCEDURES

85.21(80GA,SF375)	Definitions
85.22(80GA,SF375)	Directory of tobacco product manufacturers

TITLE XI
INHERITANCE, ESTATE, GENERATION SKIPPING, AND FIDUCIARY INCOME TAX

CHAPTER 86
INHERITANCE TAX

86.1(450)	Administration
86.2(450)	Inheritance tax returns and payment of tax

86.3(450)	Audits, assessments and refunds
86.4(450)	Appeals
86.5(450)	Gross estate
86.6(450)	The net estate
86.7(450)	Life estate, remainder and annuity tables—in general
86.8(450B)	Special use valuation
86.9(450)	Market value in the ordinary course of trade
86.10(450)	Alternate valuation date
86.11(450)	Valuation—special problem areas
86.12(450)	The inheritance tax clearance
86.13(450)	No lien on the surviving spouse's share of the estate
86.14(450)	Computation of shares
86.15(450)	Applicability

CHAPTER 87
IOWA ESTATE TAX

87.1(451)	Administration
87.2(451)	Confidential and nonconfidential information
87.3(451)	Tax imposed, tax returns, and tax due
87.4(451)	Audits, assessments and refunds
87.5(451)	Appeals
87.6(451)	Applicable rules

CHAPTER 88
GENERATION SKIPPING TRANSFER TAX

88.1(450A)	Administration
88.2(450A)	Confidential and nonconfidential information
88.3(450A)	Tax imposed, tax due and tax returns
88.4(450A)	Audits, assessments and refunds
88.5(450A)	Appeals
88.6(450A)	Generation skipping transfers prior to Public Law 99-514
88.7(421)	Applicability

CHAPTER 89
FIDUCIARY INCOME TAX

89.1(422)	Administration
89.2(422)	Confidentiality
89.3(422)	Situs of trusts
89.4(422)	Fiduciary returns and payment of the tax
89.5(422)	Extension of time to file and pay the tax
89.6(422)	Penalties
89.7(422)	Interest or refunds on net operating loss carrybacks
89.8(422)	Reportable income and deductions
89.9(422)	Audits, assessments and refunds
89.10(422)	The income tax certificate of acquittance
89.11(422)	Appeals to the director

CHAPTER 90
Reserved

TITLE XII
*MARIJUANA AND CONTROLLED
 SUBSTANCES STAMP TAX*

CHAPTER 91
 ADMINISTRATION OF MARIJUANA AND
 CONTROLLED SUBSTANCES STAMP TAX

- 91.1(453B) Marijuana and controlled substances stamp tax
- 91.2(453B) Sales of stamps
- 91.3(453B) Refunds pertaining to unused stamps

CHAPTERS 92 to 96
 Reserved

TITLE XIII
WATER SERVICE EXCISE TAX

CHAPTER 97
 STATE-IMPOSED WATER SERVICE EXCISE TAX

- 97.1(423G) Definitions
- 97.2(423G) Imposition
- 97.3(423G) Administration
- 97.4(423G) Charges and fees included in the provision of water service
- 97.5(423G) When water service is furnished for compensation
- 97.6(423G) Itemization of tax required
- 97.7(423G) Date of billing—effective date and repeal date
- 97.8(423G) Filing returns; payment of tax; penalty and interest
- 97.9(423G) Permits

CHAPTERS 98 to 101
 Reserved

TITLE XIV
HOTEL AND MOTEL TAX

CHAPTER 102
 Reserved

CHAPTER 103
 STATE-IMPOSED AND LOCALLY IMPOSED HOTEL AND
 MOTEL TAXES

- 103.1(423A) Definitions
- 103.2(423A) Administration
- 103.3(423A) Tax imposition and exemptions
- 103.4(423A) Filing returns; payment of tax; penalty and interest
- 103.5(423A) Permits
- 103.6(423A) Special collection and remittance obligations
- 103.7(423A) Certification of funds

CHAPTERS 104 to 106
 Reserved

TITLE XV
LOCAL OPTION SALES AND
SERVICE TAX

CHAPTER 107
LOCAL OPTION SALES AND SERVICES TAX

- 107.1(423B) Definitions
- 107.2(423B) Imposition of local option taxes and notification to the department
- 107.3(423B) Administration
- 107.4(423B) Filing returns; payment of tax; penalty and interest
- 107.5(423B) Permits
- 107.6(423B) Sales subject to local option sales and services tax
- 107.7(423B,423E) Sales not subject to local option tax, including transactions subject to Iowa use tax
- 107.8(423B) Local option sales and services tax payments to local governments
- 107.9(423B) Allocation procedure when sourcing of local option sales tax remitted to the department is unknown
- 107.10(423B) Application of payments
- 107.11(423B) Motor vehicle, recreational vehicle, and recreational boat rental subject to local option sales and services tax
- 107.12(423B) Computation of local option tax due from mixed sales on excursion boats

CHAPTER 108
LOCAL OPTION SCHOOL INFRASTRUCTURE
SALES AND SERVICE TAX

- 108.1(422E) Definitions
- 108.2(422E) Authorization, rate of tax, imposition, use of revenues, and administration
- 108.3(422E) Collection of the tax
- 108.4(422E) Similarities to the local option sales and service tax imposed in Iowa Code chapter 422B and 701—Chapter 107
- 108.5(422E) Sales not subject to local option tax, including transactions subject to Iowa use tax
- 108.6(422E) Deposits of receipts
- 108.7(422E) Local option school infrastructure sales and service tax payments to school districts
- 108.8(422E) Construction contract refunds
- 108.9(422E) 28E agreements

CHAPTER 109
NEW SCHOOL INFRASTRUCTURE LOCAL OPTION SALES AND SERVICES TAX—
EFFECTIVE ON OR AFTER APRIL 1, 2003, THROUGH FISCAL YEARS
ENDING DECEMBER 31, 2022

- 109.1(422E) Use of revenues and definitions
- 109.2(422E) Imposition of tax
- 109.3(422E) Application of law
- 109.4(422E) Collection of tax and distribution
- 109.5(422E) Insufficient funds
- 109.6(422E) Use of revenues by the school district
- 109.7(422E) Bonds
- 109.8(422E) 28E agreements

CHAPTERS 110 to 119
Reserved

TITLE XVI
REASSESSMENT EXPENSE FUND

CHAPTER 120
 REASSESSMENT EXPENSE FUND

- 120.1(421) Reassessment expense fund
- 120.2(421) Application for loan
- 120.3(421) Criteria for granting loan

CHAPTER 121
 Reserved

TITLE XVII
ASSESSOR CONTINUING EDUCATION

CHAPTER 122
 ADMINISTRATION

- 122.1(441) Establishment
- 122.2(441) General operation
- 122.3(441) Location
- 122.4(441) Purpose

CHAPTER 123
 CERTIFICATION

- 123.1(441) General
- 123.2(441) Confidentiality
- 123.3(441) Certification of assessors
- 123.4(441) Certification of deputy assessors
- 123.5(441) Type of credit
- 123.6(441) Retaking examination
- 123.7(441) Instructor credit
- 123.8(441) Conference board and assessor notification
- 123.9(441) Director of revenue notification

CHAPTER 124
 COURSES

- 124.1(441) Course selection
- 124.2(441) Scheduling of courses
- 124.3(441) Petitioning to add, delete or modify courses
- 124.4(441) Course participation
- 124.5(441) Retaking a course
- 124.6(441) Continuing education program for assessors

CHAPTER 125
 REVIEW OF AGENCY ACTION

- 125.1(441) Decisions final
- 125.2(441) Grievance and appeal procedures

CHAPTER 126
 PROPERTY ASSESSMENT APPEAL BOARD

- 126.1(421,441) Applicability and definitions
- 126.2(421,441) Appeal and answer
- 126.3(421,441) Nonelectronic service on parties and filing with the board
- 126.4(421,441) Electronic filing system
- 126.5(421,441) Motions and settlements

- 126.6(421,441) Hearing scheduling and discovery plan
- 126.7(421,441) Discovery and evidence
- 126.8(421,441) Hearings before the board
- 126.9(421,441) Posthearing motions
- 126.10(17A,441) Judicial review
- 126.11(22,421) Records access

CHAPTERS 127 to 149

Reserved

TITLE XVIII DEBT COLLECTION

CHAPTER 150

FEDERAL OFFSET FOR IOWA INCOME TAX OBLIGATIONS

- 150.1(421,26USC6402) Purpose and general application of offset of a federal tax overpayment to collect an Iowa income tax obligation
- 150.2(421,26USC6402) Definitions
- 150.3(421,26USC6402) Prerequisites for requesting a federal offset
- 150.4(421,26USC6402) Procedure after submission of evidence
- 150.5(421,26USC6402) Notice by Iowa to the Secretary to request federal offset
- 150.6(421,26USC6402) Erroneous payments to Iowa
- 150.7(421,26USC6402) Correcting and updating notice to the Secretary

CHAPTER 151

COLLECTION OF DEBTS OWED THE STATE OF IOWA OR A STATE AGENCY

- 151.1(421) Definitions
- 151.2(421) Scope and purpose
- 151.3(421) Participation guidelines
- 151.4(421) Duties of the agency
- 151.5(421) Duties of the department—performance of collection
- 151.6(421) Payment of collected amounts
- 151.7(421) Reimbursement for collection of liabilities
- 151.8(421) Confidentiality of information
- 151.9(421) Subpoena of records from public or private utility companies

CHAPTER 152

DEBT COLLECTION AND SELLING OF PROPERTY TO COLLECT DELINQUENT DEBTS

- 152.1(421,422,626,642) Definitions
- 152.2(421,422,626,642) Sale of property
- 152.3(421,422,626,642) Means of sale

CHAPTER 153

LICENSE SANCTIONS FOR COLLECTION OF DEBTS OWED THE STATE OF IOWA OR A STATE AGENCY

- 153.1(272D) Definitions
- 153.2(272D) Purpose and use
- 153.3(272D) Challenge to issuance of certificate of noncompliance
- 153.4(272D) Use of information
- 153.5(272D) Notice to person of potential sanction of license
- 153.6(272D) Conference
- 153.7(272D) Issuance of certificate of noncompliance

153.8(272D)	Stay of certificate of noncompliance
153.9(272D)	Written agreements
153.10(272D)	Decision of the unit
153.11(272D)	Withdrawal of certificate of noncompliance
153.12(272D)	Certificate of noncompliance to licensing authority
153.13(272D)	Requirements of the licensing authority
153.14(272D)	District court hearing

CHAPTER 154

CHALLENGES TO ADMINISTRATIVE LEVIES AND
PUBLICATION OF NAMES OF DEBTORS

154.1(421)	Definitions
154.2(421)	Administrative levies
154.3(421)	Challenges to administrative levies
154.4(421)	Form and time of challenge
154.5(421)	Issues that may be raised
154.6(421)	Review of challenge
154.7(421)	Actions where there is a mistake of fact
154.8(421)	Action if there is not a mistake of fact
154.9 to 154.15	Reserved
154.16(421)	List for publication
154.17(421)	Names to be published
154.18(421)	Release of information

CHAPTERS 155 to 210

Reserved

TITLE XIX

STREAMLINED SALES AND USE TAX RULES

CHAPTER 211

DEFINITIONS

211.1(423)	Definitions
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CHAPTER 212

ELEMENTS INCLUDED IN AND EXCLUDED
FROM A TAXABLE SALE AND SALES PRICE

212.1(423)	Tax not to be included in price
212.2(423)	Finance charge
212.3(423)	Retailers' discounts, trade discounts, rebates and coupons
212.4(423)	Excise tax included in and excluded from sales price
212.5(423)	Trade-ins
212.6(423)	Installation charges when tangible personal property is sold at retail
212.7(423)	Service charge and gratuity
212.8(423)	Payment from a third party

CHAPTER 213

MISCELLANEOUS TAXABLE SALES

213.1(423)	Tax imposed
213.2(423)	Athletic events
213.3(423)	Conditional sales contracts
213.4(423)	The sales price of sales of butane, propane and other like gases in cylinder drums, etc.

- 213.5(423) Antiques, curios, old coins, collector's postage stamps, and currency exchanged for greater than face value
- 213.6(423) Communication services furnished by hotel to its guests
- 213.7(423) Consignment sales
- 213.8(423) Electrotypes, types, zinc etchings, halftones, stereotypes, color process plates, wood mounts and art productions
- 213.9(423) Explosives used in mines, quarries and elsewhere
- 213.10(423) Sales on layaway
- 213.11(423) Memorial stones
- 213.12(423) Creditors and trustees
- 213.13(423) Sale of pets
- 213.14(423) Redemption of meal tickets, coupon books and merchandise cards as a taxable sale
- 213.15(423) Rental of personal property in connection with the operation of amusements
- 213.16(423) Repossessed goods
- 213.17(423) Sales of signs at retail
- 213.18(423) Tangible personal property made to order
- 213.19(423) Used or secondhand tangible personal property
- 213.20(423) Carpeting and other floor coverings
- 213.21(423) Goods damaged in transit
- 213.22(423) Snowmobiles, motorboats, and certain other vehicles
- 213.23(423) Photographers and photostaters
- 213.24(423) Sale, transfer or exchange of tangible personal property or taxable enumerated services between affiliated corporations
- 213.25(423) Urban transit systems

CHAPTER 214

MISCELLANEOUS NONTAXABLE TRANSACTIONS

- 214.1(423) Corporate mergers which do not involve taxable sales of tangible personal property or services
- 214.2(423) Sales of prepaid merchandise cards
- 214.3(423) Demurrage charges
- 214.4(423) Beverage container deposits
- 214.5(423) Exempt sales by excursion boat licensees
- 214.6(423) Advertising agencies, commercial artists and designers as an agent or as a nonagent of a client

CHAPTER 215

REMOTE SALES AND MARKETPLACE SALES

- 215.1(423) Definitions
- 215.2(423) Retailers with physical presence in Iowa
- 215.3(423) Remote sellers—registration and collection obligations
- 215.4(423) Marketplace facilitators—registration and collection obligations
- 215.5(423) Advertising on a marketplace
- 215.6(423) Commencement of collection obligation and sales tax liability
- 215.7(423) Retailers registered and collecting who fail to meet or exceed sales threshold
- 215.8(423) Coupons; incorporation of rule 701—212.3(423)
- 215.9(423) Customer returns marketplace purchase directly to marketplace seller
- 215.10(423) Exempt and nontaxable sales
- 215.11(423) Other taxes for marketplace sales and items not subject to sales/use tax
- 215.12(423) Administration; incorporation of 701—Chapter 11

- 215.13(423) Filing returns; payment of tax; penalty and interest; incorporation of 701—Chapter 12
- 215.14(423) Permits; incorporation of 701—Chapter 13

CHAPTERS 216 to 218

Reserved

CHAPTER 219

SALES AND USE TAX ON CONSTRUCTION ACTIVITIES

- 219.1(423) General information
- 219.2(423) Contractors—consumers of building materials, supplies, and equipment by statute
- 219.3(423) Sales of building materials, supplies, and equipment to contractors, subcontractors, builders or owners
- 219.4(423) Contractors, subcontractors or builders who are retailers
- 219.5(423) Building materials, supplies, and equipment used in the performance of construction contracts within and outside Iowa
- 219.6(423) Tangible personal property used or consumed by the manufacturer thereof
- 219.7(423) Prefabricated structures
- 219.8(423) Types of construction contracts
- 219.9(423) Machinery and equipment sales contracts with installation
- 219.10(423) Construction contracts with equipment sales (mixed contracts)
- 219.11(423) Distinguishing machinery and equipment from real property
- 219.12(423) Tangible personal property which becomes structures
- 219.13(423) Tax on enumerated services
- 219.14(423) Transportation cost
- 219.15(423) Start-up charges
- 219.16(423) Liability of subcontractors
- 219.17(423) Liability of sponsors
- 219.18(423) Withholding
- 219.19(423) Resale certificates
- 219.20(423) Reporting for use tax
- 219.21(423) Exempt sale, lease, or rental of equipment used by contractors, subcontractors, or builders

CHAPTERS 220 to 222

Reserved

CHAPTER 223

SOURCING OF TAXABLE SERVICES, TANGIBLE PERSONAL PROPERTY, AND SPECIFIED DIGITAL PRODUCTS

- 223.1(423) Definitions
- 223.2(423) General sourcing rules for taxable services
- 223.3(423) First use of services performed on tangible personal property
- 223.4(423) Sourcing rules for personal care services
- 223.5(423) Sourcing of tickets or admissions to places of amusement, fairs, and athletic events
- 223.6(423) Sourcing rules for tangible personal property and specified digital products

CHAPTER 224

TELECOMMUNICATION SERVICES

- 224.1(423) Taxable telecommunication service and ancillary service
- 224.2(423) Definitions
- 224.3(423) Imposition of tax
- 224.4(423) Exempt from the tax

- 224.5(423) Bundled transactions in telecommunication service
- 224.6(423) Sourcing telecommunication service
- 224.7(423) General billing issues
- 224.8(34A) Prepaid wireless 911 surcharge
- 224.9(423) State sales tax exemption for central office equipment and transmission equipment

CHAPTER 225

RESALE AND PROCESSING EXEMPTIONS PRIMARILY OF BENEFIT TO RETAILERS

- 225.1(423) Paper or plastic plates, cups, and dishes, paper napkins, wooden or plastic spoons and forks, and straws
- 225.2(423) A service purchased for resale
- 225.3(423) Services used in the repair or reconditioning of certain tangible personal property
- 225.4(423) Tangible personal property purchased by a person engaged in the performance of a service
- 225.5(423) Maintenance or repair of fabric or clothing
- 225.6(423) The sales price from the leasing of all tangible personal property subject to tax
- 225.7(423) Certain inputs used in taxable vehicle wash and wax services
- 225.8(423) Exemption for commercial enterprises

CHAPTER 226

AGRICULTURAL RULES

- 226.1(423) Sale or rental of farm machinery and equipment and items used in agricultural production that are attached to a self-propelled implement of husbandry
- 226.2(423) Packaging material used in agricultural production
- 226.3(423) Irrigation equipment used in agricultural production
- 226.4(423) Sale of a draft horse
- 226.5(423) Veterinary services
- 226.6(423) Commercial fertilizer and agricultural limestone
- 226.7(423) Sales of breeding livestock
- 226.8(423) Domesticated fowl
- 226.9(423) Agricultural health promotion items
- 226.10(423) Drainage tile
- 226.11(423) Materials used for seed inoculations
- 226.12(423) Fuel used in agricultural production
- 226.13(423) Water used in agricultural production
- 226.14(423) Bedding for agricultural livestock or fowl
- 226.15(423) Sales by farmers
- 226.16(423) Sales of livestock (including domesticated fowl) feeds
- 226.17(423) Farm machinery, equipment, and replacement parts used in livestock or dairy production
- 226.18(423) Machinery, equipment, and replacement parts used in the production of flowering, ornamental, and vegetable plants
- 226.19(423) Nonexclusive lists
- 226.20(423) Grain bins

CHAPTERS 227 to 229

Reserved

CHAPTER 230
EXEMPTIONS PRIMARILY BENEFITING MANUFACTURERS AND
OTHER PERSONS ENGAGED IN PROCESSING

- 230.1 Reserved
- 230.2(423) Carbon dioxide in a liquid, solid, or gaseous form, electricity, steam, and taxable services used in processing
- 230.3(423) Services used in processing
- 230.4(423) Chemicals, solvents, sorbents, or reagents used in processing
- 230.5(423) Exempt sales of gases used in the manufacturing process
- 230.6(423) Sale of electricity to water companies
- 230.7(423) Wind energy conversion property
- 230.8(423) Exempt sales or rentals of core making and mold making equipment, and sand handling equipment
- 230.9(423) Chemical compounds used to treat water
- 230.10(423) Exclusive web search portal business and its exemption
- 230.11(423) Web search portal business and its exemption
- 230.12(423) Large data center business exemption
- 230.13(423) Data center business sales and use tax refunds
- 230.14(423) Exemption for the sale of computers, machinery, equipment, replacement parts, supplies, and materials used to construct or self-construct computers, machinery, equipment, replacement parts, and supplies used for certain manufacturing purposes if the sale occurs on or after July 1, 2016
- 230.15(423) Exemption for the sale of property directly and primarily used in processing by a manufacturer if the sale occurs on or after July 1, 2016
- 230.16(423) Exemption for the sale of property directly and primarily used by a manufacturer to maintain integrity or unique environmental conditions if the sale occurs on or after July 1, 2016
- 230.17(423) Exemption for the sale of property directly and primarily used in research and development of new products or processes of processing if the sale occurs on or after July 1, 2016
- 230.18(423) Exemption for the sale of computers used in processing or storage of data or information by an insurance company, financial institution, or commercial enterprise if the sale occurs on or after July 1, 2016
- 230.19(423) Exemption for the sale of property directly and primarily used in recycling or reprocessing of waste products if the sale occurs on or after July 1, 2016
- 230.20(423) Exemption for the sale of pollution-control equipment used by a manufacturer if the sale occurs on or after July 1, 2016
- 230.21(423) Exemption for the sale of fuel or electricity used in exempt property if the sale occurs on or after July 1, 2016
- 230.22(423) Exemption for the sale of services for designing or installing new industrial machinery or equipment if the sale occurs on or after July 1, 2016

CHAPTER 231
EXEMPTIONS PRIMARILY OF BENEFIT TO CONSUMERS

- 231.1(423) Newspapers, free newspapers and shoppers' guides
- 231.2(423) Motor fuel, special fuel, aviation fuels and gasoline
- 231.3(423) Sales of food and food ingredients
- 231.4(423) Sales of candy
- 231.5(423) Sales of prepared food
- 231.6(423) Prescription drugs, medical devices, oxygen, and insulin
- 231.7(423) Exempt sales of other medical devices which are not prosthetic devices
- 231.8(423) Prosthetic devices, durable medical equipment, and mobility enhancing equipment

231.9(423)	Raffles
231.10(423)	Exempt sales of prizes
231.11(423)	Modular homes
231.12(423)	Access to on-line computer service
231.13(423)	Sale or rental of information services
231.14(423)	Exclusion from tax for property delivered by certain media
231.15(423)	Exempt sales of clothing and footwear during two-day period in August
231.16(423)	State sales tax phase-out on energies

CHAPTERS 232 to 234

Reserved

CHAPTER 235

REBATE OF IOWA SALES TAX PAID

235.1(423)	Sanctioned automobile racetrack facilities
235.2(423)	Baseball and softball complex sales tax rebate
235.3(423)	Raceway facility sales tax rebate

CHAPTER 236

Reserved

CHAPTER 237

REINVESTMENT DISTRICTS PROGRAM

237.1(15J)	Purpose
237.2(15J)	Definitions
237.3(15J)	New state tax revenue calculations
237.4(15J)	State reinvestment district fund
237.5(15J)	Reinvestment project fund
237.6(15J)	End of deposits—district dissolution

CHAPTER 238

FLOOD MITIGATION PROGRAM

238.1(418)	Flood mitigation program
238.2(418)	Definitions
238.3(418)	Sales tax increment calculation
238.4(418)	Sales tax increment fund

CHAPTER 239

LOCAL OPTION SALES TAX URBAN RENEWAL PROJECTS

239.1(423B)	Urban renewal project
239.2(423B)	Definitions
239.3(423B)	Establishing sales and revenue growth
239.4(423B)	Requirements for cities adopting an ordinance
239.5(423B)	Identification of retail establishments
239.6(423B)	Calculation of base year taxable sales amount
239.7(423B)	Determination of tax growth increment amount
239.8(423B)	Distribution of tax base and growth increment amounts
239.9(423B)	Examples
239.10(423B)	Ordinance term

CHAPTER 240
RULES NECESSARY TO IMPLEMENT THE STREAMLINED SALES
AND USE TAX AGREEMENT

- 240.1(423) Allowing use of the lowest tax rate within a database area and use of the tax rate for a five-digit area when a nine-digit zip code cannot be used
- 240.2(423) Permissible categories of exemptions
- 240.3(423) Requirement of uniformity in the filing of returns and remittance of funds
- 240.4(423) Allocation of bad debts
- 240.5(423) Purchaser refund procedures
- 240.6(423) Relief from liability for reliance on taxability matrix
- 240.7(423) Effective dates of taxation rate increases or decreases when certain services are furnished
- 240.8(423) Prospective application of defining “retail sale” to include a lease or rental

CHAPTER 241
EXCISE TAXES NOT GOVERNED BY THE STREAMLINED SALES AND
USE TAX AGREEMENT

- 241.1(423A,423D) Purpose of the chapter
- 241.2(423A,423D) Director’s administration

DIVISION I
STATE-IMPOSED HOTEL AND MOTEL TAX

- 241.3 to 241.5 Reserved

DIVISION II
EXCISE TAX ON SPECIFIC CONSTRUCTION MACHINERY AND EQUIPMENT

- 241.6(423D) Definitions
- 241.7(423D) Tax imposed
- 241.8(423D) Exemption

CHAPTER 242
FACILITATING BUSINESS RAPID RESPONSE TO STATE-DECLARED DISASTERS

- 242.1(29C) Purpose
- 242.2(29C) Definitions
- 242.3(29C) Disaster or emergency-related work

CHAPTERS 243 to 249
Reserved

CHAPTER 250
SALES AND USE TAX REFUND FOR BIODIESEL PRODUCTION

- 250.1(423) Biodiesel production refund

CHAPTER 7
PRACTICE AND PROCEDURE BEFORE THE DEPARTMENT OF REVENUE
[Prior to 12/17/86, Revenue Department[730]]

701—7.1(421,17A) Applicability and scope of rules. These rules pertain to practice and procedure and are designed to implement the requirements of the Act and aid in the effective and efficient administration and enforcement of the tax laws of this state and other activities of the department. These rules shall govern the practice, procedure and conduct of the informal proceedings, contested case proceedings, licensing, rule making, and declaratory orders involving taxation and other areas within the department's jurisdiction, which includes the following:

1. Sales and use tax—Iowa Code chapter 423;
2. Individual and fiduciary income tax—Iowa Code sections 422.4 to 422.31 and 422.110 to 422.112;
3. Franchise tax—Iowa Code sections 422.60 to 422.66;
4. Corporate income tax—Iowa Code sections 422.32 to 422.41 and 422.110 to 422.112;
5. Withholding tax—Iowa Code sections 422.16 and 422.17;
6. Estimated tax—Iowa Code sections 422.16, 422.17 and 422.85 to 422.92;
7. Motor fuel tax—Iowa Code chapter 452A;
8. Property tax—Iowa Code chapters 421, 425 to 428A and 433 to 441;
9. Cigarette and tobacco tax—Iowa Code chapters 421B and 453A;
10. Inheritance tax and qualified use inheritance tax—Iowa Code chapters 450 and 450B;
11. Local option taxes—Iowa Code chapter 423B;
12. Hotel and motel tax—Iowa Code chapter 423A;
13. Drug excise tax—Iowa Code chapter 453B;
14. Automobile rental excise tax—Iowa Code chapter 423C;
15. Environmental protection charge—Iowa Code chapter 424;
16. Replacement taxes—Iowa Code chapter 437A;
17. Statewide property tax—Iowa Code chapter 437A;
18. Equipment tax—Iowa Code chapter 423D;
19. Other taxes and activities as may be assigned to the department from time to time; and
20. The taxpayer's bill of rights—Iowa Code section 421.60.

As the purpose of these rules is to facilitate business and advance justice, any rule contained herein, pursuant to statutory authority, may be suspended or waived by the department to prevent undue hardship in any particular instance or to prevent surprise or injustice.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12; ARC 1545C, IAB 7/23/14, effective 8/27/14]

701—7.2(421,17A) Definitions. These definitions apply to this chapter, unless the text otherwise states to the contrary:

“Act” means the Iowa administrative procedure Act.

“Affiliate or subsidiary of an entity dominant in its field of operation” means an entity which is at least 20 percent owned by an entity that is dominant in its field of operation, or by a partner, officer, director, majority stockholder or the equivalent, of an entity dominant in that field of operation.

“Agency” means each board, commission, department, officer, or other administrative office or unit of the state.

“Clerk of the hearings section” means the clerk of the hearings section of the department.

“Contested case” means a proceeding, including licensing, in which the legal rights, duties or privileges of a party are required by constitution or statute to be determined by an agency after an opportunity for an evidentiary hearing. This term also includes any matter defined as a no factual dispute contested case as provided in Iowa Code section 17A.10A.

“Declaratory order” means an order issued pursuant to Iowa Code section 17A.9.

“Department” means the Iowa department of revenue.

“Department of inspections and appeals” means the state department created by Iowa Code chapter 10A.

“Director” means the director of the department or the director’s authorized representative.

“Division of administrative hearings” means the division of the department of inspections and appeals responsible for holding contested case proceedings pursuant to Iowa Code chapter 10A.

“Dominant in its field of operation” means having more than 20 full-time equivalent positions and more than \$1 million in annual gross revenues.

“Entity” means any taxpayer other than an individual or sole proprietorship.

“Intervene” means to file with the department a petition requesting that the petitioner be allowed to intervene in the proceedings for a declaratory order currently under the department’s consideration.

“Issuance” means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

“Last-known address” does not necessarily mean the taxpayer’s actual address but instead means the last address that the taxpayer makes known to the department by tax type. Thus, for instance, receipt by the department of a taxpayer’s change of address from a third person not authorized to act on behalf of the taxpayer (e.g., an employer who had filed a Form W-2 showing a new taxpayer address) is not notice to the department of a change of address of the taxpayer. However, the filing by the taxpayer of a tax return for a year subsequent to the year for which a notice is required would be notification to the department of a change of address, provided a reasonable amount of time is allowed to process such information and transfer it to the department’s central computer system. Taxpayers should be aware of their need to update their address with the department in order to receive refunds of tax and notices of assessments and denial of a claim for refund. When such a notice is sent to a “taxpayer’s last-known address,” the notice is legally effective even if the taxpayer never receives it.

“License” means the whole or a part of any permit, certificate, approval, registration, charter, or similar form of permission required by statute.

“Licensing” means the department process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

“Motion” has the same meaning as the term is defined in Iowa R. Civ. P. 1.431.

“Party” means each person or agency named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party, including intervenors.

“Person” means any individual; estate; trust; fiduciary; partnership, including limited liability partnership; corporation, including limited liability corporation; association; governmental subdivision; or public or private organization of any character or any other person covered by the Act other than an agency.

“Petition” means application for declaratory order, request to intervene in a declaratory order under consideration, application for initiation of proceedings to adopt, amend or repeal a rule or document filed in licensing.

“Pleadings” means protest, answer, reply or other similar document filed in a contested case proceeding, including contested cases involving no factual dispute.

“Presiding officer” means the person designated to preside over a proceeding involving the department. A presiding officer of a contested case involving the department will be either the director or a qualified administrative law judge appointed, pursuant to Iowa Code chapter 17A, by the division of administrative hearings established pursuant to Iowa Code section 10A.801. In cases in which the department is not a party, at the director’s discretion, the presiding officer may be the director or the director’s designee. The presiding officer of an administrative appeal is the director of the department.

“Proceeding” means informal, formal and contested case proceedings.

“Proposed decision” means the presiding officer’s recommended findings of fact, conclusions of law, decision, and order in a contested case in which the director did not preside.

“Protester” means any person entitled to file a protest which may culminate in a contested case proceeding.

“Provision of law” means the whole or part of the Constitution of the United States of America or the Constitution of the State of Iowa, or of any federal or state statute, court rule, executive order of the governor, or rule of the department.

“Review unit” means the unit composed of department employees designated by the director and of the attorney general’s staff who have been assigned to review protests filed by taxpayers.

“Rule” means a department statement of general applicability that implements, interprets, or prescribes law or policy, or that describes the organization, procedure, or practice requirements of the department. Notwithstanding any other statute, the term includes an executive order or directive of the governor which creates an agency or establishes a program or which transfers a program between agencies established by statute or rule. The term includes the amendment or repeal of an existing rule, but does not include the excluded items set forth in Iowa Code section 17A.2(11).

“Small business” means any entity including, but not limited to, an individual, partnership, corporation, joint venture, association, or cooperative. A small business is not an affiliate of an entity dominant in its field of operation. A small business has either 20 or fewer full-time equivalent positions or less than \$1 million in annual gross revenues in the preceding fiscal year.

“Taxpayer interview” means any in-person contact between an employee of the department and a taxpayer or a taxpayer’s representative which has been initiated by a department employee.

“Taxpayer’s representative” or *“authorized taxpayer’s representative”* means an individual authorized to practice before the department under rule 701—7.6(17A); an individual who has been named as an authorized representative on a fiduciary return of income form filed under Iowa Code section 422.14, or a tax return filed under Iowa Code chapter 450, “Inheritance Tax,” or chapter 450B, “Qualified Inheritance Tax”; or for proceedings before the department, any other individual the taxpayer designates who is named on a valid power of attorney if appearing on behalf of another.

Unless otherwise specifically stated, the terms used in these rules promulgated by the department shall have the meanings defined by the Act.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 0251C, IAB 8/8/12, effective 9/12/12; ARC 1545C, IAB 7/23/14, effective 8/27/14]

701—7.3(17A) Business hours. The principal office of the department in the Hoover State Office Building in Des Moines, Iowa, shall be open between the hours of 8 a.m. and 4:30 p.m. each weekday, except Saturdays, Sundays and legal holidays as prescribed in Iowa Code section 4.1(34), for the purpose of receiving protests, pleadings, petitions, motions, or requests for public information or copies of official documents or for the opportunity to inspect public records.

7.3(1) All documents or papers required to be filed with the department by these rules shall be filed with the designated clerk of the hearings section in the principal office of the department in the Hoover State Office Building, Des Moines, Iowa 50319. Requests for public information or copies of official documents or for the opportunity to inspect public records shall be made in the director’s office at the department’s principal office.

7.3(2) All documents or papers filed with an administrative law judge appointed by the division of administrative hearings to be a presiding officer shall be filed with the Department of Inspections and Appeals, Administrative Hearings Division, Third Floor, Wallace State Office Building, Des Moines, Iowa 50319.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.4(17A) Computation of time, filing of documents. In computing any period of time prescribed or allowed by these rules or by an applicable statute, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday or legal holiday. Legal holidays are prescribed in Iowa Code section 4.1(34).

7.4(1) All documents or papers required to be filed with the department shall be considered as timely filed if they are either received by the department’s principal office or are postmarked for delivery to

the department's principal office within time limits as prescribed by law or by rules or orders of the department.

7.4(2) In all cases where the time for the filing of a protest or the performance of any other act shall be fixed by law, the time so fixed by law shall prevail over the time fixed in these rules.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.5(17A) Form and style of papers. All pleadings, petitions, briefs and motions or other documents filed with the department shall be typewritten, shall have a proper caption, and shall have a signature and copies as herein provided or as specified in some other rule.

7.5(1) Papers shall be typed on only one side of plain white paper. Pleadings, petitions, motions, orders and any other papers allowed or required to be filed by these rules may be on any size paper. Citations should be underscored.

7.5(2) The proper caption shall be placed in full upon the first paper filed.

7.5(3) The signature of the petitioner, party, or authorized representative shall be subscribed in writing to the original of all pleadings, petitions, briefs or motions and shall be an individual's and not a firm's name except that the signature of a corporation shall be the name of the corporation by one of its active officers. The name and mailing address of the party or the party's representative actually signing shall be typed or printed immediately beneath the written signature. The signature shall constitute a certification that the signer has read the document; that to the best of the signer's knowledge, information and belief, every statement contained in the document is true and no such statement is misleading.

a. A taxpayer or the taxpayer's representative using email or other electronic means to submit an income tax return, a sales tax or use tax return, a return for any other tax administered by the department, an application for a sales tax permit or other permit, a deposit form for remitting withholding tax or other taxes administered by the department, or any other document to the department may use an electronic signature or a signature designated by the department in lieu of a handwritten signature. To the extent that a taxpayer or the taxpayer's representative submits to the department a tax return, deposit document, application or other document by email or other electronic means with an electronic signature or signature designated by the department, the taxpayer should include in the record of the document the taxpayer's federal identification number so that the taxpayer's identity is established. For purposes of this rule, "electronic signature" means an electronic sound, symbol, or process attached to or logically associated with a tax return, deposit document, or other document filed with the department and executed or adopted by a person with the intent to sign the return, deposit document, or other document filed with the department. For purposes of this rule, "signature designated by the department" means a symbol or other information that is provided by the department to the taxpayer or the taxpayer's representative and is to serve instead of the handwritten signature of the taxpayer.

b. In a situation where the taxpayer or the taxpayer's representative has submitted a return or other document to the department by email, the taxpayer should include the taxpayer's email address in the record of the document. However, notwithstanding the above information, a taxpayer may not submit a tax return or other document to the department with an electronic signature when a handwritten signature is required with the return or document by federal or state law.

7.5(4) Every pleading (other than protest) or motion or brief shall bear proof of service upon the opposing party as provided by the Iowa Rules of Civil Procedure.

7.5(5) Except as otherwise provided in these rules or ordered by the department, an original copy only of every pleading, brief, motion or petition shall be filed.

7.5(6) All copies shall be clear and legible but may be on any weight of paper.

7.5(7) Upon motion of an opposing party or on its own motion, the department may, in its discretion, if a person or party has failed to comply with this rule, require such person or party to follow the

provisions of this rule and may point out the defects and details needed to comply with the rule prior to the filing of the rule.

This rule is intended to implement Iowa Code chapters 17A and 554D and section 421.17.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.6(17A) Persons authorized to represent themselves or others. Due to the complex questions involved and the technical aspects of taxation, persons are encouraged to seek the aid, advice, assistance and counsel of practicing attorneys and certified public accountants.

7.6(1) The right to represent one's self or others in connection with any proceeding before the department or administrative hearings division shall be limited to the following classes of persons:

- a. Taxpayers who are natural persons representing themselves;
- b. Attorneys duly qualified and entitled to practice in the courts of the state of Iowa;
- c. Attorneys who are entitled to practice before the highest court of record of any other state and who have complied with Iowa Ct. R. 31.14;
- d. Accountants who are authorized, permitted, or licensed under Iowa Code chapter 542;
- e. Duly authorized directors or officers of corporations representing the corporation of which they are respectively a director or officer, excluding attorneys who are acting in the capacity of a director or officer of a corporation and who have not met the requirements of paragraph 7.6(1) "c" above;
- f. Partners representing their partnership;
- g. Fiduciaries;
- h. Government officials authorized by law; and
- i. Enrolled agents, currently enrolled under 31 CFR §10.6 for practice before the Internal Revenue Service, representing a taxpayer in proceedings under division II of Iowa Code chapter 422.

7.6(2) No person who has served as an official or employee of the department shall within a period of two years after the termination of such service or employment appear before the department or receive compensation for any services rendered on behalf of any person, firm, corporation, or association in relation to any case, proceeding, or application with respect to which the person was directly concerned and in which the person personally participated during the period of service or employment.

7.6(3) Any person appearing in any proceeding involving the department, regardless of whether the department is a party, must have on file with the department a valid Iowa power of attorney.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.7(17A) Resolution of tax liability. Unless a proper protest has been filed as provided hereinafter, persons interested in any tax liability, refund claim, licensing or any other tax matters shall discuss the resolution of such matters with appropriate personnel.

In the event that a proper protest has been filed as provided hereinafter, the appropriate department personnel, when authorized by the review unit, shall have the authority to discuss the resolution of any matter in the protest either with the protester or the protester's representative. The appropriate personnel shall report their activities in this regard to the review unit, and the unit shall be authorized to approve or reject any recommendations made by the appropriate personnel to resolve a protest.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.8(17A) Protest. Any person wishing to contest an assessment, denial of refund claim, or any other department action, except licensing, which may culminate in a contested case proceeding shall file a protest, in writing, with the department within the time prescribed by the applicable statute or rule for filing notice of application to the director for a hearing. The protest must either be delivered to the department by electronic means or by United States Postal Service or a common carrier, by ordinary, certified, or registered mail, directed to the attention of the clerk of the hearings section at P.O. Box 14457, Des Moines, Iowa 50306, or be personally delivered to the clerk of the hearings section or served on the clerk of the hearings section by personal service during business hours. For the purpose of mailing, a protest is considered filed on the date of the postmark. If a postmark date is not present on the mailed

article, then the date of receipt of protest will be considered the date of mailing. Any document, including a protest, is considered filed on the date personal service or personal delivery to the office of the clerk of the hearings section for the department is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

7.8(1) The period for appealing department action relating to refund claims is the same statutory period as that for contesting an assessment. Failure to timely file a written protest will be construed as a waiver of opposition to the matter involved unless, on the director's own motion, pursuant to statutory authority, the powers of abatement or settlement are exercised. The review unit created within the department by the director to review protests as provided in rule 701—7.11(17A) may seek dismissal of protests which are not in the proper form as provided by this rule. See subrule 7.11(2) for dismissals.

7.8(2) If the department has not granted or denied a filed refund claim within six months of the filing of the claim, the refund claimant may file a protest. Even though a protest is so filed, the department is entitled to examine and inspect the refund claimant's records to verify the refund claim.

7.8(3) Notwithstanding the above, the taxpayer who fails to timely protest an assessment may contest the assessment by paying the whole assessed tax, interest, and penalty and by filing a refund claim within the time period provided by law for filing such claim. However, in the event that such assessment involves divisible taxes which are not timely protested, namely, an assessment which is divisible into a tax on each transaction or event, the taxpayer may contest the assessment by paying a portion of the assessment and filing a refund claim within the time period provided by law. In this latter instance, the portion paid must represent any undisputed portion of the assessment and must also represent the liability on a transaction or event for which, if the taxpayer is successful in contesting the portion paid, the unpaid portion of the assessment would be canceled. *Flora v. United States*, 362 U.S. 145, 4 L.Ed. 2d 623, 80 S.Ct.630 (1960); *Higginbotham v. United States*, 556 F.2d 1173 (4th Cir. 1977); *Steele v. United States*, 280 F.2d 89 (8th Cir. 1960); *Stern v. United States*, 563 F. Supp. 484 (D. Nev. 1983); *Drake v. United States*, 355 F. Supp. 710 (E.D. Mo. 1973). Any such protest filed is limited to the issues covered by the amounts paid for which a refund was requested and denied by the department. Thereafter, if the department does not grant or deny the refund within six months of the filing of the refund claim or if the department denies the refund, the taxpayer may file a protest as authorized by this rule.

7.8(4) All of the taxes administered and collected by the department can be divisible taxes, except individual income tax, fiduciary income tax, corporation income tax, franchise tax, and statewide property tax. The following noninclusive examples illustrate the application of the divisible tax concept.

EXAMPLE A. As a responsible party, X is assessed withholding income taxes, penalty and interest on eight employees. X fails to timely protest the assessment. X contends that X is not a responsible party. If X is a responsible party, X is required to make monthly deposits of the withholding taxes. In this situation, the withholding taxes are divisible. Therefore, X may pay an amount of tax, penalty and interest attributable to one employee for one month and file a refund claim within the time period provided by law since, if X is successful on the refund claim, the remaining unpaid portion of the assessment would be canceled.

EXAMPLE B. Y is assessed sales tax, interest, and penalty for electricity purchased and used to power a piece of machinery in Y's manufacturing plant. Y fails to timely protest the assessment. Y was billed monthly for electricity by the power company to which Y had given an exemption certificate. Y contends that the particular piece of machinery is used directly in processing tangible personal property for sale and that, therefore, all of the electricity is exempt from sales tax. In this situation, the sales tax is divisible. Therefore, Y may pay an amount of tax, penalty and interest attributable to one month's electrical usage in that machinery and file a refund claim within the time period provided by law since, if Y is successful on the refund claim, the remaining unpaid portion of the assessment would be canceled.

7.8(5) The protest shall be brought by and in the name of the interested or affected person or by and in the full descriptive name of the fiduciary legally entitled to institute a proceeding on behalf of the person or by an intervenor in contested case proceedings. In the event of a variance in the name set forth in the protest and the correct name, a statement of the reason for the discrepancy shall be set forth in the protest.

7.8(6) The protest shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	
(state taxpayer's name and address and	*	PROTEST
designate type of proceeding, e.g.,	*	Docket No. _____
income tax refund claim)	*	(filled in by Department)

7.8(7) The protest shall substantially state in separate numbered paragraphs the following:

- a. Proper allegations showing:
 - (1) Date of department action, such as the assessment notice, refund denial, etc.;
 - (2) Whether the protester failed to timely appeal the assessment and, if so, the date of payment and the date of filing of the refund claim;
 - (3) Whether the protest involves the appeal of a refund claim after six months from the date of filing the refund claim because the department failed to deny the claim;
 - (4) Copies of the documented department action, such as the assessment notice, refund claim, and refund denial letter;
 - (5) Other items that the protester wishes to bring to the attention of the department; and
 - (6) A request for attorney fees, if applicable.
- b. The type of tax, the taxable period or periods involved and the amount in controversy.
- c. Each error alleged to have been committed, listed in a separate paragraph. For each error listed, an explanation of the error and all relevant facts related to the error shall be provided.
- d. Reference to any particular statute or statutes and any rule or rules involved, if known.
- e. Description of records or documents that were not available or were not presented to department personnel prior to the filing of the protest, if any. Copies of any records or documents that were not previously presented to the department shall be provided.
- f. Any other matters deemed relevant and not covered in the above paragraphs.
- g. The desire of the protester to waive informal or contested case proceedings if waiver is desired. Unless the protester so indicates a waiver, informal procedures will be initiated.
- h. A statement setting forth the relief sought by the protester.
- i. The signature of the protester or that of the protester's representative, the addresses of the protester and of the protester's representative, and the telephone number of the protester or the protester's representative. A copy of the power of attorney for the protester's representative shall be attached.

7.8(8) An original and two copies of the protest shall be filed with the clerk of the hearings section. Upon receipt of the protest, the clerk of the hearings section shall register receipt of the protest, docket the protest, and assign a number to the case. The assigned number shall be placed on all subsequent pleadings filed in the case.

7.8(9) The protester may amend the protest at any time prior to the commencement of the evidentiary hearing. The department may request that the protester amend the protest for purposes of clarification.

7.8(10) Upon the filing of an answer or if a demand for contested case is made by the protester, the clerk of the hearings section will transfer the protest file to the division of administrative hearings within 30 days of the date of the filing of the answer or the demand for contested case, unless the director determines not to transfer the case. If a party objects to a determination under rule 701—7.17(17A), the transfer, if any, would be made after the director makes a ruling on the objection.

7.8(11) Denial of renewal of vehicle registration or denial of issuance or renewal, or suspension, of a driver's license.

- a. A person who has had an application for renewal of vehicle registration denied, has been denied the issuance of a driver's license or the renewal of a driver's license, or has had a driver's license

suspended may file a protest with the clerk of the hearings section if the denial of the issuance or renewal or the suspension is because the person owes delinquent taxes.

b. The issues raised in a protest by the person, which are limited to a mistake of fact, may include but are not limited to:

- (1) The person has the same name as the obligor but is not the correct obligor;
- (2) The amount in question has been paid; or
- (3) The person has made arrangements with the department to pay the amount.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 0251C, IAB 8/8/12, effective 9/12/12; ARC 1303C, IAB 2/5/14, effective 3/12/14; ARC 2657C, IAB 8/3/16, effective 9/7/16]

701—7.9(17A) Identifying details.

7.9(1) Any person may file a motion to delete identifying details concerning the person from any document relating to any proceeding as defined in rule 701—7.2(421,17A) prior to disclosure to members of the public. Such a motion must be filed with the clerk of the hearings section if the motion is filed prior to the commencement of a contested case, which is before the notice for hearing is issued. If the motion is filed during a contested case proceeding pending before an administrative law judge and before the administrative law judge has entered a proposed decision on the case or has entered a closing order, the motion must be filed with and ruled upon by the administrative law judge. Otherwise, the motion must be filed with the clerk of the hearings section and ruled upon by the director. The motion shall be filed simultaneously with the presentation of the privacy or trade secret information under circumstances whereby the information may be disclosed to the public and before the issuance of any opinion, order or decision.

7.9(2) If the motion concerns information which is not a part of a contested case, the motion shall be in the form of a request to delete identifying details; if part of a contested case, the motion shall be in the form of a motion to delete identifying details. All motions to delete identifying details shall conform to subrule 7.17(5).

a. The motion shall contain the following:

(1) The name of the person requesting deletion and the docket number of the proceeding, if applicable;

(2) The legal basis for the motion for deletion, which is either that release of the material would be a clearly unwarranted invasion of personal privacy or the material is a trade secret. A corporation may not claim an unwarranted invasion of privacy;

(3) A precise description of the document, report, or other material in the possession of the department from which the deletion is sought and a precise description of the information to be deleted. If deletion is sought from more than one document, each document and the materials sought to be deleted from it shall be listed in separate paragraphs. Also contained in each separate paragraph shall be a statement of the legal basis for the deletion requested in that paragraph, which is that release of the material sought to be deleted is a clearly unwarranted invasion of privacy or the material is a trade secret and the material serves no public purpose.

b. An affidavit in support of deletion must accompany each motion. The affidavit must be sworn to by a person familiar with the facts asserted within it and shall contain a clear and concise explanation of the facts justifying deletion, not merely the legal basis for deletion or conclusionary allegations.

c. All affidavits shall contain a general and truthful statement that the information sought to be deleted is not available to the public from any source or combination of sources, direct or indirect, and a general statement that the release would serve no public purpose.

d. The burden of showing that deletion is justified shall be on the movant. The burden is not carried by mere conclusionary statements or allegations, for example, that the release of the material would be a clearly unwarranted invasion of personal privacy or that the material is a trade secret.

e. That the matter sought to be deleted is part of the pleadings, motions, evidence, and the record in a contested case proceeding otherwise open for public inspection and that the matter would otherwise constitute confidential tax information shall not be grounds for deletion (1992 Op. IA Att’y Gen. 1).

f. The ruling on the motion shall be strictly limited to the facts and legal bases presented by the movant, and the ruling shall not be based upon any facts or legal bases not presented by the movant.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.10(17A) Docket. The clerk of the hearings section shall maintain a docket of all proceedings, and each of the proceedings shall be assigned a number. Every matter coming within the purview of these rules shall be assigned a docket number which shall be the official number for the purposes of identification. Upon receipt of a protest, a petition for declaratory order or a petition to initiate rule-making proceedings, the proceeding will be docketed and assigned a number, and the parties notified thereof. The number shall be placed by the parties on all papers thereafter filed in the proceeding. After the transfer of a case to the division of administrative hearings for contested case proceedings, that division may assign a docket number to the case and, in that event, the docket number shall be placed by the parties on all papers thereafter filed in the proceeding.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.11(17A) Informal procedures and dismissals of protests.

7.11(1) Informal procedures. Persons are encouraged to utilize the informal procedures provided herein so that a settlement may be reached between the parties without the necessity of initiating contested case proceedings. Therefore, unless the protester indicates a desire to waive the informal procedures in the protest or the department waives informal procedures upon notification to the protester, such informal procedures will be initiated as herein provided upon the filing of a proper protest.

a. Review unit. A review unit is created within the department and, subject to the control of the director, the unit will:

- (1) Review and evaluate the validity of all protests made by taxpayers from the department action.
- (2) Determine the correct amount of tax owing or refund due.
- (3) Determine the best method of resolving the dispute between the protester and the department.
- (4) Take further action regarding the protest, including any additions and deletions to the audit, as may be warranted by the circumstances to resolve the protest, including a request for an informal conference.

(5) Determine whether the protest complies with rule 701—7.8(17A) and request any amendments to the protest or additional information.

b. The review unit may concede any items contained in the protest which it determines should not be controverted by the department. If the protester has not waived informal procedures, the review unit may request that the protester and the protester's representative, if any, attend an informal conference with the review unit to explore the possibility of reaching a settlement without the necessity of initiating contested case proceedings or of narrowing the issues presented in the protest if no settlement can be made. The review unit may request clarification of the issues from the protester or further information from the protester or third persons.

c. Findings dealing with the issues raised in the protest may be issued unless the issues may be more expeditiously determined in another manner or it is determined that findings are unnecessary. The protester will be notified of the decision on the issues in controversy.

d. Nothing herein will prevent the review unit and the protester from mutually agreeing on the manner in which the protest will be informally reviewed.

e. Settlements. If a settlement is reached during informal procedures, the clerk of the hearings section must be notified. A closing order stating that a settlement was reached by the parties and that the case is terminated shall be issued by the director and served upon all parties.

7.11(2) Dismissal of protests.

a. Whether informal procedures have been waived or not, the failure of the protester to timely file a protest or to pursue the protest may be grounds for dismissal of the protest by the director or the director's designee. If the protest is so dismissed, the protester may file an application for reinstatement of the protest for good cause as provided in paragraph 7.11(2) "c." Such application must be filed within

30 days of the date of the dismissal notice. Thereafter, the procedure in paragraph 7.11(2) “c” should be followed. If informal procedures have not been waived, the failure of the protester to present evidence or information requested by the review unit shall constitute grounds for the director or the director’s designee to dismiss the protest. For purposes of this subrule, an evasive or incomplete response will be treated as a failure to present evidence or information. The failure of the protester to file a protest in the format required by rule 701—7.8(17A) may be grounds for dismissal of the protest by the director or the director’s designee.

b. If the department seeks to have the protest dismissed, the review unit shall file a motion to dismiss with the clerk of the hearings section and serve a copy of the motion on the protester. The protester may file a resistance to the motion within 20 days of the date of service of the motion. If no resistance is so filed, the director or the director’s designee shall immediately enter an order dismissing the protest. If a resistance is filed, the review unit has 10 days from the date of the filing of the resistance to decide whether to withdraw its motion and so notify the protester and the clerk of the hearings section. If no such notice is issued by the review unit within the 10-day period, the protest file will be transferred to the division of administrative hearings, which shall issue a notice for a contested case proceeding on the motion as prescribed by rule 701—7.14(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be dismissed. Thereafter, rule 701—7.17(17A) pertaining to contested case proceedings shall apply in such dismissal proceedings.

c. If a motion to dismiss is filed and is unresisted, a protest so dismissed may be reinstated by the director or the director’s designee for good cause as interpreted by the Iowa supreme court in the case of *Purethane, Inc. v. Iowa State Board of Tax Review*, 498 N.W.2d 706 (Iowa 1993) if an application for reinstatement is filed with the clerk of the hearings section within 30 days of the date the protest was dismissed. The application shall set forth all reasons and facts upon which the protester relies in seeking reinstatement of the protest. The review unit shall review the application and notify the protester whether the application is granted or denied. If the review unit denies the application to reinstate the protest, the protester has 30 days from the date the application for reinstatement was denied in which to request, in writing, a formal hearing on the reinstatement. When a written request for formal hearing is received, the protest file will be transferred to the division of administrative hearings, which shall issue a notice as prescribed in rule 701—7.14(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be reinstated. Thereafter, rule 701—7.17(17A) pertaining to contested case proceedings shall apply in such reinstatement proceedings.

d. Once contested case proceedings have been commenced, whether informal proceedings have been waived or not, it shall be grounds for a motion to dismiss that a protester has either failed to diligently pursue the protest or refuses to comply with requests for discovery set forth in rule 701—7.15(17A). Such a motion must be filed with the presiding officer.

e. Notwithstanding other provisions of this subrule, if the director finds that a protest is not timely filed, including a failure within a reasonable time to file a protest in proper form after notice to the protester by the hearings section, the director, without the filing of a motion to dismiss, may dismiss the protest and shall notify the protester that the protest has been dismissed. With respect to a protest so dismissed, thereafter the provisions of paragraph 7.11(2) “c” shall apply.

This rule is intended to implement Iowa Code section 17A.10.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.12(17A) Answer. The department may, in lieu of findings, file an answer to the protest. When findings are issued, the department will file an answer within 30 days of receipt of written notification from the protester stating disagreement with the findings. The answer shall be filed with the clerk of the hearings section.

7.12(1) In the event that the protester does not so respond in writing to the findings issued on matters covered by paragraph 7.11(1) “c” within 30 days after being notified, the department may seek dismissal of the protest pursuant to subrule 7.11(2).

7.12(2) The answer of the department shall be drawn in a manner as provided by the Iowa Rules of Civil Procedure for answers filed in Iowa district courts.

7.12(3) Each paragraph contained in the answer shall be numbered or lettered to correspond, where possible, with the paragraphs of the protest. An original copy only of the answer shall be filed with the clerk of the hearings section for the department and shall be signed by the department's counsel or representative.

7.12(4) The department shall forthwith serve a copy of the answer upon the representative of record or, if there is no representative of record, then upon the protester and shall file proof of service with the clerk of the hearings section at the time of filing of the answer. The department may amend its answer at any time prior to the commencement of the evidentiary hearing.

7.12(5) The provisions of rule 701—7.12(17A) shall be considered as a part of the informal procedures since a contested case proceeding, at the time of the filing of the answer, has not yet commenced. However, an answer shall be filed pursuant to this rule whether or not informal procedures have been waived by the protester or the department.

7.12(6) Notwithstanding subrules 7.12(1) through 7.12(5), if a taxpayer makes a written demand for a contested case proceeding, as authorized by rule 701—7.14(17A), after a period of six months from the filing of a proper protest, the department shall file its answer within 30 days after receipt of the demand. If the department fails to file its answer within this 30-day period, interest shall be suspended, if the protest involves an assessment, from the time that the department was required to answer until the date that the department files its answer and, if the protest involves a refund, interest shall accrue on the refund at double the rate from the time the department was required to answer until the date that the department files its answer.

7.12(7) The department's answer may contain a statement setting forth whether the case should be transferred to the division of administrative hearings or the director should retain the case for hearing.

7.12(8) The department's answer should set forth the basis for retention of the case by the director as provided in subrule 7.17(1). If the answer fails to allege that the case should be retained by the director, the case should be transferred to the division of administrative hearings for contested case proceedings, unless the director determines on the director's own motion that the case should be retained by the director.

This rule is intended to implement Iowa Code chapter 17A and section 421.60.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.13(17A) Subpoenas. Prior to the commencement of a contested case, the department shall have the authority to subpoena books, papers, and records and shall have all other subpoena powers conferred upon it by law. Subpoenas in this case shall be issued by the director or the director's designee. Once a contested case is commenced, subpoenas must be issued by the presiding officer.

This rule is intended to implement Iowa Code section 17A.13.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.14(17A) Commencement of contested case proceedings. A demand or request by the protester for the commencement of contested case proceedings must be in writing and filed with the clerk of the hearings section by electronic means, by mail via the United States Postal Service or common carrier by ordinary, certified, or registered mail in care of the clerk of the hearings section, or by personal service on the office of the clerk of the hearings section during business hours. The demand or request is considered filed on the date of the postmark. If the demand or request does not indicate a postmark date, then the date of receipt or the date personal service is made is considered the date of filing. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

7.14(1) At the request of a party or the presiding officer made prior to the issuance of the hearing notice, the presiding officer shall hold a telephone conference with the parties for the purpose of selecting a mutually agreeable hearing date, which date shall be the hearing date contained in the hearing notice. The notice shall be issued within one week after the mutually agreeable hearing date is selected.

7.14(2) Contested case proceedings will be commenced by the presiding officer by delivery of notice by ordinary mail directed to the parties after a demand or request is made (a) by the protester and the filing of the answer, if one is required, which demand or request may include a date to be set for the

hearing, or (b) upon filing of the answer, if a request or demand for contested case proceedings has not been made by the protester. The notice will be given by the presiding officer.

7.14(3) The presiding officer may grant a continuance of the hearing. Any change in the date of the hearing shall be set by the presiding officer. Either party may apply to the presiding officer for a specific date for the hearing. The notice shall include:

- a.* A statement of the time (which shall allow for a reasonable time to conduct discovery), place and nature of the hearing;
- b.* A statement of the legal authority and jurisdiction under which the hearing is held;
- c.* A reference to the particular sections of the statutes and rules involved; and
- d.* A short and plain statement of the matters asserted, including the issues.

7.14(4) After the delivery of the notice commencing the contested case proceedings, the parties may file further pleadings or amendments to pleadings as they desire. However, any pleading or amendment thereto which is filed within seven days prior to the date scheduled for the hearing or filed on the date of the hearing shall constitute good cause for the party adversely affected by the pleading or amendment to seek and obtain a continuance.

This rule is intended to implement Iowa Code section 17A.12.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.15(17A) Discovery. The rules of the supreme court of the state of Iowa applicable in civil proceedings with respect to depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admission shall apply to discovery procedures in contested case proceedings. Disputes concerning discovery shall be resolved by the presiding officer. If necessary a hearing shall be scheduled, with reasonable notice to the parties, and, upon hearing, an appropriate order shall be issued by the presiding officer.

7.15(1) When the department relies on a witness in a contested case, whether or not the witness is a departmental employee, who has made prior statements or reports with respect to the subject matter of the witness' testimony, the department shall, on request, make such statements or reports available to a party for use on cross-examination unless those statements or reports are otherwise expressly exempt from disclosure by constitution or statute. Identifiable departmental records that are relevant to disputed material facts involved in a contested case shall, upon request, promptly be made available to the party unless the requested records are expressly exempt from disclosure by constitution or statute.

7.15(2) Evidence obtained in such discovery may be used in contested case proceedings if that evidence would otherwise be admissible in the contested case proceeding.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.16(17A) Prehearing conference.

7.16(1) Upon the motion of the presiding officer, or upon the written request of a party, the presiding officer shall direct the parties to appear at a specified time and place before the presiding officer for a prehearing conference to consider:

- a.* The possibility or desirability of waiving any provisions of the Act relating to contested case proceedings by written stipulation representing an informed mutual consent;
- b.* The necessity or desirability of setting a new date for hearing;
- c.* The simplification of issues;
- d.* The necessity or desirability of amending the pleadings either for the purpose of clarification, amplification or limitation;
- e.* The possibility of agreeing to the admission of facts, documents or records not controverted, to avoid unnecessary introduction of proof;
- f.* The procedure at the hearing;
- g.* Limiting the number of witnesses;
- h.* The names and identification of witnesses and the facts each party will attempt to prove at the hearing;

- i.* Conduct or schedule of discovery; and
- j.* Such other matters as may aid, expedite or simplify the disposition of the proceeding.

7.16(2) Any action taken at the prehearing conference shall be recorded in an appropriate order, unless the parties enter upon a written stipulation as to such matters or agree to a statement thereof made on the record by the presiding officer.

7.16(3) When an order is issued at the termination of the prehearing conference, a reasonable time shall be allowed for the parties to present objections on the grounds that the order does not fully or correctly embody the agreements at such conference. Thereafter, the terms of the order or modification thereof shall determine the subsequent course of the proceedings relative to matters the order includes, unless modified to prevent manifest injustice.

7.16(4) If either party to the contested case proceeding fails to appear at the prehearing conference, fails to request a continuance, or fails to submit evidence or arguments which the party wishes to be considered in lieu of appearance, the opposing party may move for dismissal. The motion shall be made in accordance with subrule 7.17(5).

This rule is intended to implement Iowa Code section 17A.12.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.17(17A) Contested case proceedings.

7.17(1) *Evidentiary hearing.* Unless the parties to a contested case proceeding have, by written stipulation representing an informed mutual consent, waived the provisions of the Act relating to such proceedings, contested case proceedings shall be initiated and culminate in an evidentiary hearing open to the public.

a. Evidentiary hearings in which the presiding officer is an administrative law judge employed by the division of administrative hearings shall be held at the location designated in the notice of evidentiary hearing. Generally, the location for evidentiary hearings in such cases will be at the principal office of the Department of Inspections and Appeals, Administrative Hearings Division, Third Floor, Wallace State Office Building, Des Moines, Iowa 50319.

b. If the director retains a contested case, the location for the evidentiary hearing will generally be at the main office of the department at the Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50309. However, the department retains the discretion to change the location of the evidentiary hearing if necessary. The location of the evidentiary hearing will be designated in the notice of hearing issued by the director.

7.17(2) *Determination of presiding officer.* If the director retains a contested case for evidentiary hearing and the department is a party, the initial presiding officer will be the director. If the department is not a party to the contested case retained by the director, the presiding officer may be the director or the director's designee. Upon determining that a case will be retained and not transferred to the division of administrative hearings, the director shall issue to the parties written notification of the determination which states the basis for retaining the case for evidentiary hearing.

a. The director may determine to retain a contested case for evidentiary hearing and decision upon the filing by the department of its answer under rule 701—7.12(17A). If the answer failed to allege that the case should be retained by the director and the case was transferred to the division of administrative hearings for contested case proceedings, either party may, within a reasonable time after the issuance of the hearing notice provided in rule 701—7.14(17A), make application to the director to recall and retain the case for hearing and decision. Any such application shall be served upon the assigned administrative law judge or presiding officer.

b. A protester may file a written objection to the director's determination to retain the case for evidentiary hearing and may request that the contested case be heard by an administrative law judge or presiding officer and request a hearing on the objection. Such an objection must be filed with the clerk of the hearings section within 20 days of the notice issued by the director of the director's determination to retain the case. The director may retain the case only upon a finding that one or more of the following apply:

- (1) There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety and welfare;
- (2) A qualified administrative law judge is unavailable to hear the case within a reasonable time;
- (3) The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented;
- (4) The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues;
- (5) The case involves an issue or issues the resolution of which would create important precedent;
- (6) The case involves complex or extraordinary questions of law or fact;
- (7) The case involves issues or questions of law or fact that, based on the director's discretion, should be retained by the director;
- (8) Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal;
- (9) The request was not timely filed;
- (10) The request is not consistent with a specified statute; and
- (11) Assignment of an administrative law judge will result in lengthening the time for issuance of a proposed decision, after the case is submitted, beyond a reasonable time as provided in subrule 7.17(8).

In making this determination, the director shall consider whether the assigned administrative law judge has a current backlog of submitted cases for which decisions have not been issued for one year after submission.

c. The director shall issue a written ruling specifying the grounds for the decision within 20 days after a request for an administrative law judge is filed. If a party objects to the director's determination to retain a case for evidentiary hearing, transfer of the protest file, if any, will be made after the director makes a final determination on the objection. If the ruling is contingent upon the availability of a qualified administrative law judge, the parties shall be notified at least ten days prior to the hearing whether a qualified administrative law judge will be available.

d. If there is no factual conflict or credibility of evidence offered in issue, either party, after the contested case has been heard and a proposed decision is pending with a presiding officer other than the director for at least one year, may make application to the director to transfer the case to the director for decision. In addition, if the aforementioned criteria exist, the director, on the director's own motion, may issue a notice to the parties of the director's intention to transfer the case to the director for decision. The opposing party may file, within 20 days after service of such application or notice by the director, a resistance setting forth in detail why the case should not be transferred. If the director approves the transfer of the case, the director shall issue a final contested case decision. The director or a party may request that the parties be allowed to submit proposed findings of fact and conclusions of law.

e. The director has the right to require that any presiding officer, other than the director, be a licensed attorney in the state of Iowa, unless the contested case only involves licensing. In addition, any presiding officer must possess, upon determination by the director, sufficient technical expertise and experience in the areas of taxation and presiding over proceedings to effectively determine the issues involved in the proceeding.

f. Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the director.

7.17(3) Conduct of proceedings.

a. A proceeding shall be conducted by a presiding officer who shall:

- (1) Open the record and receive appearances;
- (2) Administer oaths and issue subpoenas;
- (3) Enter the notice of hearing into the record;
- (4) Receive testimony and exhibits presented by the parties;
- (5) In the presiding officer's discretion, interrogate witnesses;
- (6) Rule on objections and motions;
- (7) Close the hearing; and
- (8) Issue an order containing findings of fact and conclusions of law.

b. The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the

consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearing. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen. Parties shall be notified at least 30 days in advance of the date and place of the hearing.

c. Evidentiary proceedings shall be oral and open to the public and shall be recorded either by electronic means or by certified shorthand reporters. Parties requesting that the hearing be recorded by certified shorthand reporters shall bear the appropriate costs. The record of the oral proceedings or the transcription thereof shall be filed with and maintained by the department for at least five years from the date of the decision. An opportunity shall be afforded to the parties to respond and present evidence and argument on all issues involved and to be represented by counsel at their own expense. Unless otherwise directed by the presiding officer, evidence will be received in the following order: (1) protester, (2) intervenor (if applicable), (3) department, (4) rebuttal by protester, (5) oral argument by parties (if necessary).

d. If the protester or the department appears without counsel or other representative who can reasonably be expected to be familiar with these rules, the presiding officer shall explain to the parties the rules of practice and procedure and generally conduct a hearing in a less formal manner than that used when the parties have such representatives appearing upon the parties' behalf. It should be the purpose of the presiding officer to assist any party appearing without such representative to the extent necessary to allow the party to fairly present evidence, testimony, and arguments on the issues. The presiding officer shall take whatever steps may be necessary and proper to ensure that all evidence having probative value is presented and that each party is accorded a fair hearing.

e. If the parties have mutually agreed to waive the provisions of the Act in regard to contested case proceedings, the hearing will be conducted in a less formal manner than when an evidentiary hearing is conducted.

f. If a party fails to appear in a contested case proceeding after proper service of notice, the presiding officer may, upon the presiding officer's own motion or upon the motion of the party who has appeared, adjourn the hearing, enter a default decision, or proceed with the hearing and make a decision on the merits in the absence of the party.

g. Contemptuous conduct by any person appearing at a hearing shall be grounds for the person's exclusion from the hearing by the presiding officer.

h. A stipulation by the parties of the issues or a statement of the issues in the notice commencing the contested case cannot be changed by the presiding officer without the consent of the parties. The presiding officer shall not, on the presiding officer's own motion, change or modify the issues agreed upon by the parties. Notwithstanding the provisions of this paragraph, a party, within a reasonable time prior to the hearing, may request that a new issue be addressed in the proceedings, except that the request cannot be made after the parties have stipulated to the issues.

7.17(4) Rules of evidence. In evaluating evidence, the department's experience, technical competence, and specialized knowledge may be utilized.

a. *Oath.* All testimony presented before the presiding officer shall be given under oath, which the presiding officer has authority to administer.

b. *Production of evidence and testimony.* The presiding officer may issue subpoenas to a party on request, as permitted by law, compelling the attendance of witnesses and the production of books, papers, records, or other real evidence.

c. *Subpoena.* When a subpoena is desired after the commencement of a contested case proceeding, the proper party shall indicate to the presiding officer the name of the case, the docket number, and the last-known addresses of the witnesses to be called. If evidence other than oral testimony is required, each item to be produced must be adequately described. When properly prepared by the presiding officer, the subpoena will be returned to the requesting party for service. Service may be made in any manner allowed by law before the hearing date of the case which the witness is required to attend. No costs for serving a subpoena will be allowed if the subpoena is served by any person other than the sheriff. Subpoenas requested for discovery purposes shall be issued by the presiding officer.

d. *Admissibility of evidence.*

(1) Evidence having probative value. Although the presiding officer is not bound to follow the technical common law rules of evidence, a finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Therefore, the presiding officer may admit and give probative effect to evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The presiding officer shall give effect to the rules of privilege recognized by law. Evidence not provided to a requesting party through discovery shall not be admissible at the hearing. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced, substantially any part of the evidence may be required to be submitted in verified written form by the presiding officer.

Objections to evidentiary offers may be made at the hearing, and the presiding officer's ruling thereon shall be noted in the record.

(2) Evidence of a federal determination. Evidence of a federal determination such as a treasury department ruling, regulation or determination letter, a federal court decision or an Internal Revenue Service assessment relating to issues raised in the proceeding shall be admissible, and the protester shall be presumed to have conceded the accuracy of the federal determination unless the protester specifically states wherein it is erroneous.

(3) Copies of evidence. A copy of any book, record, paper or document may be offered directly in evidence in lieu of the original, if the original is not readily available or if there is no objection. Upon request, the parties shall be given an opportunity to compare the copy with the original, if available.

(4) Stipulations. Approval of the presiding officer is not required for stipulations of the parties to be used in contested case proceedings. In the event the parties file a stipulation in the proceedings, the stipulation shall be binding on the parties and the presiding officer.

e. Exhibits.

(1) Identification of exhibits. Exhibits which are offered by protesters and attached to a stipulation or entered in evidence shall be numbered serially, i.e., 1, 2, 3, etc.; whereas, exhibits offered by the department shall be lettered serially, i.e., A, B, C, etc.; and those offered jointly shall be numbered and lettered, i.e., 1-A, 2-B, 3-C, etc.

(2) Disposition of exhibits. After an order has become final, either party desiring the return, at the party's expense, of any exhibit belonging to the party shall make application in writing to the clerk of the hearings section within 30 days suggesting a practical manner of delivery; otherwise, exhibits may be disposed of as the clerk of the hearings section deems advisable.

f. Official notice. The presiding officer may take official notice of all facts of which judicial notice may be taken. Parties shall be notified at the earliest practicable time, either before or during the hearing, or by reference in preliminary reports, preliminary decisions or otherwise, of the facts proposed to be noticed and their source, including any staff memoranda or data. The parties shall be afforded an opportunity to contest such facts prior to the issuance of the decision in the contested case proceeding unless the presiding officer determines as a part of the record or decision that fairness to the parties does not require an opportunity to contest such facts.

g. Evidence outside the record. Except as provided by these rules, the presiding officer shall not consider factual information or evidence in the determination of any proceeding unless the same shall have been offered and made a part of the record in the proceeding.

h. Presentation of evidence and testimony. In any hearing, each party thereto shall have the right to present evidence and testimony of witnesses and to cross-examine any witness who testifies on behalf of an adverse party. A person whose testimony has been submitted in written form shall, if available, also be subject to cross-examination by an adverse party. Opportunity shall be afforded each party for re-direct examination and re-cross-examination and to present evidence and testimony as rebuttal to evidence presented by another party, except that unduly repetitious evidence shall be excluded.

i. Offer of proof. An offer of proof may be made through the witness or by statement of counsel. The party objecting may cross-examine the witness without waiving any objection.

7.17(5) Motions.

a. After commencement of contested case proceedings, appropriate motions may be filed by any party with the presiding officer when facts requiring such motion come to the knowledge of the party. All motions shall state the relief sought and the grounds upon which the motions are based.

b. Motions made prior to a hearing shall be in writing and a copy thereof served on all parties and attorneys of record. Such motions shall be ruled on by the presiding officer. The presiding officer shall rule on the motion by issuing an order. A copy of the order containing the ruling on the motion shall be mailed to the parties and authorized representatives. A motion may be made orally during the course of a hearing; however, the presiding officer may request that the motion be reduced to writing and filed with the presiding officer.

c. To avoid a hearing on a motion, it is advisable to secure the consent of the opposing party prior to filing the motion. If consent of the opposing party to the motion is not obtained, a hearing on the motion may be scheduled and the parties notified. The burden will be on the party filing the motion to show good cause why the motion should be granted.

d. The party making the motion may affix thereto such affidavits as are deemed essential to the disposition of the motion, which shall be served with the motion and to which the opposing party may reply with counter affidavits.

e. Types of motions. Types of motions include, but are not limited to:

(1) Motion for continuance. Motions for continuance should be filed no later than ten days before the scheduled date of the contested case hearing unless the grounds for the motion are first known to the moving party within ten days of the hearing, in which case the motion shall be promptly filed and shall set forth why it could not be filed at least ten days prior to the hearing. Grounds for motion for continuance include, but are not limited to, the unavailability of a party, a party's representative or a witness, the incompleteness of discovery, and the possibility of settlement of the case.

(2) Motion for dismissal.

(3) Motion for summary judgment.

(4) Motion to delete identifying details in the decision.

(5) Motion for default.

(6) Motion to vacate default.

f. Hearing on motions. Motions subsequent to the commencement of a contested case proceeding shall be determined by the presiding officer.

g. Summary judgment procedure. Summary judgment may be obtained under the following conditions and circumstances:

(1) A party may, after a reasonable time to complete discovery, after completion of discovery, or by agreement of the parties, move, with or without supporting affidavits, for a summary judgment in the party's favor upon all or any part of a party's claim or defense.

(2) The motion shall be filed not less than 45 days prior to the date the case is set for hearing, unless otherwise ordered by the presiding officer. Any party resisting the motion shall file within 30 days from the time of service of the motion a resistance; statement of disputed facts, if any; and memorandum of authorities supporting the resistance. If affidavits supporting the resistance are filed, they must be filed with the resistance. The time fixed for hearing or normal submission on the motion shall be not less than 35 days after the filing of the motion, unless another time is ordered by the presiding officer. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

(3) Upon any motion for summary judgment pursuant to this rule, there shall be affixed to the motion a separate, short, and concise statement of the material facts as to which the moving party contends there is no genuine issue to be tried, including specific reference to those parts of the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits which support such contentions and a memorandum of authorities.

(4) Supporting and opposing affidavits shall set forth such facts as would be admissible in evidence and shall show affirmatively that the affiant is competent to testify to the matters stated therein. The presiding officer may permit affidavits to be supplemented or opposed by depositions, answers to

interrogatories, further affidavits, or oral testimony. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the party's pleading, but the party's response must set forth specific facts, by affidavits or as otherwise provided in this rule, showing that there is a genuine issue for hearing. If the party does not so respond, summary judgment, if appropriate, shall be entered against the party.

(5) If, on motion under this rule, judgment is not rendered upon the whole case or for all the relief asked and a hearing is necessary, the presiding officer at the hearing of the motion, by examining the pleadings and the evidence before the presiding officer and by interrogating counsel, shall, if practicable, ascertain what material facts exist without substantial controversy and what material facts are actually, and in good faith, controverted. The presiding officer shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the hearing of the contested case, the facts so specified shall be deemed established, and the hearing shall be conducted accordingly.

(6) Should it appear from the affidavits of a party opposing the motion that the party cannot for reasons stated present, by affidavit, facts essential to justify the party's opposition, the presiding officer may refuse the application for judgment, may order a continuance to permit affidavits to be obtained, may order depositions be taken or discovery be completed, or may make any other order appropriate.

(7) An order on summary judgment that disposes of less than the entire case is appealable to the director at the same time that the proposed order is appealable pursuant to subrule 7.17(8).

7.17(6) Briefs and oral argument.

a. At any time, upon the request of any party or in the presiding officer's discretion, the presiding officer may require the filing of briefs on any of the issues before the presiding officer prior to or at the time of hearing, or at a subsequent time. At the hearing, the parties should be prepared to make oral arguments as to the facts and law at the conclusion of the hearing if the presiding officer so directs.

b. An original copy only of all briefs shall be filed. Filed briefs shall conform to the requirements of rule 701—7.5(17A).

c. If the parties agree on a schedule for submission of briefs, the schedule shall be binding on the parties and the presiding officer except that, for good cause shown, the time may be extended upon application of a party.

7.17(7) Defaults. If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

a. Where appropriate and not contrary to law, any party may move for default against a party who has failed to file a required pleading or has failed to appear after proper service.

b. A default decision or a decision rendered on the merits after a party failed to appear or participate in a contested case proceeding becomes a final department action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided in subrule 7.17(8). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, and such affidavit(s) must be attached to the motion.

c. The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

d. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

e. “Good cause” for purposes of this rule shall have the same meaning as “good cause” as interpreted in the case of *Purethane, Inc. v. Iowa State Board of Tax Review*, 498 N.W.2d 706 (Iowa 1993).

f. A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party as provided in subrule 7.17(13).

g. If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

h. A default decision may award any relief consistent with the request for relief by the party in whose favor the default decision is made and embraced in the contested case issues; but unless the defaulting party has appeared, the relief awarded cannot exceed the relief demanded.

i. A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for a stay.

7.17(8) Orders.

a. At the conclusion of the hearing, the presiding officer, in the presiding officer’s discretion, may request the parties to submit proposed findings of fact and conclusions of law. Upon the request of any party, the presiding officer shall allow the parties an opportunity to submit proposed findings of fact and conclusions of law. In addition to or in lieu of the filing of briefs, upon the request of all of the parties waiving any contrary contested case provisions of law or of these rules, the presiding officer shall allow the parties to submit proposed findings of fact and conclusions of law, and the presiding officer may sign and adopt as the decision or proposed decision one of such proposed findings of fact and conclusions of law without any changes.

b. The decision in a contested case is an order which shall be in writing or stated in the record. The order shall include findings of fact prepared by the person presiding at the hearing, unless the person is unavailable, and based solely on the evidence in the record and on matters officially noticed in the record, and shall include conclusions of law. The findings of fact and conclusions of law shall be separately stated. If a party has submitted proposed findings of fact, the order shall include a ruling upon each proposed finding. Each conclusion of law shall be supported by cited authority or by a reasoned opinion. The decision must include an explanation of why the relevant evidence in the record supports each material finding of fact. If the issue of reasonable litigation costs was held in abeyance pending the outcome of the substantive issues in the contested case and the proposed order decides substantive issues in favor of the protester, the proposed order shall include a notice of time and place for a hearing on the issue of whether reasonable litigation costs shall be awarded and on the issue of the amount of such award, unless the parties agree otherwise. All decisions and orders in a contested case proceeding shall be based solely on the legal bases and arguments presented by the parties. In the event that the presiding officer believes that a legal basis or argument for a decision or order exists, but has not been presented by the parties, the presiding officer shall notify the parties and give them an opportunity to file a brief that addresses such legal basis or argument.

c. When a motion has been made to delete identifying details in an order on the basis of personal privacy or trade secrets, the justification for such deletion or refusal to delete shall be made by the moving party and shall appear in the order.

d. When the director initially presides at a hearing or considers decisions on appeal from or review of a proposed decision by the presiding officer other than the director, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to or review on motion of a second agency within the time provided by statute or rule. When a presiding officer other than the director presides at the hearing, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to or review on motion of the director within 30 days of the date of the order, including Saturdays, Sundays, and legal holidays, or 10 days, excluding Saturdays, Sundays, and legal holidays, for a revocation order pursuant to rule 701—7.23(17A). However, if the contested case proceeding involves a question of an award of reasonable litigation costs, the proposed order on the substantive issues shall not be appealable to or reviewable by the director on the director’s motion until the issuance of a proposed order on the

reasonable litigation costs. If there is no such appeal or review within 30 days or 10 days, whichever is applicable, from the date of the proposed order on reasonable litigation costs, both the proposed order on the substantive issues and the proposed order on the reasonable litigation costs become the final orders of the department for purposes of judicial review or rehearing. On an appeal from, review of, or application for rehearing concerning the presiding officer's order, the director has all the power which the director would initially have had in making the decision; however, the director will consider only those issues or selected issues presented at the hearing before the presiding officer or any issues of fact or law raised independently by the presiding officer, including the propriety of and the authority for raising issues. The parties will be notified of those issues which will be considered by the director.

e. Notwithstanding the provisions of this rule, where a presiding officer other than the director issues an interlocutory decision or ruling which does not dispose of all the issues, except reasonable litigation costs, in the contested case proceeding, the party adversely affected by the interlocutory decision or ruling may apply to the director within 20 days (10 days for a revocation proceeding) of the date of issuance of the interlocutory decision or ruling to grant an appeal in advance of the proposed decision. The application shall be served on the parties and the presiding officer. The party opposing the application shall file any resistance within 15 days of the service of the application unless, for good cause, the director extends the time for such filing. The director, in the exercise of discretion, may grant the application on finding that such interlocutory decision or ruling involves substantial rights and will materially affect the proposed decision and that a determination of its correctness before hearing on the merits will better serve the interests of justice. The order of the director granting the appeal may be on terms setting forth the course of proceedings on appeal, including advancing the appeal for prompt submission, and the order shall stay further proceedings below. The presiding officer, at the request of the director, shall promptly forward to the director all or a portion of the file or record in the contested case proceeding.

f. In the event of an appeal to or review of the proposed order by the director, the administrative hearings division shall be promptly notified of the appeal or review by the director. The administrative hearings division shall, upon such notice, promptly forward the record of the contested case proceeding and all other papers associated with the case to the director.

g. A decision by the director may reverse or modify any finding of fact if a preponderance of the evidence will support a determination to reverse or modify such a finding of fact, or may reverse or modify any conclusion of law that the director finds to be in error.

h. Orders will be issued within a reasonable time after termination of the hearing. Parties shall be promptly notified of each order by delivery to them of a copy of the order by personal service, regular mail, certified mail, return receipt requested, or any other method to which the parties may agree. For example, a copy of the order can be submitted by electronic mail if both parties agree.

i. A cross-appeal may be taken within the 30-day period for taking an appeal to the director or in any event within 5 days after the appeal to the director is taken. If a cross-appeal is taken from a revocation order pursuant to rule 701—7.23(17A), the cross-appeal may be taken within the 10-day period for taking an appeal to the director or in any event within 5 days after the appeal to the director is taken.

j. Upon issuance of a closing order or the proposed decision by a presiding officer other than the director, such presiding officer no longer has jurisdiction over the contested case. Thereafter, any further proceedings associated with or related to the contested case must occur before the director.

7.17(9) Stays.

a. During the pendency of judicial review of the final contested case order of the department, the party seeking judicial review may file with the director an application for a stay. The application shall set forth in detail the reasons why the applicant is entitled to a stay and shall specifically address the following four factors:

- (1) The extent to which the applicant is likely to prevail when the court finally disposes of the matter;
- (2) The extent to which the applicant will suffer irreparable injury if the stay is not granted;

(3) The extent to which the granting of a stay to the applicant will substantially harm the other parties to the proceedings; and

(4) The extent to which the public interest relied on by the department is sufficient to justify the department's actions in the circumstances.

b. The director shall consider and balance the previously mentioned four factors and may consult with department personnel and the department's representatives in the judicial review proceeding. The director shall expeditiously grant or deny the stay.

7.17(10) Expedited cases—when applicable. In case a protest is filed where the case is not of precedential value and the parties desire a prompt resolution of the dispute, the department and the protester may agree to have the case designated as an expedited case.

a. Agreement. The department and the protester shall execute an agreement to have the case treated as an expedited case. In this case, discovery is waived. The provisions of this agreement shall constitute a waiver of the rights set forth in Iowa Code chapter 17A for contested case proceedings. Within 30 days of written notice to the clerk of the hearings section sent by the parties stating that an agreement to expedite the case has been executed, the clerk of the hearings section must transfer the protest file to the division of administrative hearings.

b. Finality of decision. A decision entered in an expedited case proceeding shall not be reviewed by the director or any other court and shall not be treated as a precedent for any other case.

c. Discontinuance of proceedings. Any time prior to a decision's being rendered, the taxpayer or the department may request that expedited case proceedings be discontinued if there are reasonable grounds to believe that the issues in dispute would be of precedential value.

d. Procedure. Upon return of an executed agreement for this procedure, the department shall within 14 days file its answer to the protest. The case shall be docketed for hearing as promptly as the presiding officer can reasonably hear the matter.

7.17(11) Burden of proof. The burden of proof with respect to assessments or denials of refunds in contested case proceedings is as follows:

a. The department must carry the burden of proof by clear and convincing evidence as to the issue of fraud with intent to evade tax.

b. The burden of proof is on the department for any tax periods for which the assessment was not made within six years after the return became due, excluding any extension of time for filing such return, except where the department's assessment is the result of the final disposition of a matter between the taxpayer and the Internal Revenue Service or where the taxpayer and the department signed a waiver of the statute of limitations to assess.

c. The burden of proof is on the department as to any new matter or affirmative defense raised by the department. "New matter" means an adjustment not set forth in the computation of the tax in the assessment or refund denial, as distinguished from a new reason for the assessment or refund denial. "Affirmative defense" is a defense resting on facts not necessary to support the taxpayer's case.

d. In all instances where the burden of proof is not expressly placed upon the department by this subrule, the burden of proof is upon the protester.

7.17(12) Costs.

a. A prevailing taxpayer in a contested case proceeding related to the determination, collection, or refund of a tax, penalty, or interest may be awarded by the department reasonable litigation costs incurred subsequent to the issuance of the notice of assessment or refund denial that are based upon the following:

(1) The reasonable expenses of expert witnesses.

(2) The reasonable costs of studies, reports, and tests.

(3) The reasonable fees of independent attorneys or independent accountants retained by the taxpayer. No such award is authorized for accountants or attorneys who represent themselves or who are employees of the taxpayer.

b. An award for reasonable litigation costs shall not exceed \$25,000 per case.

c. No award shall be made for any portion of the proceeding which has been unreasonably protracted by the taxpayer.

d. For purposes of this subrule, “prevailing taxpayer” means a taxpayer who establishes that the position of the department in the contested case proceeding was not substantially justified and who has substantially prevailed with respect to the amount in controversy, or has substantially prevailed with respect to the most significant issue or set of issues presented. If the position of the department in issuance of the assessment or refund denial was not substantially justified and if the matter is resolved or conceded before the contested case proceeding is commenced, there cannot be an award for reasonable litigation costs.

e. The definition of “prevailing taxpayer” is taken from the definition of “prevailing party” in 26 U.S.C. §7430. Therefore, federal cases determining whether the Internal Revenue Service’s position was substantially justified will be considered in the determination of whether a taxpayer is entitled to an award of reasonable litigation costs to the extent that 26 U.S.C. §7430 is consistent with Iowa Code section 421.60(4).

f. The taxpayer has the burden of establishing the unreasonableness of the department’s position.

g. Once a contested case has commenced, a concession by the department of its position or a settlement of the case either prior to the evidentiary hearing or any order issued does not, per se, either authorize an award of reasonable litigation costs or preclude such award.

h. If the department relied upon information provided or action conducted by federal, state, or local officials or law enforcement agencies with respect to the tax imposed by Iowa Code chapter 453B, an award for reasonable litigation costs shall not be made in a contested case proceeding involving the determination, collection, or refund of that tax.

i. The taxpayer who seeks an award of reasonable litigation costs must specifically request such award in the protest, or the request for award will not be considered.

j. A request for an award of reasonable litigation costs shall be held in abeyance until the concession or settlement of the contested case proceeding, or the issuance of a proposed order in the contested case proceeding, unless the parties agree otherwise.

k. At the hearing held for the purpose of deciding whether an award for reasonable litigation costs should be awarded, consideration shall be given to the following points:

- (1) Whether the department’s position was substantially justified;
- (2) Whether the protester is the prevailing taxpayer;
- (3) The burden is upon the protester to establish how the alleged reasonable litigation costs were incurred. This requires a detailed accounting of the nature of each cost, the amount of each cost, and to whom the cost was paid or owed;
- (4) Whether alleged litigation costs are reasonable or necessary;
- (5) Whether the protester has met the protester’s burden of demonstrating all of these points.

7.17(13) *Interlocutory appeals.*

a. Upon written request of a party or on the director’s own motion, the director may review an interlocutory order of the presiding officer. In determining whether to do so, the director shall weigh the extent to which granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the director at the time of the review of the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

b. Interlocutory appeals do not apply to licensing.

7.17(14) *Consolidation and severance.*

a. Consolidation. The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where:

- (1) The matters at issue involve common parties or common questions of fact or law;
- (2) Consolidation would expedite and simplify consideration of the issues involved; and
- (3) Consolidation would not adversely affect the rights of any of the parties to those proceedings.

b. Severance. The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

c. Since stipulations are encouraged, it is expected and anticipated that the parties proceeding to a hearing will stipulate to evidence to the fullest extent to which complete or qualified agreement can be reached including all material facts that are not, or should not be, fairly in dispute.

d. Without the necessity of proceeding to an evidentiary hearing in a contested case, the parties may agree in writing to informally dispose of the case by stipulation, agreed settlement, or consent order or by another method agreed upon. If such informal disposition is utilized, the parties shall so indicate to the presiding officer that the case has been settled. Upon request, the presiding officer shall issue a closing order to reflect such a disposition. The contested case is terminated upon issuance of a closing order.

e. Unless otherwise precluded by law, the parties in a contested case proceeding may mutually agree to waive any provision under this rule governing contested case proceedings.

This rule is intended to implement Iowa Code sections 17A.12, 17A.14, 17A.15, 421.60 and 452A.68.

[ARC 0251C, IAB 8/8/12, effective 9/12/12; ARC 1303C, IAB 2/5/14, effective 3/12/14; ARC 2657C, IAB 8/3/16, effective 9/7/16]

701—7.18(17A) Interventions. Interventions shall be governed by the Iowa rules of civil procedure.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.19(17A) Record and transcript.

7.19(1) The record in a contested case shall include:

- a.* All pleadings, motions and rulings;
- b.* All evidence received or considered and all other submissions;
- c.* A statement of all matters officially noticed;
- d.* All questions and offers of proof, objections, and rulings thereon;
- e.* All proposed findings and exceptions;
- f.* All orders of the presiding officer; and
- g.* The order of the director on appeal or review.

7.19(2) Oral hearings regarding proceedings on appeal to or considered on motion of the director which are recorded by electronic means shall not be transcribed for the record of such appeal or review unless a party, by written notice, or the director, orally or in writing, requests such transcription. Such a request must be filed with the clerk of the hearings section who will be responsible for making the transcript. A transcription will be made only of that portion of the oral hearing relevant to the appeal or review, if so requested and if no objection is made by any other party to the proceeding or the director. Upon request, the department shall provide a copy of the whole record or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

7.19(3) Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

7.19(4) Upon issuance of a proposed decision which leaves no issues open for further consideration or upon issuance of a closing order, the administrative hearings division shall promptly forward the record of a contested case proceeding to the director. However, the administrative hearings division may keep the tapes of any evidentiary proceeding in case a transcript of the proceeding is required and, if one is required, the administrative hearings division shall make the transcription and promptly forward the tapes and the transcription to the director.

This rule is intended to implement Iowa Code section 17A.12.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.20(17A) Application for rehearing. Any party to a contested case may file an application with the director for a rehearing in the contested case, stating the specific grounds therefor and the relief sought. The application must be filed within 20 days after the final order is issued. See subrule 7.17(8) as to when a proposed order becomes a final order. A copy of such application shall be timely mailed by the applicant to all parties in conformity with rule 701—7.21(17A). The director shall have 20 days

from the filing of the application for rehearing to grant or deny the application. If the application for rehearing is granted, a notice will be served on the parties stating the time and place of the rehearing. An application for rehearing shall be deemed denied if not granted by the director within 20 days after filing.

7.20(1) The application for rehearing shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	
(state taxpayer's name and address and	*	APPLICATION FOR REHEARING
designate type of proceeding, e.g., income tax	*	Docket No. _____
refund claim)	*	
	*	

7.20(2) The application for rehearing shall substantially state in separate numbered paragraphs the following:

- a.* Clear and concise statements of the reasons for requesting a rehearing and each and every error which the party alleges to have been committed during the contested case proceedings;
- b.* Clear and concise statements of all relevant facts upon which the party relies;
- c.* Reference to any particular statute or statutes and any rule or rules involved;
- d.* The signature of the party or that of the party's representative, the address of the party or of the party's representative, and the telephone number of the party or the party's representative.

7.20(3) No applications for rehearing shall be filed with or entertained by an administrative law judge.

This rule is intended to implement Iowa Code section 17A.16.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.21(17A) Service. All papers or documents required by this chapter to be filed with the department or the presiding officer and served upon the opposing party or other person shall be served by ordinary mail unless another rule specifically refers to another method. All notices required by this chapter to be served on parties or persons by the department or presiding officer shall be served by ordinary mail unless another rule specifically refers to another method.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.22(17A) Ex parte communications and disqualification.

7.22(1) Ex parte communication. A party that has knowledge of a prohibited communication by any party or presiding officer should file a copy of the written prohibited communication or a written summary of the prohibited oral communication with the clerk of the hearings section. The clerk of the hearings section will transfer to the presiding officer the filed copy of the prohibited communication.

a. Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the department or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in this rule, prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of

a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record. Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

b. *“Ex parte” communication defined.* Written, oral or other forms of communication are “ex parte” if made without notice and opportunity for all parties to participate.

c. *How to avoid prohibited communications.* To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with this chapter and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone calls including all parties or their representatives.

d. *Joint presiding officers.* Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

e. *Advice to presiding officer.* Persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as the parties are not disqualified from participating in the making of a proposed or final decision under any provision of law and the parties comply with these rules.

f. *Procedural communications.* Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible and shall notify other parties when seeking to continue hearings or other deadlines.

g. *Disclosure of prohibited communications.* A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication, shall be submitted for inclusion in the record under seal by protective order. If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

h. *Disclosure by presiding officer.* Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

i. *Sanction.* The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, suspension, or revocation of the privilege to practice before the department or the administrative hearings division. Violation of ex parte communication prohibitions by department personnel or their representatives shall be reported to the clerk of the hearings section for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

7.22(2) Disqualification of a presiding officer. Request for disqualification of a presiding officer must be filed in the form of a motion supported by an affidavit asserting an appropriate ground for disqualification. A substitute presiding officer may be appointed by the division of administrative hearings if the disqualified presiding officer is an administrative law judge. If the disqualified presiding officer is the director, the governor must appoint a substitute presiding officer.

a. *Grounds for 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, 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 to the case;
 2. Is a lawyer 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.

b. “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 department functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and these rules.

c. Disqualification and the record. In a situation where a presiding officer or other person knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

d. Motion asserting disqualification.

(1) If a party asserts disqualification on any appropriate ground, the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17. The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

(2) If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal and seek a stay as provided under this chapter.

This rule is intended to implement Iowa Code section 17A.17.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.23(17A) Licenses.

7.23(1) *Denial of license; refusal to renew license.*

a. When the department is required by constitution or statute to provide notice and an opportunity for an evidentiary hearing prior to the refusal or denial of a license, a notice, as prescribed in rule 701—7.14(17A), shall be served by the department upon the licensee or applicant. Prior to the refusal or denial of a license, the department shall give 30 days’ written notice to the applicant or licensee in

which to appear at a hearing to show cause why a license should not be refused or denied. In addition to the requirements of rule 701—7.14(17A), the notice shall contain a statement of facts or conduct and the provisions of law which warrant the denial of the license or the refusal to renew a license. If the licensee so desires, the licensee may file a petition as provided in subrule 7.23(3) with the presiding officer within 30 days prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, rule 701—7.17(17A) governing contested case proceedings shall apply.

b. When a licensee has made timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally determined by the department, and in case the application is denied or the terms of the new license limited, until the last date for seeking judicial review of the department’s order or a later date fixed by order of the department or the reviewing court. See rule 481—100.2(99B) regarding gambling license applications.

7.23(2) Revocation of license.

a. The department shall not revoke, suspend, annul or withdraw any license until written notice is served by personal service or restricted certified mail pursuant to rule 701—7.14(17A) within the time prescribed by the applicable statute and the licensee whose license is to be revoked, suspended, annulled, or withdrawn, is given an opportunity to show at an evidentiary hearing conducted pursuant to rule 701—7.17(17A) compliance with all lawful requirements for the retention of the license. However, in the case of the revocation, suspension, annulment, or withdrawal of a sales or use tax permit, written notice will be served pursuant to rule 701—7.14(17A) only if the permit holder requests that this be done following notification, by ordinary mail, of the director’s intent to revoke, suspend, annul, or withdraw the permit. In addition to the requirements of rule 701—7.14(17A), the notice shall contain a statement of facts or conduct and the provisions of law which warrant the revocation, suspension, annulment, or withdrawal of the license. A licensee whose license may be revoked, suspended, annulled, or withdrawn, may file a petition as provided in subrule 7.23(3) with the clerk of the hearings section prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, rule 701—7.17(17A) governing contested case proceedings shall apply.

b. Notwithstanding paragraph 7.23(2) “a,” if the department finds that public health, safety, or welfare imperatively requires emergency action and the department incorporates a finding to that effect in an order to the licensee, summary suspension of a license shall be ordered pending proceedings for revocation as provided herein. These proceedings shall be promptly instituted and determined. When a summary suspension as provided herein is ordered, a notice of the time, place and nature of the evidentiary hearing shall be attached to the order.

7.23(3) Petition. When a person desires to file a petition as provided in subrules 7.23(1) and 7.23(2), the petition to be filed shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	PETITION
(state taxpayer’s name and address, and type of license)	*	Docket No. _____
	*	(filled in by Department)
	*	

The petition shall substantially state in separate numbered paragraphs the following:

- a. The full name and address of the petitioner;
- b. Reference to the type of license and the relevant statutory authority;

- c. Clear, concise and complete statements of all relevant facts showing why petitioner’s license should not be revoked, refused, or denied;
- d. Whether a similar license has previously been issued to or held by petitioner or revoked and if revoked the reasons therefor; and
- e. The signature of the petitioner or petitioner’s representative, the address of petitioner and of the petitioner’s representative, and the telephone number of petitioner or petitioner’s representative.

This rule is intended to implement Iowa Code section 17A.18.
 [ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.24(17A) Declaratory order—in general. Any oral or written advice or opinion rendered to members of the public by department personnel not pursuant to a petition for declaratory order is not binding upon the department. However, department personnel, including field personnel, ordinarily will discuss substantive tax issues with members of the public or their representatives prior to the receipt of a petition for a declaratory order, but such oral or written opinions or advice are not binding on the department. This should not be construed as preventing members of the public or their representatives from inquiring whether the department will issue a declaratory order on a particular question. In these cases, however, the name of the taxpayer shall be disclosed. The department will also discuss questions relating to certain procedural matters such as, for example, submittal of a request for a declaratory order or submittal of a petition to initiate rule-making procedures. Members of the public may, of course, seek oral technical assistance from a departmental employee in regard to the proper preparation of a return or report required to be filed with the department. Such oral advice is advisory only, and the department is not bound to recognize the advice in the examination of the return, report or records.

7.24(1) Petition for declaratory order.

a. Any person may file with the Clerk of the Hearings Section, Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319, a petition seeking a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the department. A petition is deemed filed when it is received by the clerk of the hearings section. The clerk of the hearings section shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the clerk of the hearings section an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Petitioner)	*	PETITION FOR
for a Declaratory Order on (Cite	*	DECLARATORY ORDER
provisions of law involved).	*	Docket No. _____
	*	

- b. The petition must provide the following information:
 - (1) A clear and concise statement of all relevant facts on which the order is requested;
 - (2) A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law;
 - (3) The questions the petitioner wants answered, stated clearly and concisely;
 - (4) The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers;
 - (5) The reasons for requesting the declaratory order and disclosure of the petitioner’s interest in the outcome;
 - (6) A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity;
 - (7) The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition;

- (8) Any request by petitioner for a meeting provided for by this rule; and
- (9) Whether the petitioner is presently under audit by the department.

c. The petition must be dated and signed by the petitioner or the petitioner’s representative. It must also include the name, mailing address, and telephone number of the petitioner and of the petitioner’s representative and a statement indicating the person to whom communications concerning the petition should be directed.

7.24(2) Notice of petition. Within 15 days after receipt of a petition for a declaratory order, the clerk of the hearings section shall give notice of the petition to all persons not served by the petitioner to whom notice is required by any provision of law. The clerk of the hearings section may also give notice to any other persons.

7.24(3) Intervention.

a. Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order, shall be allowed to intervene in a proceeding for a declaratory order.

b. Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the department.

c. A petition for intervention shall be filed with the Clerk of the Hearings Section, Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319. Such a petition is deemed filed when it is received by the clerk of the hearings section. The clerk of the hearings section will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Original	*	PETITION FOR
Petitioner) for a Declaratory Order	*	INTERVENTION
on (Cite provisions of law cited in	*	Docket No. _____
original Petition).	*	

d. The petition for intervention must provide the following information:

- (1) Facts supporting the intervenor’s standing and qualifications for intervention;
- (2) The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers;
- (3) Reasons for requesting intervention and disclosure of the intervenor’s interest in the outcome;
- (4) A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor’s knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity;
- (5) The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented;
- (6) Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding;
- (7) Whether the intervenor is presently under audit by the department; and
- (8) Consent of the intervenor to be bound by the declaratory order.

e. The petition must be dated and signed by the intervenor or the intervenor’s representative. It must also include the name, mailing address, and telephone number of the intervenor and of the intervenor’s representative and a statement indicating the person to whom communications should be directed.

f. For a petition for intervention to be allowed, the petitioner must have consented to be bound by the declaratory order and the petitioner must have standing regarding the issues raised in the petition for declaratory order. The petition for intervention must not correct facts that are in the petition for

declaratory order or raise any additional facts. To have standing, the intervenor must have a legally protectible and tangible interest at stake in the petition for declaratory order under consideration by the director for which the party wishes to petition to intervene. Black's Law Dictionary, Centennial Edition, p. 1405, citing *Guidry v. Roberts*, 331 So. 44, 50 (La.App.). Based on Iowa case law, the department may refuse to entertain a petition from one whose rights will not be invaded or infringed. *Bowers v. Bailey*, 237 Iowa 295, 21 N.W.2d 773 (1946). The department may, by rule, impose a requirement of standing upon those that seek a declaratory order at least to the extent of requiring that they be potentially aggrieved or adversely affected by the department action or failure to act. Arthur Earl Bonfield, "The Iowa Administrative Procedure Act: Background, Construction, Applicability, Public Access to Agency Law, The Rule making Process," 60 Iowa Law Review 731, 812-13 (1975). The department adopts this requirement of standing for those seeking a petition for a declaratory order and those seeking to intervene in a petition for a declaratory order.

g. An association or a representative group is not considered to be an entity qualifying for filing a petition requesting a declaratory order on behalf of all of the association or group members. Each member of an association may not be similarly situated or represented by the factual scenario set forth in such a petition.

h. If a party seeks to have an issue determined by declaratory order, but the facts are different from those in a petition for declaratory order that is currently under consideration by the director, the interested party should not petition as an intervenor in the petition for declaratory order currently under the director's consideration. Instead, the party should file a separate petition for a declaratory order, and the petition should include all of the relevant facts. The director may deny a petition for intervention without denying the underlying petition for declaratory order that is involved.

7.24(4) Briefs. The petitioner or any intervenor may file a brief in support of the position urged. The department may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised in the petition.

7.24(5) Inquiries. Inquiries concerning the status of a declaratory order proceeding may be made to the Policy and Communications Division, Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319.

7.24(6) Service and filing of petitions and other papers.

a. When service required. Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with its filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

b. Filing—when required. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order shall be filed with the Clerk of the Hearings Section, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the department.

c. Method of service, time of filing, and proof of mailing. Method of service, time of filing, and proof of mailing shall be as provided in rules 701—7.8(17A) and 701—7.21(17A).

7.24(7) Department consideration. Upon request by petitioner in the petition, the department may schedule a brief and informal meeting between the original petitioner, all intervenors, and the department, a member of the department, or a member of the staff of the department to discuss the questions raised. The department may solicit comments or information from any person on the questions raised. Also, comments or information on the questions raised may be submitted to the department by any person.

7.24(8) Action on petition.

a. Within 30 days after receipt of a petition for a declaratory order, the director shall take action on the petition.

b. The date of issuance of an order or of a refusal to issue an order is as defined in rule 701—7.2(17A).

7.24(9) Refusal to issue order.

a. The department shall not issue a declaratory order where prohibited by Iowa Code section 17A.9 and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

- (1) The petition does not substantially comply with the required form;
- (2) The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the department to issue an order;
- (3) The department does not have jurisdiction over the questions presented in the petition;
- (4) The questions presented by the petition are also presented in a current rule making, contested case, or other department or judicial proceeding that may definitively resolve them;
- (5) The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter;
- (6) The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order;
- (7) There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances;
- (8) The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct, in an effort to establish the effect of that conduct or to challenge a department decision already made;
- (9) The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner;
- (10) The petitioner requests the department to determine whether a statute is unconstitutional on its face; or
- (11) The petition requests a declaratory order on an issue presently under investigation or audit or in rule-making proceedings or in litigation in a contested case or court proceedings.

b. A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final department action on the petition.

c. Refusal to issue a declaratory order pursuant to this rule does not preclude the filing of a new petition that seeks to eliminate the grounds for the department's refusal to issue an order.

7.24(10) Contents of declaratory order; effective date.

a. In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

b. A declaratory order is effective on the date of issuance.

7.24(11) Copies of orders. A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

7.24(12) Effect of a declaratory order. A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. A declaratory order is binding on the department, the petitioner, and any intervenors. As to all other persons, a declaratory order serves only as precedent and is not binding on the department. The issuance of a declaratory order constitutes final department action on the petition. A declaratory order, once issued, will not be withdrawn at the request of the petitioner.

7.24(13) Prejudice or no consent. The department will not issue a declaratory order that would substantially prejudice the rights of a person who would be a necessary party and who does not consent in writing to the determination of the matter by a declaratory order proceeding.

This rule is intended to implement Iowa Code section 17A.9.

[ARC 0251C, IAB 8/8/12, effective 9/12/12; Editorial change: IAC Supplement 9/23/20]

701—7.25(17A) Department procedure for rule making.

7.25(1) The department hereby adopts and incorporates by reference the following Uniform Rules on Agency Procedure for Rule Making, which may be found on the general assembly's website at www.legis.iowa.gov/DOCS/Rules/Current/UniformRules.pdf and which are printed in the first volume of the Iowa Administrative Code, with the additions, changes, and deletions to those rules listed below:

X.2(17A) Advice on possible rules before notice of proposed rule adoption.

X.4(1) Notice of proposed rule making—contents.

X.4(3) Copies of notices. In addition to the text of this subrule, the department adds that the payment for the subscription and the subscription term is one year.

X.5(17A) Public participation. In addition to the text of this rule, the department adds that written submissions should be submitted to the Administrator of the Policy and Communications Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. Also, any requests for special requirements concerning accessibility are to be made to the Clerk of the Hearings Section, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319; telephone (515)281-3204.

X.6(17A) Regulatory analysis. In addition to the text of this rule, the department adds that small businesses or organizations of small businesses may register on the department's small business impact list by making a written application to the Administrator of the Policy and Communications Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319.

X.7(17A,25B) Fiscal impact statement.

X.8(17A) Time and manner of rule adoption.

X.9(17A) Variance between adopted rule and published notice of proposed rule adoption.

X.10(17A) Exemptions from public rule-making procedures. In addition to the text of this rule, the department adds that exempt categories are generally limited to rules for nonsubstantive changes to a rule, such as rules for correcting grammar, spelling or punctuation in an existing or proposed rule.

X.11(17A) Concise statement of reasons. In addition to the text of this rule, the department adds that a request for a concise statement of reasons for a rule must be submitted to the Administrator of the Policy and Communications Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319.

X.12(1) Contents, style, and form of rule—contents.

X.12(4) Contents, style, and form of rule—style and form.

X.14(17A) Filing of rules.

X.15(17A) Effectiveness of rules prior to publication.

X.16(17A) General statement of policy.

X.17(17A) Review by agency of rules.

7.25(2) The department hereby states that the following cited Uniform Rules on Agency Procedure for Rule Making are not adopted by the department:

X.1(17A) Applicability.

X.3(17A) Public rule-making docket.

X.4(2) Notice of proposed rule making—incorporation by reference.

X.12(2) Contents, style, and form of rule—incorporation by reference.

X.12(3) Contents, style, and form of rule—references to materials not published in full.

X.13(17A) Agency rule-making record.

This rule is intended to implement Iowa Code chapter 17A.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.26(17A) Public inquiries on rule making and the rule-making records. The department maintains records of information obtained and all actions taken and criticisms received regarding any rule within the past five years. The department also keeps a record of the status of every rule within the rule-making procedure. Inquiries concerning the status of rule making may be made by contacting the Administrator of the Policy and Communications Division, Department of Revenue, Hoover State

Office Building, Fourth Floor, Des Moines, Iowa 50319. For additional information regarding criticism of rules, see rule 701—7.27(17A).

This rule is intended to implement Iowa Code section 17A.3.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.27(17A) Criticism of rules. The Administrator of the Policy and Communications Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319, is designated as the office where interested persons may submit by electronic means or by mail criticisms, requests for waivers, or comments regarding a rule. A criticism of a specific rule must be more than a mere lack of understanding of a rule or a dislike of the rule. To constitute a criticism of a rule, the criticism must be in writing, indicate it is a criticism of a specific rule, and have a valid legal basis for support. All requests for waivers, comments, or criticisms received on any rule will be kept in a separate record for a period of five years by the department.

This rule is intended to implement Iowa Code sections 17A.7 and 421.60.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.28(17A) Waiver or variance of certain department rules. All discretionary rules or discretionary provisions in a rule over which the department has jurisdiction, in whole or in part, may be subject to waiver or variance. See subrules 7.28(3) and 7.28(4).

7.28(1) Definitions. The following terms apply to the interpretation and application of this rule:

“Discretionary rule” or *“discretionary provisions in a rule”* means rules or provisions in rules resulting from a delegation by the legislature to the department to create a binding rule to govern a given issue or area. The department is not interpreting any statutory provision of the law promulgated by the legislature in a discretionary rule. Instead, a discretionary rule is authorized by the legislature when the legislature has delegated the creation of binding rules to the department and the contents of such rules are at the discretion of the department. A rule that contains both discretionary and interpretive provisions is deemed to be a discretionary rule to the extent of the discretionary provisions in the rule.

“Interpretive rules” or *“interpretive provisions in rules”* means rules or provisions in rules which define the meaning of a statute or other provision of law or precedent where the department does not possess the delegated authority to bind the courts to any extent with its definition.

“Waiver or variance” means an agency action which suspends, in whole or in part, the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

7.28(2) Scope of rule.

a. This rule creates generally applicable standards and a generally applicable process for granting individual waivers or variances from the discretionary rules or discretionary provisions in rules adopted by the department in situations where no other specifically applicable law provides for waivers or variances. To the extent another more specific provision of law purports to govern the issuance of a waiver or variance from a particular rule, the more specific waiver or variance provision shall supersede this rule with respect to any waiver or variance from that rule.

b. The waiver or variance provisions set forth in this rule do not apply to rules over which the department does not have jurisdiction or when issuance of the waiver or variance would be inconsistent with any applicable statute, constitutional provision or other provision of law.

7.28(3) Applicability of this rule.

a. This rule applies only to waiver or variance of those departmental rules that are within the exclusive rule-making authority of the department. This rule shall not apply to interpretive rules that merely interpret or construe the meaning of a statute, or other provision of law or precedent, if the department does not possess statutory authority to bind a court, to any extent, with its interpretation or construction. Thus, this waiver or variance rule applies to discretionary rules and discretionary provisions in rules, and not to interpretive rules.

b. The application of this rule is strictly limited to petitions for waiver or variance filed outside of a contested case proceeding. Petitions for waiver or variance from a discretionary rule or discretionary provisions in a rule filed after the commencement of a contested case as provided in rule 701—7.14(17A)

will be treated as an issue of the contested case to be determined by the presiding officer of the contested case.

7.28(4) Authority to grant a waiver or variance. The director may not issue a waiver or variance under this rule unless:

- a. The legislature has delegated authority sufficient to justify the action; and
- b. The waiver or variance is consistent with statutes and other provisions of law. No waiver or variance from any mandatory requirement imposed by statute may be granted under this rule.

7.28(5) Criteria for waiver or variance. In response to a petition, the director may, in the director's sole discretion, issue an order granting a waiver or variance from a discretionary rule or a discretionary provision in a rule adopted by the department, in whole or in part, as applied to the circumstances of a specified person, if the director finds that the waiver or variance is consistent with subrules 7.28(3) and 7.28(4) and if all of the following criteria are also met:

- a. The waiver or variance would not prejudice the substantial legal rights of any person;
- b. The rule or provisions of the rule are not specifically mandated by statute or another provision of law;
- c. The application of the rule or rule provision would result in an undue hardship or injustice to the petitioner; and
- d. Substantially equal protection of public health, safety, and welfare will be afforded by means other than that prescribed in the rule or rule provision for which the waiver or variance is requested.

7.28(6) Director's discretion. The final decision to grant or deny a waiver or variance shall be vested in the director. This decision shall be made at the sole discretion of the director based upon consideration of relevant facts.

7.28(7) Burden of persuasion. The burden of persuasion shall be on the petitioner to demonstrate by clear and convincing evidence that the director should exercise discretion to grant the petitioner a waiver or variance based upon the criteria contained in subrule 7.28(5).

7.28(8) Contents of petition.

- a. A petition for waiver or variance must be in the following format:

IOWA DEPARTMENT OF REVENUE		
Name of Petitioner	*	PETITION FOR
Address of Petitioner	*	WAIVER
Type of Tax at Issue	*	Docket No. _____
	*	

- b. A petition for waiver or variance must contain all of the following, where applicable and known to the petitioner:

- (1) The name, address, telephone number, and case number or state identification number of the entity or person for whom a waiver or variance is being requested;
- (2) A description and citation of the specific rule or rule provisions from which a waiver or variance is being requested;
- (3) The specific waiver or variance requested, including a description of the precise scope and operative period for which the petitioner wants the waiver or variance to extend;
- (4) The relevant facts that the petitioner believes would justify a waiver or variance. This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts represented in the petition, and a statement of reasons that the petitioner believes will justify a waiver or variance;
- (5) A complete history of any prior contacts between the petitioner and the department relating to the activity affected by the proposed waiver or variance, including audits, notices of assessment, refund claims, contested case hearings, or investigative reports relating to the activity within the last five years;
- (6) Any information known to the petitioner relating to the department's treatment of similar cases;

(7) The name, address, and telephone number of any public agency or political subdivision which might be affected by the granting of a waiver or variance;

(8) The name, address, and telephone number of any person or entity that would be adversely affected by the granting of the waiver or variance;

(9) The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver or variance;

(10) Signed releases of information authorizing persons with knowledge of relevant facts to furnish the department with information relating to the waiver or variance;

(11) If the petitioner seeks to have identifying details deleted, which deletion is authorized by statute, such details must be listed with the statutory authority for the deletion; and

(12) Signature by the petitioner at the conclusion of the petition attesting to the accuracy and truthfulness of the information set forth in the petition.

7.28(9) *Filing of petition.* A petition for waiver or variance must be filed with the Clerk of the Hearings Section, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319.

7.28(10) *Additional information.* Prior to issuing an order granting or denying a waiver or variance, the director may request additional information from the petitioner relating to the petition and surrounding circumstances. The director may, on the director's own motion, or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner or the petitioner's representative, or both, and the director to discuss the petition and surrounding circumstances.

7.28(11) *Notice of petition for waiver or variance.* The petitioner shall provide, within 30 days of filing the petition for waiver or variance, a notice consisting of a concise summary of the contents of the petition for waiver or variance and stating that the petition is pending. Such notice shall be mailed by the petitioner to all persons entitled to such notice. Such persons to whom notice must be mailed include, but are not limited to, the director and all parties to the petition for waiver or variance, or the parties' representatives. The petitioner must then file written notice with the clerk of the hearings section (address indicated above) attesting that the notice has been mailed. The names, addresses and telephone numbers of the persons to whom the notices were mailed shall be included in the filed written notice. The department has the discretion to give such notice to persons other than those persons notified by the petitioner.

7.28(12) *Ruling on a petition for waiver or variance.* An order granting or denying a waiver or variance must conform to the following:

a. An order granting or denying a waiver or variance shall be in writing and shall contain a reference to the particular person and rule or rule provision to which the order pertains, a statement of the relevant facts and reasons upon which the action is based, and a description of the narrow and precise scope and operative time period of a waiver or variance, if one is issued.

b. If a petition requested the deletion of identifying details, then the order must either redact the details prior to the placement of the order in the public record file referenced in subrule 7.28(17) or set forth the grounds for denying the deletion of identifying details as requested.

c. Conditions. The director may condition the grant of a waiver or variance on any conditions which the director deems to be reasonable and appropriate in order to protect the public health, safety and welfare.

7.28(13) *Time period for waiver or variance; extension.* Unless otherwise provided, an order granting a petition for waiver or variance will be effective for 12 months from the date the order granting the waiver or variance is issued. Renewal of a granted waiver or variance is not automatic. To renew the waiver or variance beyond the 12-month period, the petitioner must file a new petition requesting a waiver or variance. The renewal petition will be governed by the provisions in this rule and must be filed prior to the expiration date of the previously issued waiver or variance or extension of waiver or variance. Even if the order granting the waiver or variance was issued in a contested case proceeding, any request for an extension shall be filed with and acted upon by the director. However, renewal petitions must request an extension of a previously issued waiver or variance. Granting the

extension of the waiver or variance is at the director's sole discretion and must be based upon whether the factors set out in subrules 7.28(4) and 7.28(5) remain valid.

7.28(14) *Time for ruling.* The director shall grant or deny a petition for waiver or variance as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees in writing to a later date or the director indicates in a written order that it is impracticable to issue the order within the 120-day period.

7.28(15) *When deemed denied.* Failure of the director to grant or deny a waiver or variance within the 120-day or the extended time period shall be deemed a denial of that petition.

7.28(16) *Service of orders.* Within seven days of its issuance, any order issued under this rule shall be transmitted to the petitioner or the person to whom the order pertains and to any other person entitled to such notice by any provision of law.

7.28(17) *Record keeping.* The department is required to maintain a record of all petitions for waiver or variance and rulings granting or denying petitions for waiver or variance.

a. Petitions for waiver or variance. The department shall maintain a record of all petitions for waiver or variance available for public inspection. Such records will be indexed and filed and made available for public inspection at the office of the clerk of the hearings section at the address set forth in subrule 7.28(9).

b. Report of orders granting or denying a waiver or variance. All orders granting or denying a waiver or variance shall be summarized in a semiannual report to be drafted by the department and submitted to the administrative rules coordinator and the administrative rules review committee.

7.28(18) *Cancellation of waiver or variance.* A waiver or variance issued pursuant to this rule may be withdrawn, canceled, or modified if, after appropriate notice, the director issues an order finding any of the following:

a. The person who obtained the waiver or variance order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver or variance; or

b. The alternative means for ensuring that public health, safety, and welfare will be adequately protected after issuance of the waiver or variance order have been demonstrated to be insufficient, and no other means exist to protect the substantial legal rights of any person; or

c. The person who obtained the waiver or variance has failed to comply with all of the conditions in the waiver or variance order.

7.28(19) *Violations.* A violation of a condition in a waiver or variance order shall be treated as a violation of the particular rule or rule provision for which the waiver or variance was granted. As a result, the recipient of a waiver or variance under this rule who violates a condition of the waiver or variance may be subject to the same remedies or penalties as a person who violates the rule or rule provision at issue.

7.28(20) *Defense.* After an order granting a waiver or variance is issued, the order shall constitute a defense, within the terms and the specific facts indicated therein, for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked, unless subrules 7.28(18) and 7.28(19) are applicable.

7.28(21) *Hearing and appeals.*

a. Appeals from a decision granting or denying a waiver or variance in a contested case proceeding shall be in accordance with the rules governing hearings and appeals from decisions in contested cases. These appeals shall be taken within 30 days of the issuance of the ruling granting or denying the waiver or variance request, unless a different time is provided by rule or statute, such as provided in the area of license revocation (see rule 701—7.23(17A)).

b. The provisions of Iowa Code sections 17A.10 to 17A.18A and rule 701—7.17(17A) regarding contested case proceedings shall apply to any petition for waiver or variance of a rule or provisions in a rule filed within a contested case proceeding. A petition for waiver or variance of a provision in a rule outside of a contested case proceeding will not be considered under the statutes or rule 701—7.17(17A).

Instead, the director's decision on the petition for waiver or variance is considered to be "other agency action."

This rule is intended to implement Iowa Code section 17A.9A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.29(17A) Petition for rule making.

7.29(1) Form of petition.

a. Any person or agency may file a petition for rule making at the Office of the Director, Department of Revenue, Hoover State Office Building, Fourth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319. A petition is deemed filed when it is received by the director. The department will provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Petitioner)	*	PETITION FOR
for the (adoption, amendment, or	*	RULE MAKING
repeal) of rules relating to (state	*	
subject matter).	*	

b. The petition must provide the following information:

(1) A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.

(2) A citation to any law deemed relevant to the department's authority to take the action urged or to the desirability of that action.

(3) A brief summary of the petitioner's arguments in support of the action urged in the petition.

(4) A brief summary of any data supporting the action urged in the petition.

(5) The names and addresses of other persons, or a description of any class of persons, known by the petitioner to be affected by or interested in the proposed action which is the subject of the petition.

(6) Any request by the petitioner for a meeting.

(7) Any other matters deemed relevant that are not covered by the above requirements.

7.29(2) Form signed and dated. The petition must be signed and dated by the petitioner or the petitioner's representative. It must also include the name, mailing address, telephone number and, if requested, the email address of the petitioner and of the petitioner's representative and a statement indicating the person to whom communications concerning the petition should be directed.

7.29(3) Denial by department. The department may deny a petition because it does not substantially conform to the required form or because all the required information has not been provided.

7.29(4) Briefs. The petitioner may attach a brief to the petition in support of the action urged in the petition. The department may request a brief from the petitioner or from any other person concerning the substance of the petition.

7.29(5) Status of petition. Inquiries concerning the status of a petition for rule making may be made to the Office of the Director, Department of Revenue, Hoover State Office Building, Fourth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319.

7.29(6) Informal meeting. If requested in the petition by the petitioner, the department may schedule an informal meeting between the petitioner and the department, or a member of the staff of the department, to discuss the petition. The department may request that the petitioner submit additional information or argument concerning the petition. The department may also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the department by any person.

7.29(7) Action required. Within 60 days after the filing of the petition, or within an extended period as agreed to by the petitioner, the department must, in writing, either: (a) deny the petition and notify the petitioner of the department's action and the specific grounds for the denial; or (b) grant the petition and notify the petitioner that the department has instituted rule-making proceedings on the subject of the petition. The petitioner shall be deemed notified of the denial of the petition or the granting of the petition on the date that the department mails or delivers the required notification to the petitioner.

7.29(8) New petition. Denial of a petition because the petition does not substantially conform to the required form does not preclude the filing of a new petition on the same subject when the new petition contains the required information that was the basis for the original denial.

This rule is intended to implement Iowa Code chapter 17A.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.30(9C,91C) Procedure for nonlocal business entity bond forfeitures. Upon the failure of a transient merchant or an out-of-state contractor to pay any taxes payable, the amount of bond posted with the secretary of state by the transient merchant or out-of-state contractor necessary to pay the tax shall be forfeited. The following subrules shall govern the procedure for that forfeiture.

7.30(1) Definitions.

a. "Nonlocal business entity" is either an out-of-state contractor or a transient merchant as those terms are defined in paragraphs 7.30(1)"b" and "f."

b. "Out-of-state contractor" means a general contractor, subcontractor, architect, engineer, or other person who contracts to perform in this state construction or installation of structures or other buildings or any other work covered by Iowa Code chapter 103A and whose principal place of business is outside Iowa.

c. "Taxes payable by a transient merchant" refers to all taxes administered by the department, and penalties, interest, and fees which the department has previously determined to be due by assessment or due as a result of an appeal from an assessment.

d. "Taxes payable by an out-of-state contractor" means tax, penalty, interest, and fees which the department, another state agency, or a subdivision of the state, has determined to be due by assessment or due as a result of an appeal from an assessment. The tax assessed must accrue as the result of a contract to perform work covered by Iowa Code chapter 103A.

e. "Taxes payable" means any amount referred to in paragraphs 7.30(1)"c" and "d" above.

f. "Transient merchant" shall be defined, for the purposes of this rule, as that term is defined in Iowa Code section 9C.1.

7.30(2) Increases in existing bonds. If an out-of-state contractor has on file with the secretary of state a bond for any particular contract and for that particular contract the contractor has tax due and owing but unpaid and this tax is greater than the amount of the bond, the department shall require the out-of-state contractor to increase the bond on file with the secretary of state in an amount sufficient to pay tax liabilities which will become due and owing under the contract in the future.

7.30(3) Responsibility for notification. Concerning taxes which are payable by an out-of-state contractor but which are not administered by the department of revenue, it shall be the duty of the department or subdivision of Iowa state government to which the taxes are owed to notify the department of revenue of the taxes payable by the out-of-state contractor in order to institute bond forfeiture proceedings or an increase in the amount of the bond which the out-of-state contractor must post.

7.30(4) Initial notification. After it is determined that a bond ought to be forfeited, notice of this intent shall be sent to the nonlocal business entity and its surety of record, if any. Notice sent to the nonlocal business entity or its surety shall be sent to the last-known address as reflected in the records of the secretary of state. The notice sent to an out-of-state contractor shall also be mailed to the contractor's registered agent for service of process, if any, within Iowa. This notice may be sent by ordinary mail. The notice shall state the intent to demand forfeiture of the nonlocal business entity's bond, the amount of bond to be forfeited, the nature of the taxes alleged to be payable, the period for which these taxes are due, and the department or subdivision of Iowa to which the taxes are payable. The notice shall also state the statutory authority for the forfeiture and the right to a hearing upon timely application.

7.30(5) *Protest of bond forfeiture.* The application of a nonlocal business entity for a hearing shall be written and substantially in the form set out for protests of other departmental action in rule 701—7.8(17A). The caption of the application shall be basically in the form set out in subrule 7.8(6) except the type of proceeding shall be designated as a bond forfeiture collection. The body of the application for hearing must substantially resemble the body of the protest described in subrule 7.8(7). However, referring to paragraph 7.8(7)“a,” the nonlocal business entity shall state the date of the notice described in subrule 7.30(4). With regard to paragraph 7.8(7)“c,” in the case of a tax payable which is not administered by the department, the errors alleged may be errors on the part of other departments or subdivisions of the state of Iowa. The application for hearing shall be filed with the department’s administrative law judge in the manner described in rule 701—7.8(17A). The docketing of an application for hearing shall follow the procedure for the docketing of a protest under that rule.

7.30(6) *Prehearing, hearing and rehearing procedures.* The following rules are applicable to preliminary and contested case proceedings under this rule: 701—7.3(17A) to 701—7.7(17A), 701—7.9(17A) to 701—7.13(17A), and 701—7.15(17A) to 701—7.22(17A).

7.30(7) *Sureties and state departments other than revenue.*

a. A surety shall not have standing to contest the amount of any tax payable.

b. If there exist taxes payable by an out-of-state contractor and these taxes are payable to a department or subdivision of state government other than the department of revenue, that department or subdivision shall be the real party in interest to any proceeding conducted under this rule, and it shall be the responsibility of that department or subdivision to provide its own representation and otherwise bear the expenses of representation.

This rule is intended to implement Iowa Code sections 9C.4 and 91C.7.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.31(421) *Abatement of unpaid tax.* For assessment notices issued on or after January 1, 1995, if the statutory period for appeal has expired, the director may abate any portion of unpaid tax, penalties or interest which the director determines is erroneous, illegal, or excessive. The authority of the director to settle doubtful and disputed claims for taxes or tax refunds or tax liability of doubtful collectability is not covered by this rule.

7.31(1) *Assessments qualifying for abatement.* To be subject to an abatement, an assessment or a portion of an assessment for which abatement is sought must not have been paid and must have exceeded the amount due as provided by the Iowa Code and the administrative rules issued by the department interpreting the Iowa Code. If a taxpayer fails to timely appeal an assessment that is based on the Iowa Code or the department’s administrative rules interpreting the Iowa Code within the statutory period, then the taxpayer cannot request an abatement of the assessment or a portion thereof.

7.31(2) *Procedures for requesting abatement.* The taxpayer must make a written request to the director for abatement of that portion of the assessment that is alleged to be erroneous, illegal, or excessive. A request for abatement must contain:

a. The taxpayer’s name and address, social security number, federal identification number, or any permit number issued by the department;

b. A statement on the type of proceeding, e.g., individual income tax or request for abatement; and

c. The following information:

(1) The type of tax, the taxable period or periods involved, and the amount of tax that was excessive or erroneously or illegally assessed;

(2) Clear and concise statements of each and every error which the taxpayer alleges to have been committed by the director in the notice of assessment and which causes the assessment to be erroneous, illegal, or excessive. Each assignment of error must be separately numbered;

(3) Clear and concise statements of all relevant facts upon which the taxpayer relies (documents verifying the correct amount of tax liability must be attached to the request);

(4) Reference to any particular statute or statutes and any rule or rules involved, if known;

(5) The signature of the taxpayer or that of the taxpayer's representative and the addresses of the taxpayer and the taxpayer's representative;

(6) Description of records or documents which were not available or were not presented to department personnel prior to the filing of this request, if any (copies of any records or documents that were not previously presented to the department must be provided with the request); and

(7) Any other matters deemed relevant and not covered in the above subparagraphs.

This rule is intended to implement Iowa Code section 421.60.

[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.32(421) Time and place of taxpayer interviews. The time and place of taxpayer interviews are to be fixed by an employee of the department, and employees of the department are to endeavor to schedule a time and place that are reasonable under the circumstances.

7.32(1) *Time of taxpayer interviews.* The department will schedule the day(s) for a taxpayer interview during a normally scheduled workday(s) of the department, during the department's normal business hours. The department will schedule taxpayer interviews throughout the year without regard to seasonal fluctuations in the business of particular taxpayers or their representatives. The department will, however, work with taxpayers or their representatives to try to minimize any adverse effects in scheduling the date and time of a taxpayer interview.

7.32(2) *Type of taxpayer interview.*

a. The department will determine whether a taxpayer interview will be an office interview (i.e., an interview conducted at a department office) or a field interview (i.e., an interview conducted at the taxpayer's place of business or residence, or some other location that is not a department office) based on which form of interview will be more conducive to effective and efficient tax administration.

b. The department will grant a request to hold an office interview at a location other than a department office in case of a clear need, such as when it would be unreasonably difficult for the taxpayer to travel to a department office because of the taxpayer's advanced age or infirm physical condition or when the taxpayer's books, records, and source documents are too cumbersome for the taxpayer to bring to a department office.

7.32(3) *Place of taxpayer interview.* The department will make an initial determination of the place for an interview, including the department regional office to which an interview will be assigned, based on the address shown on the return for the tax period to be examined. Requests by taxpayers to transfer the place of interview will be resolved on a case-by-case basis, using the criteria set forth in paragraph 7.32(3) "c."

a. Office taxpayer interviews. An office interview of an individual or sole proprietorship generally is based on the residence of the individual taxpayer. An office interview of a taxpayer which is an entity generally is based on the location where the taxpayer entity's original books, records, and source documents are maintained.

b. Field taxpayer interviews. A field interview generally will take place at the location where the taxpayer's original books, records, and source documents pertinent to the interview are maintained. In the case of a sole proprietorship or taxpayer entity, this usually will be the taxpayer's principal place of business. If an interview is scheduled by the department at the taxpayer's place of business, which is a small business and the taxpayer represents to the department in writing that conducting the interview at the place of business would essentially require the business to close or would unduly disrupt business operations, the department upon verification will change the place of interview.

c. Requests by taxpayers to change place of interview. The department will consider, on a case-by-case basis, written requests by taxpayers or their representatives to change the place that the department has set for an interview. In considering these requests, the department will take into account the following factors:

- (1) The location of the taxpayer's current residence;
- (2) The location of the taxpayer's current principal place of business;
- (3) The location where the taxpayer's books, records, and source documents are maintained;
- (4) The location at which the department can perform the interview most efficiently;

(5) The department resources available at the location to which the taxpayer has requested a transfer; and

(6) Other factors which indicate that conducting the interview at a particular location could pose undue inconvenience to the taxpayer.

d. Granting of requests to change place of interview. A request by a taxpayer to transfer the place of interview generally will be granted under the following circumstances:

(1) If the current residence of the taxpayer in the case of an individual or sole proprietorship, or the location where the taxpayer's books, records, and source documents are maintained, in the case of a taxpayer entity, is closer to a different department office than the office where the interview has been scheduled, the department normally will agree to transfer the interview to the closer department office.

(2) If a taxpayer does not reside at the residence where an interview has been scheduled, the department will agree to transfer the examination to the taxpayer's current residence.

(3) If, in the case of an individual, a sole proprietorship, or a taxpayer entity, the taxpayer's books, records, and source documents are maintained at a location other than the location where the interview has been scheduled, the department will agree to transfer the interview to the location where the taxpayer's books, records, and source documents are maintained.

(4) The location of the place of business of a taxpayer's representative generally will not be considered in determining the place for an interview. However, the department in its sole discretion may determine, based on the factors described in paragraph 7.32(3) "c," to transfer the place of interview to the representative's office.

(5) If any applicable period of limitations of assessment and collection provided in the Iowa Code will expire within 13 months from the date of a taxpayer's request to transfer the place of interview, the department may require, as a condition to the transfer, that the taxpayer agree in writing to extend the limitations period up to one year.

(6) The department is not required to transfer an interview to an office that does not have adequate resources to conduct the interview.

(7) Notwithstanding any other provision of this rule, employees of the department may decline to conduct an interview at a particular location if it appears that the possibility of physical danger may exist at that location. In these circumstances, the department may transfer an interview to a department office and take any other steps reasonably necessary to protect its employees.

(8) Nothing in this rule shall be interpreted as precluding the department from initiating the transfer of an interview if the transfer would promote the effective and efficient conduct of the interview. Should a taxpayer request that such a transfer not be made, the department will consider the request according to the principles and criteria set forth in paragraph 7.32(3) "c."

(9) Regardless of where an examination takes place, the department may visit the taxpayer's place of business or residence to establish facts that can only be established by direct visit, such as inventory or asset verification. The department generally will visit for these purposes on a normal workday of the department during the department's normal business hours.

7.32(4) Audio recordings of taxpayer interviews.

a. A taxpayer is permitted, upon advance notice to the department, to make an audio recording of any interview of the taxpayer by the department relating to the determination or collection of any tax. The recording of the interview is at the taxpayer's own expense and must be with the taxpayer's own equipment.

b. Requests by taxpayers to make audio recordings must be addressed to the department employee who is conducting the interview and must be received by no later than ten calendar days before the interview. If ten calendar days' advance notice is not given, the department may, in its discretion, conduct the interview as scheduled or set a new date.

c. The department employee conducting the interview will approve the request to record the interview if:

- (1) The taxpayer (or representative) supplies the recording equipment;
- (2) The department may produce its own recording of the proceedings;
- (3) The recording takes place in a suitable location; and

(4) All participants in the proceedings other than department personnel consent to the making of the audio recording, and all participants identify themselves and their role in the proceedings.

d. A department employee is also authorized to record any taxpayer interview, if the taxpayer receives prior notice of the recording and is provided with a transcript or a copy of the recording upon the taxpayer's request.

e. Requests by taxpayers (or their representatives) for a copy or transcript of an audio recording produced by the department must be addressed to the employee conducting the interview and must be received by the department no later than 30 calendar days after the date of the recording. The taxpayer must pay the costs of duplication or transcription.

f. At the beginning of the recording of an interview, the department employee conducting the interview must state the employee's name, the date, the time, the place, and the purpose of the interview. At the end of the interview, the department employee will state that the interview has been completed and that the recording has ended.

g. When written records are presented or discussed during the interview being recorded, they must be described in sufficient detail to make the audio recording a meaningful record when matched with the other documentation contained in the case file.

This rule is intended to implement Iowa Code section 421.60.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.33(421) Mailing to the last-known address.

7.33(1) If the department fails to mail a notice of assessment to the taxpayer's last-known address or fails to personally deliver the notice to the taxpayer, interest is waived for the month the failure occurs through the month of correct mailing or personal delivery.

a. In addition, if the department fails to mail a notice of assessment or denial of a claim for refund to the taxpayer's last-known address or fails to personally deliver the notice to a taxpayer and, if applicable, to the taxpayer's authorized representative, the time period to appeal the notice of assessment or a denial of a claim for refund is suspended until the notice or claim denial is correctly mailed or personally delivered or for a period not to exceed one year, whichever is the lesser period.

b. Collection activities, except when a jeopardy situation exists, shall be suspended and the statute of limitations for assessment and collection of the tax shall be tolled during the period in which interest is waived.

7.33(2) The department will make the determination of the taxpayer's last-known address on a tax-type-by-tax-type basis. However, a notice of assessment or refund claim denial will be considered to be mailed to the last-known address if it is mailed to an address used for another tax type. A notice of assessment mailed to one of two addresses used by a taxpayer was sufficient. Langdon P. Marvin, Jr., 40 TC 982; Jack Massengale, TC Memo 1968-64.

7.33(3) The last-known address is the address used on the most recent filed and processed return. The following principles, established by case law, for the Internal Revenue Service (IRS) also will be applied in determining the taxpayer's last-known address for purposes of this rule.

a. Although the taxpayer filed a tax return showing a new address, the IRS had not processed the return sufficiently for the new address to be available by computer to the IRS agent who sent the notice of deficiency. Before a change of address is considered available, a reasonable amount of time must be allowed to process and transfer information to the IRS's central computer system. *Diane Williams v. Commissioner of Internal Revenue*, U.S. Court of Appeals, 9th Circuit; 935 F. 2d 1066.

b. If the department knows the taxpayer has moved but does not know the new mailing address, the prior mailing address is the proper place to send a deficiency notice. *Kaestner v. Schmidt*, 473 F. 2d 1294; *Kohn vs. U.S. et al.*, 56 AFTR 2d 85-6147.

c. Knowledge acquired by a collection agent regarding the taxpayer's address in an unrelated investigation was not required to be imputed to the examination division responsible for mailing a notice of deficiency. *Wise v. Commissioner*, 688 F. Supp. 1164.

d. However, information acquired by the department in a related investigation of the taxpayer is binding upon the department, e.g., where the taxpayer files a power of attorney showing a change of address.

7.33(4) Procedures for notifying the department of a change in taxpayer's address. The department generally will use the address on the most recent filed and properly processed return by tax type as the address of record for all notices of assessment and denial of claims for refund. If a taxpayer no longer wishes the address of record to be the address on the most recently filed return, the taxpayer must give clear and concise written notification of a change in address to the department. Notifications of a change in address should be addressed to: Changes in Name or Address, Iowa Department of Revenue, P.O. Box 10465, Des Moines, Iowa 50306.

a. If after a joint return or married filing separately on a combined return is filed either taxpayer establishes a separate residence, each taxpayer should send clear and concise written notification of a current address to the department.

b. If a department employee contacts a taxpayer in connection with the filing of a return or an adjustment to a taxpayer's return, the taxpayer may provide clear and concise written notification of a change of address to the department employee who initiated the contact.

c. A taxpayer should notify the U.S. Postal Service facility serving the taxpayer's old address of the taxpayer's new address in order that mail from the department can be forwarded to the new address. However, notification to the U.S. Postal Service does not constitute the clear and concise written notification that is required to change a taxpayer's address of record with the department.

This rule is intended to implement Iowa Code section 421.60.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.34(421) Power of attorney. No attorney, accountant, or other representative will be recognized as representing any taxpayer in regard to any claim, appeal, or other matter relating to the tax liability of such taxpayer in any hearing before or conference with the department, or any member or agent thereof, unless there is first filed with the department a written authorization.

7.34(1) A power of attorney is required by the department when the taxpayer wishes to authorize an individual to perform one or more of the following acts on behalf of the taxpayer:

a. To receive copies of any notices or documents sent by the department, its representatives or its attorneys.

b. To receive, but not to endorse and collect, checks in payment of any refund of Iowa taxes, penalties, or interest.

c. To execute waivers (including offers of waivers) of restrictions on assessment or collection of deficiencies in tax and waivers of notice of disallowance of a claim for credit or refund.

d. To execute consents extending the statutory period for assessment or collection of taxes.

e. To fully represent the taxpayer(s) in any hearing, determination, final or otherwise, or appeal.

f. To enter into any compromise with the director's office.

g. To execute any release from liability required by the department prerequisite to divulging otherwise confidential information concerning the taxpayer(s).

h. Other acts as stipulated by the taxpayer.

7.34(2) A power of attorney or any supplemental notification intended to be utilized as a power of attorney must contain the following information to be valid:

a. Name and address of the taxpayer;

b. Identification number of the taxpayer (i.e., social security number, federal identification number, or any state-issued tax identification number relative to matters covered by the power of attorney);

c. Name, mailing address, and PTIN (preparer's tax identification number), FEIN (federal employer identification number) or SSN (social security number) of the representative;

d. Description of the matter(s) for which representation is authorized which, if applicable, must include:

(1) The type of tax(es) involved;

(2) The specific year(s) or period(s) involved; and

(3) In estate matters, decedent's date of death; and

e. A clear expression of the taxpayer's intention concerning the scope of authority granted to the recognized representative(s) as provided in subrule 7.34(1).

7.34(3) A power of attorney may not be used for tax periods that end more than three years after the date on which the power of attorney is received by the department. A power of attorney may concern an unlimited number of tax periods which have ended prior to the date on which the power of attorney is received by the department; however, each tax period must be separately stated.

7.34(4) The individual who must execute a power of attorney depends on the type of taxpayer involved as follows:

a. *Individual taxpayer.* In matters involving an individual taxpayer, a power of attorney must be signed by the individual.

b. *Husband and wife.* In matters involving a joint return or married taxpayers who have elected to file separately on a combined return in which both husband and wife are to be represented by the same representative(s), the power of attorney must be executed by both husband and wife. In any matters concerning a joint return or married taxpayers who have elected to file separately on a combined return in which both husband and wife are not to be represented by the same representative(s), the power of attorney must be executed by the spouse who is to be represented. However, the recognized representative of such spouse cannot perform any act with respect to a tax matter that the spouse represented cannot perform alone.

c. *Corporation.* In the case of a corporation, a power of attorney must be executed by an officer of the corporation having authority to legally bind the corporation, which must certify that the officer has such authority.

d. *Association.* In the case of an association, a power of attorney must be executed by an officer of the association having authority to legally bind the association, which must certify that the officer has such authority.

e. *Partnership.* In the case of a partnership, a power of attorney must be executed by all partners, or if executed in the name of the partnership, by the partner or partners duly authorized to act for the partnership, which must certify that the partner(s) has such authority.

7.34(5) A power of attorney is not needed for individuals who have been named as an authorized representative on a fiduciary return of income filed under Iowa Code section 422.14 or a tax return filed under Iowa Code chapter 450.

7.34(6) A new power of attorney for a particular tax type(s) and tax period(s) revokes a prior power of attorney for that tax type(s) and tax period(s) unless the taxpayer has indicated on the power of attorney form that a prior power of attorney is to remain in effect. For a previously designated representative to remain as the taxpayer's representative when a subsequent power of attorney form is filed, the taxpayer must attach a copy of the previously submitted power of attorney form which designates the representative that the taxpayer wishes to retain. To revoke a designated power of attorney without appointing a new power of attorney, see subrule 7.34(7).

EXAMPLE A. A taxpayer executes a power of attorney for the taxpayer's accountant to represent the taxpayer during an audit of the taxpayer's books and records. After the department issues a notice of assessment, the taxpayer wishes to have the taxpayer's attorney-at-law as an authorized representative in addition to the taxpayer's accountant. The taxpayer may use one of two options to designate the accountant and the attorney-at-law as the taxpayer's representatives: (1) The taxpayer may complete and submit to the department a new power of attorney, Form IA2848 or federal Form 2848, designating both the accountant and the attorney-at-law as the taxpayer's authorized representatives (by submittal of a new power of attorney form, the prior power of attorney designations are revoked, leaving only the subsequent new power of attorney form effective); or (2) the taxpayer may properly complete a new power of attorney form by including the designated attorney-at-law's name, address, PTIN, FEIN or SSN, tax type(s) and tax period(s) on the first page and checking the appropriate box on page 2 of Form IA2848 or page 2 of federal Form 2848. In addition, to retain the accountant as the taxpayer's

representative, the taxpayer must also attach to the new completed power of attorney form a copy of the previously submitted power of attorney form designating the accountant as the taxpayer's representative.

EXAMPLE B. A taxpayer wishes to designate an additional power of attorney and retain a prior power of attorney. However, the taxpayer does not wish to utilize a Form IA2848 or a federal Form 2848. In this situation, the taxpayer must send written notification to the department designating the new power of attorney's name, address, PTIN, SSN or FEIN, the tax type(s), the tax period(s) of representation and the name, address, and PTIN, SSN or FEIN of the previously designated power of attorney that the taxpayer seeks to retain for that tax period.

In each of the foregoing examples, the original power of attorney will continue to automatically receive the notices concerning the specified tax matter, unless such authority is explicitly revoked by the taxpayer. Also see subrule 7.34(13) regarding notices.

7.34(7) By filing a statement of revocation with the department, a taxpayer may revoke a power of attorney without authorizing a new representative. The statement of revocation must indicate that the authority of the previous power of attorney is revoked and must be signed by the taxpayer. Also, the name and address of each representative whose authority is revoked must be listed (or a copy of the power of attorney must be attached).

7.34(8) By filing a statement with the department, a representative may withdraw from representation in a matter in which a power of attorney has been filed. The statement must be signed by the representative and must identify the name and address of the taxpayer(s) and the matter(s) from which the representative is withdrawing.

7.34(9) A properly completed Iowa power of attorney, Form IA2848, or a properly designated federal form as described in this subrule, satisfies the requirements of this rule. In addition to the Iowa power of attorney, Form IA2848, the department can accept Internal Revenue Service Form 2848, if references to the "Internal Revenue Service" are crossed out and "Iowa Department of Revenue" is inserted in lieu thereof, as long as such a form contains specific designation by the taxpayer for the state-related taxes at issue. Designation must include, but is not limited to, name, address, PTIN, SSN or FEIN of the representative, the tax type(s) and tax period(s). In addition, the department will accept any other document which satisfies the requirements of this rule.

7.34(10) The department will not recognize as a valid power of attorney a power of attorney form attached to a tax return filed with the department except in the instance of a form attached to a fiduciary return of income form or an inheritance tax return.

7.34(11) The department will accept either the original, an electronically scanned and transmitted power of attorney form, or a copy of a power of attorney. A copy of a power of attorney received by facsimile transmission (fax) will be accepted. All copies, facsimiles and electronically scanned and transmitted power of attorney forms must include a valid signature of the taxpayer to be represented.

7.34(12) If an individual desires to represent a taxpayer through correspondence with the department, the individual must submit a power of attorney even though no personal appearance is contemplated.

7.34(13) Any notice or other written communication (or copy thereof) required or permitted to be given to the taxpayer in any matter before the department must be given to the taxpayer and, unless restricted by the taxpayer, to the taxpayer's first designated power of attorney who is representing the taxpayer for the tax type(s) and tax period(s) contained in the notice. Due to limitations of the department's automated systems, it is the general practice of the department to limit distribution of copies of documents by the department to the taxpayer's first designated power of attorney. Determination of the first designated power of attorney will be based on the earliest execution date of the power of attorney and the first name designated on a power of attorney form listing more than one designated representative.

7.34(14) Information from power of attorney forms, including the representative's PTIN, SSN or FEIN, is utilized by department personnel to:

a. Determine whether a representative is authorized to receive or inspect confidential tax information;

b. Determine whether the representative is authorized to perform the acts set forth in subrule 7.34(1);

c. Send copies of computer-generated notices and communications to the representative as authorized by the taxpayer; and

d. Ensure that the taxpayer's representative receives all notices and communications authorized by the taxpayer, but that notices and communications are not sent to a representative with the same or similar name.

This rule is intended to implement Iowa Code section 421.60.
[ARC 0251C, IAB 8/8/12, effective 9/12/12; ARC 1545C, IAB 7/23/14, effective 8/27/14]

701—7.35(421) Taxpayer designation of tax type and period to which voluntary payments are to be applied.

7.35(1) A taxpayer may designate in separate written instructions accompanying the payment the type of tax and tax periods to which any voluntary payment is to be applied. The taxpayer may not designate the application of payments which are the result of enforced collection.

7.35(2) Enforced collection includes, but is not limited to, garnishment of wages, bank accounts, or payments due the taxpayer, or seizure of assets.

This rule is intended to implement Iowa Code section 421.60.
[ARC 0251C, IAB 8/8/12, effective 9/12/12]

701—7.36(421) Tax return preparers.

7.36(1) Definitions. For the purposes of this rule and for Iowa Code sections 421.62, 421.63, and 421.64, the following definitions apply:

“An enrolled agent enrolled to practice before the federal Internal Revenue Service (IRS) pursuant to 31 CFR §10.4” means an individual who has an active status as an enrolled agent under 31 CFR §10.4(a) or (d) and is not currently under suspension or disbarment from practice before the IRS. An enrolled agent does not include an enrolled retirement plan agent under 31 CFR §10.4(b) or a registered tax return preparer under 31 CFR §10.4(c).

“An individual admitted to practice law in this state or another state” means an individual who has an active license to practice law in this state or another state, is considered in good standing with the licensing authority of this or another state, and is currently authorized to engage in the practice of law.

“An individual licensed as a certified public accountant or a licensed public accountant under Iowa Code chapter 542 or a similar law of another state” means an individual who has an active certified public accountant license or an active public accountant license under Iowa Code chapter 542 or a similar law of another state and is in good standing with the Iowa accountancy examining board or similar authority of another state.

“Hour of continuing education” means a minimum of 50 minutes spent by a tax return preparer in actual attendance at or completion of an IRS-approved provider of continuing education course.

“Income tax return or claim for refund” means any return or claim for refund under Iowa Code chapter 422, excluding withholding returns under Iowa Code section 422.16.

“New tax preparer” means an individual who qualifies as a “tax return preparer” under Iowa Code section 421.62 for the current tax year but would not have qualified as such during any prior calendar year. See paragraph 7.36(8)“a” for examples regarding who qualifies as a new tax preparer.

“Tax return preparer” means any individual who, for a fee or other consideration, prepares ten or more income tax returns or claims for refund during a calendar year, or who assumes final responsibility for completed work on such income tax returns or claims for refund on which preliminary work has been done by another individual.

“Tax return preparer” does not include any of the following:

1. An individual licensed as a certified public accountant or a licensed public accountant under Iowa Code chapter 542 or a similar law of another state.
2. An individual admitted to practice law in this state or another state.
3. An enrolled agent enrolled to practice before the federal IRS pursuant to 31 CFR §10.4.
4. A fiduciary of an estate, trust, or individual, while functioning within the fiduciary's legal duty and authority with respect to that individual or that estate or trust or its testator, trustor, grantor, or beneficiaries.

5. An individual who prepares the tax returns of the individual's employer, while functioning within the individual's scope of employment with the employer.

6. An individual employed by a local, state, or federal government agency, while functioning within the individual's scope of employment with the government agency.

7. An employee of a tax return preparer, if the employee provides only clerical or other comparable services and does not sign tax returns.

See paragraph 7.36(8) "a" for examples regarding who qualifies as a tax return preparer.

7.36(2) *Penalty for tax return preparer's failure to include preparer tax identification number (PTIN) on income tax returns or claims for refund.* On or after January 1, 2020, a tax return preparer who fails to include the tax return preparer's PTIN on any income tax return or claim for refund prepared by the tax return preparer and filed with the department shall pay to the department a penalty of \$50 for each violation, unless the tax return preparer shows that the failure was reasonable under the circumstances and not willful or reckless conduct. The maximum aggregate penalty imposed upon a tax return preparer pursuant to Iowa Code section 421.62 and this rule shall not exceed \$25,000 during any calendar year. See paragraph 7.36(8) "c" for examples pertaining to the tax return preparer PTIN requirement.

7.36(3) *Tax return preparer continuing education requirement.* Beginning January 1, 2020, and every year thereafter, a tax return preparer shall complete a minimum of 15 hours of continuing education courses each year. At least two hours of continuing education shall be on professional ethics, and the remaining hours shall pertain to federal or state income tax. Each course shall be taken from an IRS-approved provider of continuing education. If a course offered by an IRS-approved provider is primarily on state-specific income tax content, the course will qualify for the continuing education requirements under Iowa Code section 421.64 and this rule, even if such course does not count toward federal continuing professional education. Tax return preparers who complete more than the required 15 hours of continuing education in one calendar year may not count the excess hours toward a subsequent year's requirement. See paragraph 7.36(8) "b" for examples pertaining to the tax return preparer continuing education requirement.

7.36(4) *Preparation of income tax returns or claims for refund.* An individual prepares an income tax return or claim for refund when the individual signs (or should sign) a return, either because the individual completes the return or because the individual assumes final responsibility for preliminary work completed by other individuals.

7.36(5) *Approved providers and courses.*

a. Approved providers of continuing education. Any IRS-approved provider of continuing education is acceptable. It is not mandatory that a continuing education course be taken from an Iowa provider.

b. Approved continuing education course subject matters. All continuing education courses shall be on the topics of federal or state income tax or professional ethics.

c. Approved continuing education format. Continuing education courses that satisfy the requirements of Iowa Code section 421.64 and this rule may be taken for credit in person, online, or by self-study, as long as they are administered by an IRS-approved provider of continuing education.

7.36(6) *Reporting hours of continuing education and retaining records.*

a. Reporting hours of continuing education to the department. Tax return preparers shall report their continuing education hours to the department by February 15 of the calendar year following the year in which hours were completed to be eligible to prepare income tax returns or claims for refund. Hours must be reported using IA Form 78-012. If a tax return preparer fails to complete the required minimum hours of continuing education by the date prescribed in this subrule, the individual must show that failure to do so was reasonable under the circumstances and not willful or reckless conduct. IRS-approved providers are not required to report continuing education courses to the department.

b. Retaining records of continuing education. Tax return preparers are required to retain records of continuing education completion for a minimum of five years. This record retention shall include,

but is not limited to, certificates of completion if offered by the IRS-approved provider of continuing education upon completion of a course.

7.36(7) Reinstatement of a tax return preparer. When a tax return preparer fails to complete the minimum 15 hours of continuing education courses as required by Iowa Code section 421.64 and this rule but demonstrates that the failure was reasonable under the circumstances and not willful or reckless conduct, the department may require the tax return preparer to make up any uncompleted hours and submit a completed IA Form 78-012 to the department by a date set by the department before the tax return preparer may engage in activity as a tax return preparer.

7.36(8) Examples.

a. Tax return preparer examples.

EXAMPLE 1: During the 2020 calendar year and every prior year, an individual, N, prepares nine or fewer income tax returns or claims for refund described in this rule for a fee or other consideration. During the 2021 calendar year, N, for a fee or other consideration, prepares ten income tax returns or claims for refund described in this rule. N meets the definition of a tax return preparer for the 2021 calendar year. Therefore, N will be subject to the penalty for failure to include N's PTIN on every income tax return or claim for refund described in this rule that N prepares during the 2021 calendar year. However, N also qualifies as a "new tax preparer" for the 2021 calendar year because this is the first year N satisfies the definition of a "tax return preparer." Therefore, N does not need to complete 15 hours of continuing education courses during 2020 to prepare returns in 2021, but N will need to complete the minimum 15 hours of continuing education courses during the 2021 calendar year to be eligible to prepare returns during the 2022 calendar year if N will meet the definition of "tax return preparer" in 2022.

EXAMPLE 2: An individual, B, prepares ten income tax returns or claims for refund described in this rule during the 2019 calendar year for a fee or other consideration. Therefore, B is a tax return preparer. However, B is not required to complete any hours of continuing education courses prior to preparing returns in 2020, nor will B incur a penalty for failing to include B's PTIN on any of those returns prepared in calendar year 2019 because the requirements described in this rule do not take effect until January 1, 2020. Assume B continues to prepare income tax returns or claims for refund described in this rule for a fee or other consideration during the 2020 calendar year, but B only prepares a total of nine such tax returns throughout the entire 2020 calendar year. B does not complete any hours of continuing education courses during the 2020 calendar year. B will not be eligible to prepare ten or more income tax returns or refund claims described in this rule for a fee or other consideration during the 2021 calendar year because even though B did not prepare ten or more income tax returns or claims for refund in 2020, B would have been classified as a tax return preparer in 2019. Thus, B is not considered a new tax preparer for purposes of the 2021 calendar year.

b. Continuing education requirement examples.

EXAMPLE 3: During the 2020 calendar year, an individual, P, prepares ten income tax returns or claims for refund described in this rule for a fee or other consideration. Therefore, P is a tax return preparer. During the 2020 calendar year, P also completes 30 hours of continuing education courses from programs offered by an IRS-approved provider of continuing education, 4 hours of which are on professional ethics and the remaining hours on income tax. P is eligible to prepare returns during the 2021 calendar year. However, P must complete 15 additional hours of continuing education courses offered by an IRS-approved provider, including 2 hours on professional ethics and the remaining hours on income tax, during the 2021 calendar year to be eligible to prepare returns during the 2022 calendar year if P will meet the definition of "tax return preparer" in 2022. P's excess hours completed in 2020 may not be applied toward the 15 hours of continuing education courses that P must complete in 2021 to be eligible to prepare returns in 2022.

EXAMPLE 4: During the 2020 calendar year, a tax return preparer, P, completes 12 hours of continuing education courses from programs offered by an IRS-approved provider of continuing education. Two of the hours are on professional ethics, and the rest relate to income tax. P is not eligible to prepare income tax returns or claims for refund during the 2021 calendar year, regardless of the year of the returns P is preparing, because P has not completed a total of 15 continuing education hours during the 2020

calendar year. During the 2021 calendar year, P completes 15 hours of continuing education courses from programs offered by an IRS-approved provider. Two of P's hours are from professional ethics courses, and the remaining 13 hours are from income tax courses. P is eligible to prepare returns during the 2022 calendar year, regardless of the years of the returns P prepares. However, P is still ineligible to prepare returns for the remaining duration of the 2021 calendar year, regardless of the years of the returns P wishes to prepare.

c. PTIN requirement examples.

EXAMPLE 5: An individual, X, works at a firm in the business of preparing income tax returns for a fee or other consideration. X completes a substantial amount of preliminary work on ten returns described in this rule during the scope of X's employment (that are not the returns of X's employer) during the 2020 calendar year, but X does not assume final responsibility for the work or sign the returns. Instead, X's supervisor, Y, reviews the work completed by X and signs the returns. Y is a tax return preparer because Y assumed final responsibility for the returns. Therefore, Y's PTIN is required on all of the returns. X's PTIN is not required on any of the returns, nor will X incur any penalties for omitting X's PTIN on the returns.

EXAMPLE 6: An individual, X, has a partnership with another individual, Y, in which X and Y prepare income tax returns for a fee or other consideration. X completes ten returns described in this rule during the 2020 calendar year. However, before X signs or files the returns, X asks Y to review the returns. Y reviews the returns and suggests substantial changes, but Y then gives the returns back to X. X makes the necessary changes, then signs and files the returns. X is a tax return preparer. X's PTIN is required on all of the returns because X assumed final responsibility for the returns. Y's PTIN is not required on any of the returns. If X fails to include X's PTIN on any of the returns, X will incur a \$50 civil penalty for each violation unless X shows that X's failure was reasonable under the circumstances and not willful or reckless conduct.

EXAMPLE 7: An individual, X, completes five income tax returns and five claims for refund described in this rule for a fee or other consideration during the 2020 calendar year. X does not sign the returns, even though no other paid tax return preparer reviewed X's work and took final responsibility for the return. X's PTIN is required on all of the returns because X is a paid tax return preparer for those returns, even though X failed to sign the returns as required. X is subject to a fine of \$50 per return that did not contain the required PTIN because X is a tax return preparer.

This rule is intended to implement Iowa Code sections 421.62, 421.63, and 421.64.
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