Sec. 46. Section 904A.1, Code Supplement 1989, is amended to read as follows:

904A.1 BOARD OF PAROLE.

The board of parole is created to consist of five members. Each member, except the chairperson, shall be compensated on a day-to-day basis. Each member shall serve a term of four years beginning ~~July 1~~ and ending as provided by section 69.19, except for members appointed to fill vacancies who shall serve for the balance of the unexpired term. The terms shall be staggered. The chairperson of the board shall be a full-time, salaried member of the board. A majority of the members of the board constitutes a quorum to transact business.

Sec. 47. Section 452.6, Code 1989, is repealed.

Approved May 2, 1990

CHAPTER 1234

INSURANCE REGULATION

H.F. 2320

AN ACT relating to the regulation of insurers, insurance, and annuity contracts, including fire and casualty insurance, altering the method of filing rates subject to the approval of the commissioner of insurance, except for workers' compensation liability insurance rates, providing special effective dates, and authorizing civil penalties.

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

Section 1. Section 296.7, Code Supplement 1989, is amended by striking the section and inserting in lieu thereof the following:

296.7 INDEBTEDNESS FOR INSURANCE AUTHORIZED – TAX LEVY.

1. A school district or merged area school corporation may contract indebtedness and issue general obligation bonds or enter into insurance agreements obligating the school district or corporation to make payments beyond its current budget year for one or more of the following mechanisms to protect the school district or corporation from tort liability, loss of property, environmental hazards, or any other risk associated with the operation of the school district or corporation:

a. To procure or provide for a policy of insurance.

b. To provide a self-insurance program.

c. To establish and maintain a local government risk pool.

However, this subsection does not apply to an insurance program described in subsection 3.

2. For purposes of subsection 1, an employee benefit plan which includes a specific or aggregate excess loss coverage or a program that self-insures only a per-employee or per-family deductible for each year and which transfers the risk remaining beyond this deductible is not a self-insurance program, but is instead an insurance program. As used in this section, an "employee benefit plan" includes, but is not limited to benefits for hospital and surgical, medical expense, major medical, dental, prescription drug, disability, or life insurance costs or benefits.

3. A school district, providing an insurance program as described in subsection 2, shall not contract indebtedness and issue general obligation bonds or enter into insurance agreements obligating the school district to make payments beyond its current budget year for that employee benefit plan. A school district may, however, apply to the school budget review committee for relief if necessitated by the expenses in the school district's insurance program as described in subsection 2.

4. Taxes may be levied in excess of any limitation imposed by statute for payment of one or more of the following authorized by subsection 1:

a. Principal, premium, or interest on bonds.

b. Premium on an insurance policy, including a stop loss or reinsurance policy, except as limited by subsection 3.

c. Costs of a self-insurance program.

d. Costs of a local government risk pool.

e. Amounts payable under an insurance agreement.

However, for a school district, a tax levied under this section shall be included in the district management levy under section 298.4.

5. A self-insurance program or local government risk pool authorized by subsection 1 is not insurance and is not subject to regulation under chapters 505 through 523C. However, those self-insurance plans regulated pursuant to section 509A.14 shall remain subject to the requirements of section 509A.14 and rules adopted pursuant to that section.

6. Notwithstanding the other provisions of this section or any other statute, the tax levy authorized by this section shall not be used to pay the costs of employee benefits, including, but not limited to costs for hospital and surgical, medical expense, major medical, dental, prescription drug, disability, or life insurance benefits.

7. If the board by resolution restricts the use of money in a fund as a reserve for uninsured liability or a self-insurance program, the use shall be restricted and unavailable for any other purpose until the board removes the restriction. The removal is not effective until all obligations of the restricted fund have been satisfied, or the next fiscal year, whichever occurs later.

Sec. 2. Section 505.8, subsection 2, Code 1989, is amended to read as follows:

2. The commissioner shall, subject to ~~the provisions of~~ chapter 17A, establish, publish, and enforce rules not inconsistent with ~~the~~ law for the enforcement of ~~the provisions of~~ this title and for the enforcement of the laws, the administration and supervision of which are imposed on the division, including rules to establish fees sufficient to administer the laws, where appropriate fees are not otherwise provided for in rule or statute, and as necessary to obtain from persons authorized to do business in the state or regulated by the division that data required pursuant to section 145.3 by the state health data commission.

Sec. 3. Section 507.14, Code 1989, is amended by striking the section and inserting in lieu thereof the following:

507.14 CONFIDENTIAL DOCUMENTS – EXCEPTIONS.

A report, preliminary or final, of an examination of a domestic or foreign insurer, and all notes, work papers, or other documents related to an examination of an insurer are not public records under chapter 22 except when sought by the insurer to whom they relate or an insurance regulator of another state, and shall be privileged and confidential in any judicial or administrative proceeding except any of the following:

1. An action commenced by the commissioner under chapter 507C.

2. An administrative proceeding brought by the insurance division under chapter 17A.

3. A judicial review proceeding under chapter 17A brought by an insurer to whom the records relate.

4. An action or proceeding which arises out of the criminal provisions of the laws of this state or the United States.

5. An action brought in a shareholders' derivative suit against an insurer.

6. An action brought to recover moneys or to recover upon an indemnity bond for embezzlement, misappropriation, or misuse of insurer funds.

Sec. 4. Section 507C.6, subsection 1, paragraph b, Code 1989, is amended to read as follows:

b. To make available to the commissioner any books, accounts, documents, or other records, ~~or~~ information, or property of or pertaining to the insurer and in the ~~commissioner's~~ person's possession, custody, or control.

Sec. 5. Section 508.5, Code 1989, is amended to read as follows:

508.5 CAPITAL AND SURPLUS REQUIRED.

A stock life insurance company shall not be authorized to transact business under ~~the provisions of~~ this chapter with less than ~~one~~ two million five hundred thousand dollars capital stock fully paid for in cash and ~~one~~ two million five hundred thousand dollars of surplus paid in ~~in~~ cash or invested as provided by law. A stock life insurance company shall not increase its capital stock unless the amount of the increase is fully paid in cash. The stock shall be divided into shares of not less than one dollar par value each.

Sec. 6. Section 508.9, Code 1989, is amended to read as follows:

508.9 MUTUAL COMPANIES – CONDITIONS.

Level premium and natural premium life insurance companies organized under the laws of this state upon the mutual plan shall, before issuing policies, have actual applications on at least two hundred and fifty lives for an average amount of one thousand dollars each. A list of the applications giving the name, age, residence, amount of insurance, and annual premium of each applicant shall be filed with the commissioner of insurance, and a deposit made with the commissioner of an amount equal to three-fifths of the whole annual premium on the applications, in cash or the securities required by section 508.5. In addition, a deposit of cash or securities of the character provided by law for the investment of funds for life insurance companies in the sum of ~~two~~ five million dollars shall be made with the commissioner, which shall constitute a guaranty fund for the protection of policyholders. ~~In no event shall the~~ The contribution to the guaranty fund shall not give to contributors to the fund or to other persons any voting or other power in the management of the affairs of the company. The guaranty fund may be repaid to the contributors ~~thereto~~ to the guarantee fund with interest at six percent from the date of contribution, at any time, in whole or in part, ~~provided~~ if the repayment does not reduce the surplus of the company below the amount of two million dollars and then only ~~provided~~ if consent in writing for the repayment is obtained from the commissioner of insurance. Upon compliance with ~~the provisions of~~ this section, the commissioner shall issue to the mutual company the certificate prescribed in this chapter.

Sec. 7. Section 508B.1, subsection 4, paragraph a, Code 1989, is amended to read as follows:

a. "Plan of conversion" or "conversion plan" means a plan authorized by section 508B.3 and, in the case of plans authorized by section 508B.3, subsections 1 and 3, includes a procedure by which the mutual company's participating policies and contracts in force on the effective date of the conversion plan are operated by the reorganized company as a closed block of participating business for the exclusive benefit of the policies and contracts included, for dividend purposes only~~,~~; to which are allocated assets of the mutual company in an amount which together with anticipated revenue from the business is reasonably expected to be sufficient to support the business~~,~~; and which includes, but is not limited to, provisions for payment of claims and reasonable expenses, and provisions for continuation of current payable dividend scales if the experience underlying the scales continues, and a procedure for appropriate adjustments in the scales if the experience changes. However, at the option of the mutual company, some or all classes of group policies and contracts shall not be placed in the closed block but shall continue to be eligible to receive dividends based on the experience of ~~such~~ the class or classes.

Sec. 8. Section 508B.2, unnumbered paragraph 3, Code 1989, is amended to read as follows:

In lieu of selecting a plan of conversion provided for in this chapter, a mutual company may convert to a stock company pursuant to a plan approved by the commissioner. The commissioner or the mutual company may use any provisions or combination of provisions provided for a plan in this chapter and may adopt any other provisions which are not unfair or inequitable to the policyholders of the mutual company. If a mutual company selects this procedure for conversion purposes, the mutual company shall reimburse the state for expenses incurred by the division in connection with the conversion plan except for expenses that are normal operating expenses of the division.

Sec. 9. Section 508B.3, subsection 2, paragraph a, Code 1989, is amended to read as follows:

a. The mutual company's participating business, comprised of its participating policies and contracts in force on the effective date of the conversion, shall be operated by the reorganized insurer as a closed block of participating business. However, at the option of the mutual company, group policies and group contracts may be omitted from the closed block.

Sec. 10. Section 508B.3, subsection 2, paragraph e, Code 1989, is amended to read as follows:

e. The reorganized company or its parent corporation shall issue and sell shares of one or more classes having a total price equal to the estimated value in the market on the initial offering date of ~~such~~ the shares.

Sec. 11. Section 508B.3, subsection 2, paragraph g, Code 1989, is amended to read as follows:

g. If a purchaser or a group of purchasers acting in concert is to attain such control in the initial offering, the mutual company shall not, directly or indirectly, pay for any of the costs or expenses of ~~the proposed~~ conversion of the mutual company, whether or not the conversion is effected.

Sec. 12. Section 508B.3, subsection 3, paragraph b, Code 1989, is amended to read as follows:

b. The participating policyholders' consideration shall be based on the latest annual statement, updated to the effective date of the conversion plan, and filed prior to the effective date of the adoption by the board of directors of the plan of conversion ~~and~~. The policyholders' consideration shall be equal to the ~~excess of both of the following:~~

~~(1) The total amount of the mutual company's assets accumulated from the operations of participating policies and contracts in force on the date of the statement over the sum of the total amount of assets allocated to the participating business.~~

~~(2) An amount equal to reserves and other liabilities attributable to any group participating policies and contracts not included in the closed block of participating business~~ sum of the total amount of assets allocated to the participating business and an amount equal to reserves and other liabilities attributable to any group participating policies and contracts not included in the closed block of participating business.

Sec. 13. Section 508B.3, subsection 3, paragraph j, Code 1989, is amended to read as follows:

j. The liquidation account referred to in paragraph "c" must be equal to the excess of the total amount of the assets of the mutual company as of the effective date of the conversion over the sum of the total amount of assets allocated to the closed block of participating business and the policyholders' consideration and other reserves and liabilities attributed to policies and contracts not included in the amount attributable to policies and contracts in force on that effective date. The determinations shall be based on the latest annual statement of the mutual company, updated to the effective date, and filed before the effective date of the conversion plan. The function of the liquidation account ~~shall be~~ is solely to establish a priority on liquidation and its existence ~~shall~~ does not ~~operate to~~ restrict the use or application of the surplus of the reorganized company except as specified in paragraph "i". The liquidation account shall be allocated equally as of the effective date of conversion among the then participating policyholders. The amount allocated to ~~any~~ a policy or contract shall not increase and shall be reduced to zero when the policy or contract terminates. In the event of a complete liquidation of the reorganized company, the policyholders among which the liquidation account is allocated ~~shall be~~ are entitled to receive a liquidation distribution in the then amount of the liquidation account before any liquidation distribution is made with respect to shares.

Sec. 14. Section 508B.3, subsection 3, paragraph k, Code 1989, is amended to read as follows:

k. At the option of the mutual company, the consideration to be given in exchange for the policyholders' membership ~~interest or into which the membership is to be converted~~ interests may consist of cash, securities of the reorganized company, securities of another institution, a certificate of contribution, additional life insurance, annuity benefits, increased dividends, or other consideration or any combination of forms of consideration. The consideration, if any,

given to ~~any~~ a class or category of ~~policyholder~~ policyholders may differ from the consideration given to another class or category of policyholders. The certificate of contribution shall be repayable in ten years, equal to one hundred percent of the value of the policyholders' membership interest, and bear interest at the highest rate charged by the reorganized company for policy loans on the effective date of the conversion.

Sec. 15. Section 508B.5, unnumbered paragraph 2, Code 1989, is amended to read as follows:

The consultant may assist in determining the equity ~~or value~~ of the policyholders ~~and~~ or value of the mutual company. The consultant may consider the value of the consideration to be given to the participating policyholders in exchange for their membership interests ~~or into which the membership interest is to be converted~~ and may consider the valuations necessary to carry out the plans provided for in section 508B.3. Valuations shall be made taking into account the latest filed annual statement of the mutual company, updated to the effective date of the conversion plan, and any significant developments occurring subsequent to the date of the statement.

Sec. 16. Section 508B.7, Code 1989, is amended to read as follows:

508B.7 REVIEW OF PLAN BY COMMISSIONER – HEARING AUTHORIZED – APPROVAL.

The commissioner of insurance shall review the plan. The commissioner shall approve the plan if the commissioner finds the plan complies with all provisions of law, is not unfair or inequitable to the mutual company and its policyholders, and that the reorganized company will have the amount of capital and surplus deemed by the commissioner to be reasonably necessary for its future solvency. The commissioner may order a hearing on the fairness and equity of the terms of the plan after giving written notice of the hearing to the mutual company, its policyholders, and other interested persons, all of whom have the right to appear at the hearing. Costs incurred in connection with the notice shall be paid by the company.

Sec. 17. Section 508B.13, Code 1989, is amended to read as follows:

508B.13 PROHIBITIONS ON CERTAIN OFFERS TO ACQUIRE SHARES.

Prior to and for a period of five years following the effective date of the conversion, and in the case of the plans of conversion specified in subsections 1 and 3 of section 508B.3, five years following the date of distribution of consideration to the policyholders in exchange for their membership interests, ~~an officer or director, including family members and their spouses, of the mutual company or the reorganized company~~ a person, shall not directly or indirectly acquire or offer to acquire ~~or acquire~~ the beneficial ownership of the reorganized company unless the acquisition is made pursuant to a ~~stock option~~ plan approved by the commissioner, made pursuant to the plan of conversion, or made after the initial public offering from a broker or dealer of registered securities with the securities and exchange commission at the quoted price on the date of purchase. An approved plan may include a stock option plan. As used in this section, "beneficial ownership" means, with respect to ~~any~~ a security, the sole or shared power to vote or direct the voting of the security or the sole power to dispose or direct the disposition of the security, ~~and "family member" includes a brother, sister, spouse, parent, grandparent, ancestor, or descendant of the officer or director~~.

Sec. 18. Section 508B.14, unnumbered paragraph 2, Code 1989, is amended to read as follows:

The reorganized company or ~~any~~ a defendant may ~~require the plaintiff~~ petition the court in such an action to give security for the reasonable attorney fees which may be incurred by any party to the action. The amount of the security may be increased or decreased in the discretion of the court having jurisdiction if a showing is made that the security provided is or may become inadequate or excessive.

Sec. 19. Section 508C.5, subsection 6, unnumbered paragraph 1, Code 1989, is amended to read as follows:

"Impaired insurer" means a member insurer ~~domiciled in this state~~ which, after July 1, 1987, is either of the following:

Sec. 20. Section 508C.5, subsection 7, Code 1989, is amended to read as follows:

7. "Insolvent insurer" means a member insurer which, after July 1, 1987, becomes insolvent and is placed under a final order of liquidation~~, rehabilitation, or conservation~~ by a court of competent jurisdiction.

Sec. 21. Section 508C.8, subsection 1, unnumbered paragraph 1, Code 1989, is amended to read as follows:

If a domestic, foreign, or alien insurer is an impaired insurer, the association, subject to conditions imposed by the association and approved by the impaired insurer and the commissioner, may:

Sec. 22. Section 508C.8, subsection 2, Code 1989, is amended by striking the subsection and inserting in lieu thereof the following:

2. a. If a domestic, foreign, or alien insurer is an impaired insurer and the insurer is not paying claims timely, then, subject to the approval of the commissioner and to the preconditions specified in this subsection, the association may do either or both of the following:

(1) Take any of the actions specified in subsection 1, subject to the conditions in that subsection.

(2) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefits, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition for the benefits under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

b. The association is subject to this subsection only if all of the following conditions are met:

(1) The laws of the state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all interest on the payments and expenses have been repaid to the guaranty associations or a plan of repayment by the impaired insurer has been approved by the guaranty associations all of the following apply:

(a) The delinquency proceeding shall not be dismissed.

(b) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management.

(c) The impaired insurer shall not be permitted to solicit or accept new business or have any suspended or revoked license restored.

(2) If the impaired insurer is a domestic insurer it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or, if the impaired insurer is a foreign or alien insurer it has been prohibited from soliciting or accepting new business in this state, its certificate of authority has been suspended or revoked in this state, and a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state or nation of domicile by the commissioner of that state or similar authority in an alien nation.

Sec. 23. Section 508C.9, subsection 3, paragraph a, Code 1989, is amended to read as follows:

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

Sec. 24. Section 508C.9, subsection 3, paragraph b, Code 1989, is amended to read as follows:

b. Class A assessments in excess of one hundred dollars per company per calendar year and class B assessments against member insurers for each account shall be in the proportion that the aggregate premiums received on business in this state by each assessed member insurer on policies or contracts related to that account for the three most recent calendar years for

which information is available, preceding the year ~~of impairment or insolvency~~ in which the insurer became impaired or insolvent, ~~bear to~~ is to the aggregate premiums received on business in this state by all assessed member insurers on policies related to that account for the three most recent calendar years for which information is available preceding the assessment.

Sec. 25. Section 508C.9, subsection 5, paragraph a, Code 1989, is amended to read as follows:

a. The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed two percent of the insurer's premiums received in this state during the ~~calendar year preceding the assessment~~ three most recent calendar years for which information is available, preceding the year in which the insurer becomes impaired or insolvent, on the policies related to that account. If the maximum assessment for ~~any~~ an account, together with the other assets of the association in the account, does not provide in any one year in the account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed for the account ~~as soon thereafter~~ in succeeding years as soon as permitted by this chapter.

Sec. 26. Section 508C.13, subsection 5, paragraph b, Code 1989, is amended to read as follows:

b. ~~Stock dividends~~ Distributions are not recoverable if the insurer shows that when paid the ~~distribution was~~ distributions were lawful and reasonable and that the insurer did not know and could not reasonably have known that the ~~distribution~~ distributions might adversely affect the ability of the insurer to fulfill its contractual obligations.

Sec. 27. Section 509.16, Code 1989, is amended to read as follows:

509.16 PREMIUM RATES APPROVED.

~~No~~ An individual policy of credit life or credit accident and health insurance or certificate under a policy of group credit life or credit accident and health insurance shall not be issued for delivery or delivered in this state unless the premium rates charged for the insurance are approved by the commissioner of insurance.

The commissioner of insurance, after notice and hearing, may adopt rules as are necessary to identify specific methods of competition or acts or practices within the business of credit life and credit accident and health insurance which are unfair or deceptive.

Sec. 28. Section 509.17, subsection 2, Code 1989, is amended to read as follows:

2. Due consideration shall be given to past and prospective loss experience within and outside this state, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both countrywide and those especially applicable to this state, and to all other relevant factors within and outside this state~~, but rates shall be deemed reasonable under this section and section 509.16 if they reasonably may be expected to produce a ratio of fifty percent by dividing claims incurred by premiums earned~~.

Sec. 29. Section 509.17, subsection 3, Code 1989, is amended to read as follows:

3. The commissioner shall, after a public hearing, approve a reasonable charge or premium for credit accident and health insurance and for credit life insurance as the commissioner deems appropriate and necessary for the implementation of this section. ~~A charge or premium of not more than sixty-five cents per annum per one hundred dollars of the initial amount of decreasing term credit life insurance, or its actuarial equivalent for credit life insurance written on other than the decreasing term basis, shall be conclusively presumed to meet the requirements of this section.~~

Sec. 30. NEW SECTION. 509.17A SMALL GROUP RATING.

1. The commissioner shall with all due diligence adopt by rule the recommendations of the national association of insurance commissioners concerning life and accident or health insurance rating practices for small employer groups, provided that the final recommendations are generally consistent with the following principles:

a. Better disclosure to the group of the insurer's group rating practices.

b. Limits on the amount of rate increase that can be based upon the group's own claim experience in the small group market.

c. Actuarial certification that the insurer's rating practices meet the requirements of the national association of insurance commissioners and meet generally accepted actuarial practice.

2. Specific limitations which may be contained in the rules adopted pursuant to subsection 1 include, but are not limited to, the following:

a. The annual rate increase for a group cannot exceed the change in the block's new business rate level plus a fixed percentage of the average rate level for the block.

b. The maximum renewal rate within a block of business cannot exceed the average rate for that block of business by more than a fixed percentage.

c. The maximum renewal rate in any block of business of an insurer cannot exceed the lowest new business rate for any block of business for that insurer by more than a fixed percentage.

d. Other limits on tier and duration rating practices.

3. Within six months of adopting any rule pursuant to subsection 1, the commissioner shall prepare a report to the general assembly regarding the success, if any, of the rules, and make such recommendations as necessary, including offering proposed legislation, to effectuate the general assembly's goals of reducing the potential for abuse in charging higher than actuarially justified rates for some small groups and in underpricing for new small group business.

Sec. 31. Section 514A.3, subsection 1, paragraph m, unnumbered paragraph 3, Code 1989, is amended to read as follows:

~~(In addition to incorporating the~~ The foregoing provision ~~into the policy, the insurer shall deliver to the insured at the time of delivery of the policy a duplicate statement of the foregoing provision which shall be contained in conspicuous print on a separate and otherwise blank sheet of paper.)~~ shall be prominently printed on the first page of the policy or attached to the policy.

Sec. 32. NEW SECTION. 514D.9 REGULATIONS REGARDING LIMITATION ON COMPENSATION.

The commissioner shall issue rules to establish minimum standards to assure fair and reasonable benefits, claim payment, marketing practices, and compensation arrangements and reporting practices for the following classes of policies:

1. Medicare supplement insurance.
2. Nursing home insurance.
3. Long-term care insurance.

Sec. 33. Section 515.8, Code 1989, is amended to read as follows:

515.8 PAID-UP CAPITAL REQUIRED.

An insurance company other than a life insurance company shall not be incorporated to transact business upon the stock plan with less than ~~one~~ two million five hundred thousand dollars capital, the entire amount of which shall be fully paid up in cash and invested as provided by law. An insurance company other than a life insurance company shall not increase its capital stock unless the amount of the increase is fully paid up in cash. The stock shall be divided into shares of not less than one dollar each.

Sec. 34. Section 515.10, Code 1989, is amended to read as follows:

515.10 SURPLUS REQUIRED.

An insurance company other than a life insurance company shall have, in addition to the required paid-up capital, a surplus in cash or invested in securities authorized by law of not less than ~~one~~ two million five hundred thousand dollars. ~~If the commissioner of insurance finds that a company offers or plans to offer only one kind of insurance the commissioner may reduce the amount of surplus required, but in no event shall it be reduced to less than three hundred thousand dollars.~~

Sec. 35. Section 515.11, Code 1989, is amended to read as follows:

515.11 PROHIBITED LOANS.

~~No part of the capital referred to~~ Capital, surplus, funds, or other assets, or any part of any or all of the foregoing, shall not be directly or indirectly loaned to ~~any~~ an officer, director, stockholder, or employee of ~~the~~ a company or to a relative of ~~any~~ an officer or director of ~~the~~ a company.

Sec. 36. Section 515.12, subsection 5, Code 1989, is amended to read as follows:

5. The mutual company shall have in cash or in securities in which insurance companies are authorized to invest, surplus in an amount not less than ~~two~~ five million dollars. The surplus so required may be advanced in accordance with ~~the provisions of~~ section 515.19.

~~Provided, however, that such~~ However, the surplus requirements ~~shall~~ do not apply to a company which establishes and maintains a guaranty fund as provided by section 515.20.

Sec. 37. Section 515.70, Code 1989, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. An alien insurer, with the approval of the commissioner, may be treated as a domestic insurer of this state in whole or in part. The approval of the commissioner may be based upon such factors as:

1. Maintenance of an appropriate trust account, surplus account, or other financial mechanism in this state.
2. Maintenance of all books and records of United States operations in this state.
3. Maintenance of a separate financial reporting system for its United States operations.
4. Any other provisions deemed necessary by the commissioner.

Sec. 38. Section 515.80, Code 1989, is amended by striking the section and inserting in lieu thereof the following:

515.80 FORFEITURE OF POLICIES — NOTICE.

A policy or contract of insurance, unless otherwise provided in section 515.81A or 515.81B, provided for in this chapter shall not be forfeited, suspended, or canceled except by notice to the insured as provided in this chapter. A notice of cancellation is not effective unless mailed or delivered by the insurer to the named insured at least twenty days before the effective date of cancellation, or, where cancellation is for nonpayment of a premium, assessment, or installment provided for in the policy, or in a note or contract for the payment thereof, at least ten days prior to the date of cancellation. The notice may be made in person, or by sending by mail a letter addressed to the insured at the insured's address as given in or upon the policy, anything in the policy, application, or a separate agreement to the contrary notwithstanding.

An insurer shall not fail to renew a policy except by notice to the insured as provided in this chapter. A notice of intention not to renew is not effective unless mailed or delivered by the insurer to the named insured at least thirty days prior to the expiration date of the policy.

If the reason does not accompany the notice of cancellation or nonrenewal, the insurer shall, upon receipt of a timely request by the named insured, state in writing the reason for cancellation or nonrenewal.

Sec. 39. Section 515.81, Code 1989, is amended to read as follows:

515.81 CANCELLATION OF POLICY — NOTICE TO INSURED OR MORTGAGEE.

Unless otherwise provided in section 515.81A or 515.81B, at any time after the maturity of a premium, assessment, or installment provided for in the policy, or ~~any~~ a note or contract for the payment thereof, or after the suspension, forfeiture, or cancellation of ~~any~~ a policy or contract of insurance, the insured may pay to the company the customary short rates and costs of action, if one has been commenced or judgment rendered thereon, and may, if the insured so elects, have the policy and all contracts or obligations connected ~~therewith~~ with the policy, whether in judgment or otherwise, canceled, and all such policy and contracts shall be void; and in case of suspension, forfeiture, or cancellation of ~~any~~ a policy or contract of insurance, the insured ~~shall~~ is not ~~be~~ liable for ~~any~~ a greater amount than the short rates earned at the date of ~~such~~ the suspension, forfeiture, or cancellation and the costs of action provided for in

this section. ~~The policy may be canceled by the insurance company by service of notice in writing upon the insured which notice shall fix the date of cancellation which shall be not less than ten days after service of the notice. The service of notice may be made in person, or by mailing the notice to the insured at the insured's post office address as given in or upon the policy, or to another address given to the company in writing by the insured. A post office department receipt of certified or registered mailing shall be deemed proof of receipt of the notice.~~ If the policy is canceled by the insurance company, the insurer may retain only the pro rata premium, and if the initial cash premium, or any part ~~thereof~~ of the premium, has not been paid, the policy may be canceled by the insurance company by giving notice to the insured as provided in section 515.80 and ten days' notice to the mortgagee, or other person to whom the policy is made payable, if any, without tendering any part ~~or portion~~ of the premium, anything to the contrary in the policy notwithstanding.

Sec. 40. NEW SECTION. 515.81C CANCELLATION OR NONRENEWAL OF COMMERCIAL UMBRELLA OR EXCESS POLICIES OR CONTRACTS.

1. As used in this section, "umbrella or excess insurance policy" means a commercial line policy or contract of insurance providing liability or property coverage over one or more underlying policies or over a specified amount of self-insured retention. Umbrella or excess insurance policy includes policies or contracts written over an umbrella or excess insurance policy or policies.

2. An umbrella or excess insurance policy which has not previously been renewed may be canceled by the insurer if it has been in effect for less than sixty days at the time notice of cancellation is mailed or delivered.

3. An umbrella or excess insurance policy which has been renewed or which has been in effect for sixty or more days shall not be canceled by the insurer, except as provided in section 515.81A, subsections 2 and 3, except by notice to the insured as required by this section or unless at least one of the following conditions occurs:

a. A material change in the limits, scope of coverage, or exclusions in one or more of the underlying policies.

b. Cancellation or nonrenewal of one or more of the underlying policies where the policies are not replaced without lapse.

c. A reduction in the financial rating or grade of one or more of the insurers insuring one or more of the underlying policies based on an evaluation by a recognized financial rating organization.

4. A notice of cancellation is not effective unless mailed by certified mail or delivered to the named insured and any loss payee at least ten days prior to the effective date of cancellation. A notice of cancellation shall include the reason for cancellation of the umbrella or excess insurance policy. A post office department certificate of mailing to the named insured at the address shown in the umbrella or excess policy is proof of receipt of the mailing; however, such a certificate of mailing is not required if cancellation is for nonpayment of premium.

5. An insurer shall not fail to renew an umbrella or excess insurance policy except by notice to the insured as provided in this section; however, an insurer may condition renewal of an umbrella or excess insurance policy upon requirements relating to the underlying policy or policies. If the requirements are not satisfied as of the expiration date of the umbrella or excess insurance policy, or thirty days after mailing or delivery of the notice, whichever is later, the conditional renewal notice shall be deemed to be an effective notice of nonrenewal. This subsection does not apply if the insurer has offered to renew or if the insured fails to pay a premium due or any advance premium required by the insurer for renewal.

6. A notice of nonrenewal is not effective unless mailed by certified mail or delivered to the named insured and any loss payee at least forty-five days prior to the expiration date of the umbrella or excess insurance policy. If the insurer fails to meet the notice requirements of this subsection the insured has the option of continuing the policy for the remainder of the notice period plus an additional thirty days at the premium rate of the existing umbrella or excess policy.

7. Section 515.81A and 515.81B are not applicable to umbrella or excess insurance policies except as provided in subsection 3.

Sec. 41. Section 515.147, Code 1989, is amended to read as follows:

515.147 BUSINESS WITH UNAUTHORIZED INSURERS.

~~Nothing contained in this~~ This chapter ~~shall be construed to~~ does not prevent a licensed resident agent of this state from procuring insurance in certain ~~unauthorized~~ nonadmitted insurers ~~providing that~~ if such insurance is restricted to the type and kind of insurance authorized by this chapter and the agent makes oath to the commissioner of insurance in ~~such~~ the form ~~as is~~ prescribed by the commissioner that the agent has made diligent effort to place ~~said~~ the insurance in authorized insurers and has either exhausted the capacity of all authorized insurers or has been unable to obtain the desired insurance in insurers licensed to transact business in this state. The procuring of ~~any such contracts~~ a contract of insurance in ~~unauthorized insurers~~ a nonadmitted insurer makes ~~such insurers~~ the insurer liable for, and the agent shall pay, the taxes on ~~such~~ the premiums as if ~~such~~ the insurer were duly authorized to transact business in the state. A sworn report of all business transacted by agents of this state in ~~such unauthorized~~ nonadmitted insurers shall be made to the commissioner of insurance on or before March 1 of each year for the preceding calendar year, on ~~such~~ the form ~~as~~ required by the commissioner of insurance ~~may require; such~~. The report shall be accompanied by a remittance to cover the taxes ~~thereon~~ on the premiums. ~~Any~~ An agent who makes the oath ~~as above provided~~, pays the taxes on the premiums, and files the report ~~above provided, shall~~ has not ~~be deemed to have~~ written such contracts of insurance unlawfully, and ~~such agent shall~~ is not ~~be~~ personally liable for ~~such~~ the contracts.

Sec. 42. Section 515.148, Code 1989, is amended to read as follows:

515.148 BANNED COMPANIES.

~~No~~ An agent shall not knowingly place insurance, either directly or through an intermediary broker, in insurers who are insolvent or unsound financially; and ~~in no event~~ shall ~~an agent~~ not place or renew ~~any~~ insurance with ~~unauthorized~~ nonadmitted insurers found by the commissioner of insurance to have failed or refused to furnish, in ~~such~~ the manner ~~as is~~ provided in section 515.149, information reasonably showing the ability or willingness of ~~such~~ the insurers to satisfy obligations undertaken with respect to insurance issued by them.

Sec. 43. Section 515A.2, Code 1989, is amended by striking the section and inserting in lieu thereof the following:

515A.2 DEFINITIONS — SCOPE OF CHAPTER.

1. As used in this chapter:

a. "Insurance" means workers' compensation liability insurance.

b. "Insurer" means an insurer which issues a policy of workers' compensation liability insurance.

c. "Policy" means a policy of workers' compensation liability insurance.

d. "Rate" means a rate for workers' compensation liability insurance.

e. "Rating organization" means a workers' compensation rating organization licensed pursuant to this chapter.

f. "Rate filing" means a rate filing by a rating organization or an insurer.

2. This chapter applies only to workers' compensation liability insurance.

Sec. 44. Section 515E.9, Code 1989, is amended by striking the section and inserting in lieu thereof the following:

515E.9 PURCHASING GROUP RESTRICTIONS.

A purchasing group shall not purchase insurance from an insurer not admitted in this state unless the purchase is effected through a duly licensed agent or broker acting pursuant to sections 515.147 through 515.149.

Sec. 45. NEW SECTION. 515F.1 PURPOSE OF CHAPTER.

1. The purpose of this chapter is to promote the public welfare by regulating insurance rates so they are not excessive, inadequate, or unfairly discriminatory, and to authorize and

regulate limited cooperative action among insurers in ratemaking-related activities and in other matters within the scope of this chapter. This chapter is not intended to:

a. Prohibit or discourage reasonable competition.

b. Prohibit or encourage, except to the extent necessary to accomplish its purpose, uniformity in rating systems, rating plans, or practices.

2. This chapter shall be liberally interpreted to carry into effect the provisions of this section.

Sec. 46. NEW SECTION. 515F.2 DEFINITIONS.

1. "Advisory organization" means an entity, including its affiliates or subsidiaries, which either has two or more member insurers or is controlled either directly or indirectly by two or more insurers, and which assists insurers in ratemaking-related activities such as enumerated in sections 515F.10 and 515F.11. Two or more insurers having a common ownership or operating in this state under common management or control constitute a single insurer for purposes of this definition.

2. "Commercial risk" means any kind of risk which is not a personal risk.

3. "Developed losses" means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those needed to provide actual ultimate loss (including loss adjustment expense) payments.

4. "Expenses" means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees.

5. "Joint underwriting" means a voluntary arrangement established on an ad hoc basis to provide insurance coverage for a commercial risk pursuant to which two or more insurers jointly contract with the insured at a price and under policy terms agreed upon between the insurers.

6. "Loss trending" means a procedure for projecting developed losses to the average date of loss for the period during which the policies are to be effective.

7. "Personal risk" means insurance covering homeowners, tenants, private passenger nonfleet automobiles, and mobile homes, and other property and casualty insurance for personal, family, or household needs.

8. "Pool" means a voluntary arrangement, established on an ongoing basis, pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate, or other pooling agreement.

9. "Prospective loss costs" means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and is based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

10. "Rate" means the cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premium.

11. "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be offered to applicants who are unable to obtain insurance through ordinary methods.

12. "Supplementary rating information" includes a manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, underwriting rule, statistical plan, and any other similar information needed to determine the applicable rate in effect or to be in effect.

13. "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or advisory organizations relied upon by the filer, the interpretation of any other data relied upon by the filer, descriptions of methods used in making the rates, and any other information required by the commissioner to be filed.

Sec. 47. NEW SECTION. 515F.3 SCOPE OF CHAPTER.

This chapter applies to all forms of casualty insurance, including fidelity, surety, and guaranty bonds, including but not limited to all forms of fire and inland marine insurance, and to any combination of any of the foregoing, on risks or operations located in this state.

This chapter does not apply to:

1. Reinsurance, other than statutorily authorized joint reinsurance mechanisms to the extent stated in section 515F.13.

2. Accident and health insurance.

3. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, excluding inland marine insurance, as determined by the commissioner.

4. Workers' compensation insurance.

5. Surplus lines insurance.

6. Insurance written by a county mutual assessment association as provided in chapter 518A.

Sec. 48. NEW SECTION. 515F.4 RATE STANDARDS.

Rates shall be made in accordance with the following:

1. Rates shall not be excessive, inadequate, or unfairly discriminatory.

2. Due consideration may be given to past and prospective loss experience within and outside this state; to the conflagration and catastrophe hazards; to a reasonable margin for profit and contingencies; to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers; to past and prospective expenses both within and outside this state; and to all other relevant factors within and outside this state; and in the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which experience data is available.

3. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. A risk classification, however, shall not be based upon race, creed, national origin, or the religion of the insured.

4. The expense provisions included in the rates to be used by an insurer shall reflect to the extent possible the operating methods of the insurer and its anticipated expenses.

5. The rates may contain a provision for contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of the profit, consideration shall be given to investment income attributable to unearned premium and loss reserves. Income from other sources shall not be considered.

Sec. 49. NEW SECTION. 515F.5 RATE FILINGS.

1. An insurer shall file with the commissioner, except as to inland marine risks which are not written according to manual rates or rating plans, every manual, minimum premium, class rate, rating schedule, rating plan, and every other rating rule, and every modification of any of the foregoing which it proposes to use. A filing shall state its proposed effective date, and shall indicate the character and extent of the coverage contemplated.

An insurer shall file or incorporate by reference to material which has been approved by the commissioner, at the same time as the filing of the rate, all supplementary rating and supporting information to be used in support of or in conjunction with a rate. The information furnished in support of a filing may include or consist of a reference to any of the following:

a. The experience or judgment of the insurer or rating information filed by the advisory organization on behalf of the insurer as permitted by section 515F.11.

b. An interpretation of any statistical data the insurer relies upon.

c. The experience of other insurers or rating advisory organizations.

d. Any other relevant factors. A filing and any supporting information shall be open to public inspection after the filing becomes effective.

When a filing is not accompanied by the information upon which the insurer supports the filing, the commissioner may require the insurer to furnish the supporting information and the waiting period commences on the date the information is furnished. Until the required information is furnished, the filing shall not be deemed complete or filed or available for use by the insurer. If the requested information is not furnished within a reasonable time period, the filing may be returned to the insurer as not filed and not available for use.

After reviewing an insurer's filing, the commissioner may require that the insurer's rates be based upon the insurer's own loss and expense information. If an insurer's loss or allocated loss adjustment expense information is not actuarially credible, as determined by the commissioner, the insurer may supplement its experience with information filed with the commissioner by an advisory organization.

Insurers using the services of an advisory organization shall, at the request of the commissioner, provide with a rate filing, a description of the rationale for that use, including its own information and method of using the advisory organization's information.

2. The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

3. Subject to the exception in subsection 4, a filing shall be on file for a waiting period of fifteen days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed fifteen days if written notice is given within the waiting period to the insurer or advisory organization which made the filing that additional time is needed for the consideration of the filing. Upon written application by the insurer, the commissioner may authorize a filing which has been reviewed to become effective before the expiration of the waiting period or an extension of the waiting period. A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or an extension of the waiting period.

4. Under rules adopted under chapter 17A, the commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, or subdivision or combination of insurance, or as to classes of risks, the rates for which cannot practicably be filed before they are used. The commissioner may make an examination as the commissioner deems advisable to ascertain whether rates affected by the order meet the standards set forth in section 515F.4.

5. Upon the written application of the insured stating the insured's reasons, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on a specific risk.

6. An insurer shall not make or issue a contract or policy except in accordance with the filings which have been approved and are in effect for the insurer as provided in this chapter. This subsection does not apply to contracts or policies for inland marine risks as to which filings are not required.

Sec. 50. NEW SECTION. 515F.6 DISAPPROVAL OF FILINGS.

1. If, within the waiting period or any extension of it as provided in section 515F.5, subsection 3, the commissioner finds that a filing does not meet the requirements of this chapter, written notice of disapproval shall be sent to the insurer or advisory organization which made the filing, specifying in what respects the filing fails to meet the requirements of this chapter and stating that the filing shall not become effective. If a filing is disapproved by the commissioner, the insurer or advisory organization, may request a hearing on the disapproval within thirty days. The insurer bears the burden of proving compliance with the standards established by this chapter.

2. If, at any time after a rate has been approved, the commissioner finds that the rate no longer meets the requirements of this chapter, the commissioner may order the discontinuance of use of the rate. The order of discontinuance may be issued only after a hearing with

at least ten days' prior notice for all insurers affected by the order. The order must be in writing and state the grounds for the order. The order shall state when, within a reasonable period after the order is issued, the order of discontinuance shall be effective. The order shall not affect a contract or policy made or issued prior to the expiration of the period set forth in the order.

3. An insured which is aggrieved with respect to a filing which is in effect may make written application to the commissioner for a hearing on that filing. The application shall specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds are established, and that the grounds otherwise justify holding a hearing, a hearing shall be held within thirty days after receipt of the application, upon not less than ten days' written notice to the applicant and to every insurer and advisory organization which made that filing.

If, after hearing, the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period after the order is issued, the filing shall no longer be in effect. Copies of the order shall be sent to the applicant and to every insurer and advisory organization which made that filing. The order shall not affect a contract or policy made or issued prior to the expiration of the period set forth in the order.

Sec. 51. NEW SECTION. 515F.7 INFORMATION TO BE FURNISHED INSUREDS — HEARINGS AND APPEALS OF INSUREDS.

An insurer shall, within a reasonable time after receiving written request and upon payment of reasonable charges set by the commissioner, furnish to an insured affected by a rate made by the insurer, or to the authorized representative of the insured, all pertinent information as to the rate. An insurer shall provide within this state reasonable means for the insured aggrieved by the application of its rating system to be heard, in person or by the insured's authorized representative, on written request to review the manner in which the rating system has been applied in connection with the insurance afforded the insured. If the insurer fails to grant or reject a request for hearing and review within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected. The insured affected by the action of the insurer on a request may, within thirty days after written notice of the action, appeal to the commissioner, who, after a hearing held upon not less than ten days' written notice to the appellant and to the insurer, may affirm or reverse the action.

Sec. 52. NEW SECTION. 515F.8 LICENSING ADVISORY ORGANIZATIONS.

1. LICENSE REQUIRED. An advisory organization shall not provide a service relating to the rates of insurance subject to this chapter, and an insurer shall not utilize the services of an advisory organization for such purposes unless the advisory organization has obtained a license under subsection 3.

2. AVAILABILITY OF SERVICES. An advisory organization shall not refuse to supply any services for which it is licensed in this state to an insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services.

3. LICENSING.

a. APPLICATION. An advisory organization applying for a license shall include with its application all of the following:

(1) A copy of its constitution, charter, articles of organization, agreement, association, or incorporation, and a copy of its bylaws, plan of operation, and any other rules or regulations governing the conduct of its business.

(2) A list of its members and subscribers.

(3) The name and address of one or more residents of this state upon whom notices, process affecting it, or orders of the commissioner may be served.

(4) A statement showing its technical qualifications for acting in the capacity for which it seeks a license.

(5) A biography of the ownership and management of the organization.

(6) Any other relevant information and documents that the commissioner may require.

b. CHANGE OF CIRCUMSTANCES. An advisory organization which has applied for a license shall notify the commissioner of every material change in the facts or in the documents on which its application was based. An amendment to a document filed under this section shall be filed at least thirty days before it becomes effective.

c. GRANTING OF LICENSE. If the commissioner finds that the applicant and the natural persons through whom it acts are competent, trustworthy, and technically qualified to provide the services proposed, and that all requirements of the law are met, the commissioner shall issue a license specifying the authorized activity of the applicant. The commissioner shall not issue a license if the proposed activity would tend to create a monopoly or to substantially lessen the competition in any market.

d. DURATION. A license issued under this section shall remain in effect for one year unless the license is suspended or revoked. The commissioner may, at any time after hearing, revoke or suspend the license of an advisory organization which does not comply with the requirements and standards of this chapter.

Sec. 53. NEW SECTION. 515F.9 INSURERS AND ADVISORY ORGANIZATIONS — PROHIBITED ACTIVITY.

1. An insurer or advisory organization shall not:

a. Attempt to monopolize, or combine or conspire with any other person to monopolize, an insurance market.

b. Engage in a boycott, on a concerted basis, of an insurance market.

2. a. An insurer shall not agree with any other insurer or with an advisory organization to mandate adherence to or to mandate use of a rate, rating plan, rating schedule, rating rule, policy or bond form, rate classification, rate territory, underwriting rule, survey, inspection, or similar material, except as needed to develop statistical plans permitted by section 515F.11, subsection 1. The fact that two or more insurers, whether or not members or subscribers of an advisory organization, use consistently or intermittently, the same rates, rating plans, rating schedules, rating rules, policy or bond forms, rate classifications, rate territories, underwriting rules, surveys or inspections or similar materials is not sufficient in itself to support a finding that an agreement exists.

b. Two or more insurers having a common ownership or operating in this state under common management or control may act in concert between or among themselves with respect to any matters pertaining to those activities authorized in this chapter as if they constituted a single insurer.

3. An insurer or advisory organization shall not make an arrangement with any other insurer, advisory organization, or other person which has the purpose or effect of restraining trade unreasonably or of substantially lessening competition in the business of insurance.

Sec. 54. NEW SECTION. 515F.10 ADVISORY ORGANIZATIONS — PROHIBITED ACTIVITY.

In addition to the other prohibitions contained in this chapter, except as specifically permitted under section 515F.11, an advisory organization shall not compile or distribute recommendations relating to rates that include profit or expenses, other than loss adjustment expenses.

Sec. 55. NEW SECTION. 515F.11 ADVISORY ORGANIZATIONS — PERMITTED ACTIVITY.

An advisory organization, in addition to other activities not prohibited, may, on behalf of its members and subscribers, do any or all of the following:

1. Develop statistical plans including territorial and class definitions.

2. Collect statistical data from members, subscribers, or any other source.

3. Prepare and distribute prospective loss costs.

4. Prepare and distribute factors, calculations, or formulas pertaining to classifications, territories, increased limits, and other variables.

5. Prepare and distribute manuals of rating rules and rating schedules that do not include final rates, expense provisions, profit provisions, or minimum premiums.

6. Distribute information that is required or directed to be filed with the commissioner.

7. Conduct research and on-site inspections in order to prepare classifications of public fire defenses.

8. Consult with public officials regarding public fire protection as it would affect members, subscribers, and others.

9. Conduct research and collect statistics in order to discover, identify, and classify information relating to causes or prevention of losses.

10. Prepare policy forms and endorsements and consult with members, subscribers, and others relative to their use and application.

11. Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures.

12. Collect, compile, and distribute past and current prices of individual insurers and publish such information.

13. File final rates, at the direction of the commissioner, for residual market mechanisms.

14. Collect, compile, and distribute historical expense information.

15. Furnish any other services, as approved or directed by the commissioner, related to those enumerated in this section.

Sec. 56. NEW SECTION. 515F.12 ADVISORY ORGANIZATIONS — FILING REQUIREMENTS.

An advisory organization shall file with the commissioner for approval all prospective loss costs and all supplementary rating information and every change or amendment or modification of any of the foregoing proposed for use in this state. The filings are subject to sections 515F.5 and 515F.6 and other provisions of this chapter relating to filings made by insurers.

Sec. 57. NEW SECTION. 515F.13 POOL AND RESIDUAL MARKET ACTIVITIES.

1. AUTHORIZATION. Notwithstanding section 515F.9, rating organizations, advisory organizations, and insurers participating in joint underwriting, joint reinsurance pools, or residual market mechanisms may in connection with such activity act in cooperation with each other in the making of rates, rating systems, policy forms, underwriting rules, surveys, inspections, and investigations, the furnishing of loss and expense statistics or other information, or carrying on research. Joint underwriting, joint reinsurance pools, and residual market mechanisms shall not be deemed advisory organizations.

2. REGULATION.

a. Except to the extent modified by this section, insurers, and joint underwriting, joint reinsurance pool, and residual market mechanism activities are subject to the other provisions of this chapter.

b. If, after hearing, the commissioner finds that an activity or practice of an insurer participating in joint underwriting or a pool is unfair, is unreasonable, will tend to lessen competition in a market, or is otherwise inconsistent with the provisions or purposes of this chapter, the commissioner may issue a written order and require the discontinuance of that activity or practice.

c. A pool shall file with the commissioner a copy of its constitution; its articles of incorporation, agreement, or association; its bylaws, rules, and regulations governing its activities; its members; the name and address of a resident of this state upon whom notices or orders of the commissioner or process may be served; and any changes in amendments or changes in the foregoing.

d. A residual market mechanism, or plan or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the commissioner for consideration and approval, together with information as reasonably required by the commissioner. The commissioner shall only approve agreements found to contemplate both of the following:

(1) The use of rates which meet the standards prescribed by this chapter.

(2) Activities and practices that are not unfair, unreasonable, or otherwise inconsistent with this chapter.

At any time after the agreements are in effect, the commissioner may review the practices and activities of the adherents to the agreements and if, after a hearing, the commissioner finds that any such practice or activity is unfair or unreasonable, or is otherwise inconsistent with this chapter, the commissioner may issue a written order to the parties and either require the discontinuance of the acts or revoke approval of the agreement.

Sec. 58. NEW SECTION. 515F.14 EXAMINATIONS.

The commissioner may, as often as deemed expedient, make or cause to be made an examination of each advisory organization referred to in section 515F.8 and of each group, association, or other organization referred to in section 515F.13. The reasonable costs of an examination shall be paid by the advisory organization or group, association, or other organization examined. The officers, manager, agents, and employees of the advisory organization, or group, association, or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation. In lieu of an examination, the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

Sec. 59. NEW SECTION. 515F.15 RATE ADMINISTRATION.

1. RECORDING AND REPORTING OF LOSS AND EXPENSE EXPERIENCE.

The commissioner may adopt reasonable rules for use by companies to record and report to the commissioner their rates and other information determined by the commissioner to be necessary or appropriate for the administration of this chapter and the effectuation of its purposes.

The commissioner may adopt reasonable rules and statistical plans, which shall then be used by each insurer in the recording and reporting of its loss and expense experience, in order that the experience of all insurers may be made available at least annually in the form and detail necessary to aid the commissioner in determining whether rating systems comply with the standards set forth in section 515F.4. The commissioner may designate one or more advisory organizations or other agencies to assist in gathering the experience and making compilations, and the compilations shall be public documents.

2. INTERCHANGE OF RATING PLAN DATA.

Reasonable rules and plans may be adopted by the commissioner for the interchange of data necessary for the application of rating plans.

3. CONSULTATION WITH OTHER STATES.

In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and advisory organization may exchange information and experience data with insurance supervisory officials, insurers, and advisory organizations in other states and may consult with them with respect to the application of rating systems.

4. RULES.

The commissioner may make reasonable rules necessary, including definitions of the rate standards contained in section 515F.4, to effect the purposes of this chapter.

Sec. 60. NEW SECTION. 515F.16 FALSE OR MISLEADING INFORMATION.

A person, including an insurer, or advisory organization, shall not willfully withhold information which will affect the rates or premiums chargeable under this chapter from, or knowingly give false or misleading information to, the commissioner, a statistical agency designated by the commissioner, an advisory organization, or an insurer. A violation of this section subjects the one guilty of the violation to the penalties provided in section 515F.19.

Sec. 61. NEW SECTION. 515F.17 ASSIGNED RISKS.

Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to, but who

are unable to procure, the insurance through ordinary methods, and the insurers may agree among themselves on the use of reasonable rate modifications for such insurance, the agreements and rate modifications to be subject to the approval of the commissioner.

Sec. 62. NEW SECTION. 515F.18 EXEMPTIONS.

The commissioner may, upon the commissioner's own initiative or upon request of any person, by rule, exempt a market from any or all of the provisions of this chapter, if and to the extent that the exemption is necessary to achieve the purposes of this chapter.

Sec. 63. NEW SECTION. 515F.19 PENALTIES.

The commissioner may, upon a finding that a person or organization has violated a provision of this chapter, impose a civil penalty of not more than ten thousand dollars for each violation, but if the violation is found to be willful, a penalty of not more than twenty-five thousand dollars may be imposed for each violation. The civil penalties may be in addition to any other penalty provided by law.

For purposes of this section, an insurer using a rate for which the insurer has failed to file the rate, supplementary rate information, underwriting rules or guides, or supporting information as required by this chapter, has committed a separate violation for each day the failure continues.

The commissioner may suspend or revoke the license of an advisory organization or insurer which fails to comply with an order of the commissioner within the time limit set by the order, or an extension of the order.

The commissioner may determine when a suspension of license becomes effective and it shall remain in effect for the period fixed by the commissioner, unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

A penalty shall not be imposed and a license shall not be suspended or revoked except upon a written order of the commissioner stating the commissioner's findings, made after hearing.

Sec. 64. Section 507B.4, subsection 11, Code Supplement 1989, is amended to read as follows:

11. Rating organizations. Any violation of section ~~515A.16~~ 515F.16.

Sec. 65. Section 515A.21, Code 1989, is amended to read as follows:

515A.21 SCOPE OF APPLICATION.

Section 515A.20 and sections 515A.22 through 515A.25 apply to all forms of casualty insurance except ~~those described in sections 515A.11 and 515A.15~~ joint underwriting and joint reinsurance, assigned risks, and those excluded by section 515A.2.

Sec. 66. Section 515A.23, Code 1989, is amended to read as follows:

515A.23 NONCOMPETITIVE MARKET.

Unless the commissioner has determined a market to be competitive, the provisions of sections ~~515A.1~~ 515F.1 through ~~515A.19~~ 515F.19 apply.

Sec. 67. Section 515A.24, Code 1989, is amended to read as follows:

515A.24 FILING OF RATES IN A COMPETITIVE MARKET.

1. Subject to the inland marine exception specified in section ~~515A.4, subsection 5~~ 515F.5, subsection 1, a competitive filing shall become effective when filed and shall be deemed to meet the requirements of section ~~515A.3~~ 515F.4 as long as the filing remains in effect unless it is disapproved upon review by the commissioner.

2. In a competitive market, every insurer shall file with the commissioner all rates and supplementary rate information which are used in this state. The rates and supplementary rate information shall be filed not later than fifteen days after the effective date of the rates.

3. In a competitive market, if the commissioner finds that an insurer's rates require closer supervision because of the insurer's financial condition or unfairly discriminatory rating practices, the insurer shall file with the commissioner at least thirty days prior to the effective

date of the rates all the rates and supplementary rate information and supporting information as prescribed by the commissioner. Upon application by the filer, the commissioner may authorize an earlier effective date.

Sec. 68. Section 515A.25, Code 1989, is amended to read as follows:

515A.25 DISAPPROVAL OF A RATE FILING IN A COMPETITIVE MARKET.

1. If the commissioner believes that an insurer's rate filing in a competitive market violates the requirements of section ~~515A.3~~ 515F.4 through 515F.5, the commissioner may require the insurer to file supporting information. If after reviewing the supporting information the commissioner continues to believe that the filing violates section ~~515A.3~~ 515F.4 through 515F.5, the commissioner shall notify the insurer of the insurer's right to petition for a hearing on any subsequent order relating to the filing.

2. The commissioner may disapprove prefiled rates that have not become effective. However, the commissioner shall notify the insurer whose rates have been disapproved of the insurer's right to petition for a hearing on the disapproval within thirty days after the disapproval.

3. If the commissioner disapproves a filing in a competitive market, the commissioner shall issue an order specifying the reasons the filing fails to meet the requirements of section ~~515A.3~~ 515F.4 through 515F.5. For rates in effect at the time of disapproval, the commissioner shall inform the insurer within a reasonable period of time the date when further use of the rates for policies or contracts of insurance is prohibited. The order shall be issued within thirty days of disapproval, or within thirty days of a hearing on the disapproval if a hearing is held. The order may include a provision for premium adjustment for the period after the effective date of the order for policies or contracts in effect on the date of the order.

4. Whenever an insurer has filed no legally effective rates as a result of the commissioner's disapproval of a filing, the commissioner shall on request of the insurer work with the insurer to develop interim rates for the insurer that are sufficient to protect the interest of all parties and the commissioner may order that a specified portion of the premium be placed in an escrow account approved by the commissioner. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately. The commissioner may waive distribution if the commissioner determines that the amount involved would not warrant such action.

Sec. 69. Section 518.10, Code 1989, is amended by adding the following new unnumbered paragraph:

NEW UNNUMBERED PARAGRAPH. An alien insurer, with the approval of the commissioner, may be treated as a domestic insurer of this state in whole or in part. The approval of the commissioner may be based upon such factors as:

1. Maintenance of an appropriate trust account, surplus account, or other financial mechanism in this state.

2. Maintenance of all books and records of United States operations in this state.

3. Maintenance of a separate financial reporting system for its United States operations.

4. Any other provisions deemed necessary by the commissioner.

Sec. 70. NEW SECTION. 518.25 SURPLUS.

An association organized under this chapter shall at all times maintain a surplus of not less than fifty thousand dollars or one-tenth of one percent of the gross property risk in force, whichever is greater. Reinsurance sufficient to protect the financial stability of the company is also required. The insurance commissioner may require additional reinsurance if necessary to protect the policyholders of the company. An association authorized to transact business in this state before July 1, 1990, shall meet this requirement not later than July 1, 1993.

Sec. 71. NEW SECTION. 518A.37 SURPLUS.

An association organized under this chapter shall at all times maintain a surplus of not less than one hundred thousand dollars. Reinsurance sufficient to protect the financial stability

of the company is also required. The insurance commissioner may require additional reinsurance if necessary to protect the policyholders of the company. An association authorized to transact business in this state before July 1, 1990, shall meet this requirement not later than July 1, 1992.

Sec. 72. Section 521A.1, subsection 6, unnumbered paragraph 1, Code 1989, is amended to read as follows:

Insurer ~~shall mean~~ means a company qualified and licensed by the insurance division to transact the business of insurance in this state by certificate issued pursuant to chapters 508, 514B, 515, 518A, and 520, except that it shall not include:

Sec. 73.

Sections 5, 6, 33, 34, and 36 of this Act do not affect insurance companies which, on or before the effective date of this Act, were authorized to transact business in this state.

Sec. 74.

Section 1 of this Act, applies to all indebtedness contracted for, general obligation bonds issued, or insurance agreements entered into or renewed pursuant to section 296.7 on or after the effective date of section 1, but shall not apply to an act permitted by section 296.7 at any time prior to January 1, 1990.

Sec. 75.

Sections 1 and 74 of this Act, being deemed of immediate importance, take effect upon enactment.

Sec. 76. Sections 515A.1 through 515A.19, Code 1989, are repealed effective July 1, 1992.

Sec. 77.

The Code editor shall transfer sections 515A.20 through 515A.25 to be a division of new chapter 515F.

Approved May 2, 1990

CHAPTER 1235

PETROLEUM STORAGE TANKS

H.F. 2552

AN ACT relating to storage tanks, including the conditions and funding mechanisms of the Iowa comprehensive petroleum underground storage tank fund, and providing an effective date.

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

Section 1. Section 101.12, Code Supplement 1989, is amended to read as follows:

101.12 ABOVEGROUND PETROLEUM TANKS AUTHORIZED.

Rules of the state fire marshal shall permit installation of aboveground petroleum storage tanks for retail motor vehicle fuel outlets ~~in cities of one thousand or less population~~ as permitted by the latest edition of the national fire protection association rule 30A, subject to the approval of the governing body of the local governmental subdivision with jurisdiction over the site of the outlet.

Sec. 2. Section 101.21, Code Supplement 1989, is amended to read as follows:

101.21 DEFINITIONS.