the committee, the selection of voting members of the committee, and any other provisions deemed necessary for establishing the benefits advisory committee consistent with the requirements of section 97B.8B.

3. The transition benefits advisory committee shall be dissolved by July 31, 2002.

Sec. 21. AMENDMENTS CHANGING TERMINOLOGY — DIRECTIVES TO CODE EDITOR. Except as otherwise provided in this Act, the Iowa Code editor is directed to strike the words "department", "department of personnel", and "department's" and insert the words "division" and "division's" wherever the word "department", "department of personnel", or "department's" appears in chapter 97B of the Iowa Code and the reference to "department", "department of personnel", or "department's" means the department of personnel unless a contrary intent is clearly evident.

Sec. 22. ADMINISTRATIVE RULES. To the extent not inconsistent with this Act, the administrative rules promulgated and adopted by the department of personnel concerning the Iowa public employees' retirement system prior to July 1, 2002, shall be the rules of the Iowa public employees' retirement system division and shall remain in effect on and after July 1, 2002, subject to the authority of the division to modify or change the rules pursuant to Iowa Code chapter 17A.

Sec. 23. Sections 97B.5, 97B.6, 97B.8, 97B.57, 97B.59, 97B.60, 97B.61, Code 2001, are repealed.

Sec. 24. EFFECTIVE DATE. This Act takes effect July 1, 2002. However, section 20 of this Act, establishing a benefits advisory committee transition, takes effect July 1, 2001.

Approved April 24, 2001

CHAPTER 69

INSURANCE REGULATION

S.F. 500

AN ACT relating to insurance, by addressing the operation and regulation of insurance companies, mutual insurance associations, the Iowa insurance guaranty association, and other insurance or risk-assuming entities, including the rights and duties of such entities and the powers and authority of the insurance commissioner; by establishing jurisdiction and venue requirements for actions against the Iowa insurance guaranty association; and providing penalties, repeals, and effective dates.

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

Section 1. Section 87.11, unnumbered paragraph 1, Code 2001, is amended to read as follows:

When an employer coming under this chapter furnishes satisfactory proofs to the insurance commissioner of such employer's solvency and financial ability to pay the compensation and benefits as by law provided and to make such payments to the parties when entitled thereto, or when such employer deposits with the insurance commissioner security satisfactory to the insurance commissioner and the workers' compensation commissioner as guaranty for the payment of such compensation, such employer shall be relieved of the provisions of this chapter requiring insurance; but such employer shall, from time to time, fur-

nish such additional proof of solvency and financial ability to pay as may be required by such insurance commissioner or workers' compensation commissioner. A political subdivision, including a city, county, community college, or school corporation, that is self-insured for workers' compensation is not required to submit a plan or program to the insurance commissioner for review and approval.

Sec. 2. Section 505.11, Code 2001, is amended to read as follows:

505.11 REFUNDS.

Whenever it appears to the satisfaction of the commissioner of insurance that because of error, mistake, or erroneous interpretation of statute that a foreign or domestic insurance corporation has paid to the state of Iowa taxes, fines, penalties, or license fees in excess of the amount legally chargeable against it, the commissioner of insurance shall have power to refund to such corporation any such excess by applying the amount ~~thereof~~ of the excess payment toward the payment of taxes, fines, penalties, or license fees already due or which may ~~hereafter~~ become due, until such excess payments have been fully refunded. ~~The commissioner shall certify to the department of revenue and finance the amount of any such credit to be applied to future taxes due and notify the insurance company affected of the amount thereof.~~

Sec. 3. Section 507.10, subsection 2, Code 2001, is amended to read as follows:

2. FILING OF EXAMINATION REPORT. No later than sixty days following completion of the examination, the examiner in charge shall file with the division a verified written report of examination ~~under oath~~. Upon receipt of the verified report and after administrative review, the division shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

Sec. 4. Section 507A.4, subsection 7, Code 2001, is amended by striking the subsection.

Sec. 5. Section 507B.4, subsection 9, paragraph f, Code 2001, is amended to read as follows:

f. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear, or failing to include interest on the payment of claims when required under section 511.38 or subsection 10B.

Sec. 6. Section 507B.4, subsection 9, Code 2001, is amended by adding the following new paragraph:

NEW PARAGRAPH. o. Failing to comply with the procedures for auditing claims submitted by health care providers as set forth by rule of the commissioner. However, this paragraph shall have no applicability to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 7. Section 507B.4, Code 2001, is amended by adding the following new subsection:

NEW SUBSECTION. 10B. PAYMENT OF INTEREST. Failure of an insurer to pay interest at the rate of ten percent per annum on all health insurance claims that the insurer fails to timely accept and pay pursuant to section 507B.4A, subsection 1, paragraph "e".[1] Interest shall accrue commencing on the thirty-first day after receipt of all properly completed proof of loss forms.

For purposes of this subsection, "insurer" means an entity providing a plan of health insurance, health care benefits, or health care services, or an entity subject to the jurisdiction of the commissioner performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the department of public health, a nonprofit health service corporation, a plan established pursuant to

[1] See chapter 118, §15 herein

chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. However, "insurer" does not include an entity that sells disability income or long-term care insurance.

Sec. 8. NEW SECTION. 507B.4A DUTY TO RESPOND TO INQUIRIES AND PROMPT PAYMENT OF CLAIM.

1. A person shall promptly respond to inquiries from the commissioner.

a. A person's actions are deemed untimely under this subsection if the person fails to respond to an inquiry from the commissioner within thirty days of the receipt of the inquiry, unless good cause exists for delay.

b. Failure to respond to inquiries from the commissioner pursuant to this subsection with such frequency as to indicate a general business practice shall subject the person to penalty under this chapter.

2. a. An insurer providing accident and sickness insurance under chapter 509, 514, or 514A; a health maintenance organization; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the department of public health; or another entity providing health insurance or health benefits subject to state insurance regulation shall either accept and pay or deny a clean claim.

b. For purposes of this subsection, "clean claim" means a properly completed paper or electronic billing instrument containing all reasonably necessary information, that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

c. The commissioner shall adopt rules establishing processes for timely adjudication and payment of claims by insurers for health care benefits. The rules shall be consistent with the time frames and other procedural standards for claims decisions by group health plans established by the United States department of labor pursuant to 29 C.F.R. pt. 2560 in effect at the time of passage of this Act.[2]

d. Payment of a clean claim shall include interest at the rate of ten percent per annum when an insurer or other entity as defined in this subsection that administers or processes claims on behalf of the insurer or other entity fails to timely pay a claim.

e. This subsection shall not apply to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 9. Section 507B.6, subsection 1, Code 2001, is amended to read as follows:

1. Whenever the commissioner ~~shall have reason to believe~~ believes that any ~~such~~ person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in section 507B.4, 507B.4A, or 507B.5 and that a proceeding by the commissioner in respect ~~thereto~~ to such method of competition or unfair or deceptive act or practice would be ~~to the interest of~~ in the public interest, the commissioner shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing ~~thereon~~ on such charges to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service ~~thereof~~ of such notice.

Sec. 10. Section 507B.7, subsection 1, Code 2001, is amended to read as follows:

1. If, after such hearing, the commissioner ~~shall determine~~ determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings, an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of section 507B.4, 507B.4A, or 507B.5, the commissioner may at the commissioner's discretion order any one or more of the following:

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[2] See chapter 176, §71 herein

a. Payment of a civil penalty of not more than one thousand dollars for each act or violation, but not to exceed an aggregate of ten thousand dollars, unless the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or 507B.5, in which case the penalty shall be not more than five thousand dollars for each act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any one six-month period. ~~The commissioner shall, if~~ If the commissioner finds ~~the violations~~ that a violation of section 507B.4, 507B.4A, or 507B.5 ~~were~~ was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer.

b. Suspension or revocation of the license of a person as defined in section 507B.2, subsection 1, if the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or ~~section~~ 507B.5.

c. Payment of interest at the rate of ten percent per annum if the commissioner finds that the insurer failed to pay interest as required under section 507B.4, subsection 10B.

Sec. 11. Section 507B.12, unnumbered paragraph 1, Code 2001, is amended to read as follows:

The commissioner may, after notice and hearing, promulgate reasonable rules, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by section 507B.4, 507B.4A, or 507B.5, but the rules shall not enlarge upon or extend the provisions of such sections. Such rules shall be subject to review in accordance with chapter 17A.

Sec. 12. Section 511.4, Code 2001, is amended to read as follows:

511.4 ADVERTISEMENTS — WHO DEEMED AGENT.

The provisions of sections ~~515.122~~ 515.123 to 515.126 shall apply to life insurance companies and associations.

Sec. 13. Section 513B.2, subsections 3 and 20, Code 2001, are amended to read as follows:

3. "Basic health benefit plan" means a plan ~~which is offered~~ established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

20. "Standard health benefit plan" means a plan ~~which is offered~~ established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

Sec. 14. Section 513B.4, subsection 1, paragraphs d and e, Code 2001, are amended by striking the paragraphs.

Sec. 15. Section 513B.4, subsection 2, Code 2001, is amended by striking the subsection.

Sec. 16. Section 513B.10, subsection 1, paragraph a, Code 2001, is amended to read as follows:

a. A carrier or an organized delivery system that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter. ~~A carrier or organized delivery system shall offer health insurance coverage which constitutes a basic health benefit plan and which constitutes a standard health benefit plan.~~

Sec. 17. Section 513B.10, subsection 3, Code 2001, is amended by striking the subsection.

Sec. 18. Section 513B.13, subsection 3, paragraph c, Code 2001, is amended by striking the paragraph.

Sec. 19. Section 513B.13, subsection 3, paragraph d, Code 2001, is amended to read as follows:

d. ~~Subsequent members~~ Members shall be appointed for terms of three years. A board member's term shall continue until the member's successor is appointed.

Sec. 20. Section 513B.13, subsections 4 and 5, Code 2001, are amended to read as follows:

4. The board~~, within one hundred eighty days after the initial appointments, shall~~ may submit a plan of operation to the commissioner. The commissioner, after notice and hearing, may approve ~~the~~ a plan of operation if the commissioner determines that the plan is suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains and losses on an equitable and proportionate basis in accordance with the provisions of this section. ~~The~~ A plan of operation is effective upon written approval of the commissioner. ~~After the initial plan of operation is submitted and approved by the commissioner, the~~

5. The board may submit to the commissioner any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The amendments shall be effective upon the written approval of the commissioner.

~~5. If the board fails to submit a plan of operation within one hundred eighty days after the board's appointment, the commissioner, after notice and hearing, shall establish and adopt a temporary plan of operation. The commissioner shall amend or rescind a plan adopted pursuant to this subsection at the time a plan is submitted by the board and approved by the commissioner.~~

Sec. 21. Section 513B.13, subsection 8, paragraph a, Code 2001, is amended to read as follows:

a. ~~With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the~~ The program shall reinsure up to the level of coverage provided in either a basic health benefit plan or standard health benefit plan established by the board.

Sec. 22. Section 513B.13, subsection 13, Code 2001, is amended by striking the subsection.

Sec. 23. Section 514E.1, subsection 15, paragraph a, Code 2001, is amended to read as follows:

a. "Health insurance coverage" means health insurance coverage offered to individuals~~, but does not include short-term limited duration insurance~~.

Sec. 24. NEW SECTION. 514J.3A NOTICE.

When a claim is denied in whole or in part based on medical necessity, the carrier or organized delivery system shall provide a notice in writing to the enrollee of the internal appeal mechanism provided under the carrier or organized delivery system's plan or policy.

At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

Sec. 25. Section 514J.4, subsection 1, Code 2001, is amended by striking the subsection.

Sec. 26. Section 514J.5, Code 2001, is amended to read as follows:

514J.5 CERTIFICATION OF REQUEST — ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed or received.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed or received service or treatment does not meet the definition of medical necessity as defined in the ~~enrollee's evidence of coverage~~ carrier's or organized delivery system's plan or policy.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's ~~contract~~ plan or policy.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the ~~decision~~ certification.

3. The carrier or organized delivery system has three business days to contest ~~the eligibility of the request for external review with the commissioner~~ the commissioner's certification decision. If the commissioner finds that the request for external review is not eligible for ~~full review~~ certification, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for ~~full review~~ certification.

4. If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the carrier or organized delivery system, the commissioner shall notify the carrier or organized delivery system in writing of the reasons for upholding the certification.

Sec. 27. Section 514J.7, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, or within three business days of receipt of the commissioner's denial of the carrier's or organized delivery system's contest of the certification of the request under section 514J.5, subsection 3, whichever is later, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and telephone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information.

c. Notify the selected independent review entity by facsimile that the carrier or organized delivery system has chosen it to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.

d. Provide to the commissioner by facsimile a copy of the notices sent to the enrollee and to the selected independent review entity.

2. The independent review entity, within three business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the enrollee of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner. If the independent review entity does not have a person who is an expert in the treatment of the medical condition under review and certified by the commissioner to conduct an independent review, the independent review entity may either decline the review

request or may request from the commissioner additional time to have such an expert certified. The independent review entity shall notify the commissioner by facsimile of its choice between these options within three business days of receipt of the notice from the carrier or organized delivery system. The commissioner shall provide a notice to the enrollee and carrier or organized delivery system of the independent review entity's decision and of the commissioner's decision as to how to proceed with the external review process within three business days of receipt of the independent review entity's decision.

3. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the independent review entity selected by the carrier or organized delivery system or to the person selected as the reviewer by the independent review entity by notifying the commissioner and carrier or organized delivery system within ten days of the mailing of the notice by the independent review entity. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

4. The carrier or organized delivery system, within fifteen days of the mailing of the notice by the independent review entity, or within three business days of a receipt of notice by the commissioner following an objection by the enrollee, whichever is later, shall do all of the following:

a. Provide to the independent review entity any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

b. Provide to the independent review entity any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

c. Provide to the commissioner a confirmation that the information required in paragraphs "a" and "b" has been provided to the independent review entity, including the date the information was provided.

5. The enrollee, or the enrollee's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the carrier's or organized delivery system's evidence of coverage, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the ten-day period.

6. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 4. The enrollee or the enrollee's treating health care provider shall provide the requested information to the independent review entity within five days after receipt of the notification requesting additional medical information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the carrier or organized delivery system of this request.

7. The independent review entity shall submit its external review decision as soon as possible, but not later than thirty days from the date the independent review entity received the information required under subsection 4 from the carrier or organized delivery system. The independent review entity, for good cause, may request an extension of time from the commissioner. The independent review entity's external review decision shall be mailed to the enrollee or the treating health care provider acting on behalf of the enrollee, the carrier or organized delivery system, and the commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 28. NEW SECTION. 514J.15 PENALTIES.

A carrier who fails to comply with this chapter or with rules adopted pursuant to this chapter is subject to the penalties provided under chapter 507B.

Sec. 29. Section 515.35, subsection 4, paragraph n, subparagraph (1), Code 2001, is amended to read as follows:

(1) A company organized under this chapter may invest up to ~~two~~ five percent of its admitted assets in securities or property of any kind, without restrictions or limitations except those imposed on business corporations in general.

Sec. 30. Section 515.51, Code 2001, is amended to read as follows:

515.51 POLICIES — EXECUTION — REQUIREMENTS.

All policies or contracts of insurance except surety bonds made or entered into by the company may be made either with or without the seal of the company, but shall be subscribed by the president, or such other officer as may be designated by the directors for that purpose, and be attested to by the secretary or the secretary's designee of the company. A group motor vehicle or group homeowners policy shall not be written or delivered within this state unless such policy is an individual policy or contract form.

Sec. 31. Section 515B.1, subsection 2, Code 2001, is amended to read as follows:

2. Mortgage guaranty, financial guaranty, residual value, or other forms of insurance offering protection against investment risks.

Sec. 32. Section 515B.5, subsection 1, paragraph b, Code 2001, is amended to read as follows:

b. Be obligated to pay covered claims subject to a limitation as established by the rights, duties, and obligations under the policy of the insolvent insurer. However, the association is not obligated to pay a claimant an amount in excess of the obligation under the policy of the insolvent insurer, regardless of whether such claim is based on contract or tort.

Sec. 33. Section 515B.16, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

515B.16 ACTIONS AGAINST THE ASSOCIATION.

Any action against the association shall be brought against the association in the association's own name. The Polk county district court shall have exclusive jurisdiction and venue of such actions. Service of the original notice in actions against the association may be made on any officer of the association or upon the commissioner of insurance on behalf of the association. The commissioner shall promptly transmit any notice so served upon the commissioner to the association.

Sec. 34. NEW SECTION. 515F.4A REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGED.

Benefits provided by credit personal property insurance shall be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than fifty percent or such lower loss ratio as designated by the commissioner to afford a reasonable allowance for actual and expected loss experience including a reasonable catastrophe provision, general and administrative expenses, reasonable acquisition expenses, reasonable creditor compensation, investment income, premium taxes, licenses, fees, assessments, and reasonable insurer profit.

Sec. 35. Section 518.23, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in

person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded to the insured upon the surrender of the policy to the association at its home office.

Sec. 36. Section 518A.29, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded upon the surrender of the policy to the association at its home office.

Sec. 37. Section 515.122, Code 2001, is repealed.

Sec. 38. Sections 432.12, 513B.14, 513B.16, 513B.17A, 513B.18, and 513B.31 through 513B.43, Code 2001, are repealed.

Sec. 39. EFFECTIVE DATE. Sections 4,[3] 7 through 11, 13 through 22, 34, and 38 of this Act take effect January 1, 2002.

Approved April 24, 2001

CHAPTER 70

INFORMATION TECHNOLOGY DEPARTMENT — FINANCIAL OPERATIONS AND TRANSACTIONS

H.F. 292

AN ACT relating to the financial operations and transactions of the information technology department.

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

Section 1. Section 14B.102, subsection 2, Code 2001, is amended by adding the following new paragraphs:

NEW PARAGRAPH. k. Receiving and accepting donations, gifts, and contributions in the form of money, services, materials, or otherwise, from the United States or any of its agencies, from this state or any of its agencies, or from any other person, and to using or expending such moneys, services, materials, or other contributions in carrying on information technology operations.

NEW PARAGRAPH. l. Charging a negotiated fee to recover a share of the costs related to the research and development, initial production, and derivative products of the department's proprietary software and hardware, information technology architecture design, and pro-

[3] See chapter 118, §56 herein