CHAPTER 514B

HEALTH MAINTENANCE ORGANIZATIONS

Referred to in §87.4, 249H.8, 296.7, 331.301, 364.4, 421C.2, 505.16, 505.28, 505.29, 505.32, 507.1, 508C.3, 509.19, 509B.1, 510.11, 513B.3, 514C.2, 514C.3, 514C.4, 514C.6, 514C.9, 514C.10, 514C.11, 514C.12, 514C.18, 514C.19, 514C.20, 514C.21, 514C.23, 514C.24, 514C.25, 514C.26, 514C.29, 514D.7, 514E.1, 514E.11, 514F.4, 514G.103, 514L.1, 515.1, 521.1, 521.2, 521A.1, 521E.1, 521F.2, 533C.103, 669.14, 670.7

514B.1 Definitions — services required or available.

As provided in this chapter, unless the context otherwise requires:

1. *"Basic health care services"* means services which an enrollee might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services rendered within or outside of a hospital.

2. *"Commissioner"* means the commissioner of insurance.

3. *"Enrollee"* means an individual who is enrolled in a health maintenance organization.

4. *"Evidence of coverage"* means any certificate, agreement or contract issued to an enrollee setting out the coverage to which the enrollee is entitled.

5. *a. "Health care services"* means services included in the furnishing to any individual of medical or dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of all other services for the purposes of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

b. The health care services available to enrollees under prepaid group plans covering vision care services or procedures shall include a provision for payment of necessary medical or surgical care and treatment provided by an optometrist licensed under chapter 154, if performed within the scope of the optometrist's license, and the plan would pay for the care and treatment when the care and treatment were provided by a person engaged in the practice of medicine or surgery as licensed under chapter 148. The plan shall provide that the plan enrollees may reject the coverage for services which may be provided by an optometrist if the coverage is rejected for all providers of similar vision care services as licensed under chapter 148 or 154. This paragraph applies to services provided under plans made after July 1, 1983, and to existing group plans on their next anniversary or renewal date, or upon the expiration

of the applicable collective bargaining contract, if any, whichever is the later. This paragraph does not apply to enrollees eligible for coverage under Tit. XVIII of the Social Security Act or any other similar coverage under a state or federal government plan.

c. The health care services available to enrollees under prepaid group plans covering diagnosis and treatment of human ailments shall include a provision for payment of necessary diagnosis or treatment provided by a chiropractor licensed under chapter 151 if the diagnosis or treatment is provided within the scope of the chiropractor's license and if the plan would pay or reimburse for the diagnosis or treatment of human ailment, irrespective of and disregarding variances in terminology employed by the various licensed professions in describing the human ailment or its diagnosis or its treatment, if it were provided by a person licensed under chapter 148. The plan shall also provide that the plan enrollees may reject the coverage for diagnosis or treatment of a human ailment by a chiropractor if the coverage is rejected for all providers of diagnosis or treatment for similar human ailments licensed under chapter 148 or 151. A prepaid group plan of health care services may limit or make optional the payment or reimbursement for lawful diagnostic or treatment service by all licensees under chapters 148 and 151 on any rational basis which is not solely related to the license under or the practices authorized by chapter 151 or is not dependent upon a method of classification, categorization, or description based upon differences in terminology used by different licensees in describing human ailments or their diagnosis or treatment. This paragraph applies to services provided under plans made after July 1, 1986, and to existing group plans on their next anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is the later. This paragraph does not apply to enrollees eligible for coverage under Tit. XVIII of the Social Security Act, or any other similar coverage under a state or federal government plan.

d. The health care services available to enrollees under prepaid group plans covering hospital, medical, or surgical expenses, may include, at the option of the employer purchaser, a provision for payment of covered services determined to be medically necessary provided by a certified registered nurse certified by a national certifying organization, which organization shall be identified by the Iowa board of nursing pursuant to rules adopted by the board, if the services are within the practice of the profession of a registered nurse as that practice is defined in section 152.1, under terms and conditions agreed upon between the employer purchaser and the health maintenance organization, subject to utilization controls. This paragraph shall not require payment for nursing services provided by a certified registered nurse practicing in a hospital, nursing facility, health care institution, a physician's office, or other noninstitutional setting if the certified registered nurse is an employee of the hospital, nursing facility, health care institution, physician, or other health care facility or health care provider. This paragraph applies to services provided under plans within this state made on or after July 1, 1989, and to existing group plans on their next anniversary or renewal date, or upon the expiration of the applicable collective bargaining contract, if any, whichever is later. This paragraph does not apply to enrollees eligible for coverage under an individual contract or coverage designed only for issuance to enrollees eligible for coverage under Tit. XVIII of the federal Social Security Act, or under coverage which is rated on a community basis, or any other similar coverage under a state or federal government plan.

6. "*Health maintenance organization*" means any person, who:

a. Provides either directly or through arrangements with others, health care services to enrollees on a fixed prepayment basis;

b. Provides either directly or through arrangements with other persons for basic health care services; and,

c. Is responsible for the availability, accessibility and quality of the health care services provided or arranged.

7. *"Provider"* means any physician, hospital, or person as defined in chapter 4 which is licensed or otherwise authorized in this state to furnish health care services.

[C75, 77, 79, 81, §514B.1]

83 Acts, ch 166, §3; 84 Acts, ch 1290, §3; 86 Acts, ch 1180, §7; 89 Acts, ch 164, §5; 99 Acts, ch 75, §4; 2008 Acts, ch 1088, §128; 2010 Acts, ch 1061, §180; 2010 Acts, ch 1193, §71

Referred to in §135.61, 514.4, 514.23

514B.2 Establishment of health maintenance organizations.

Any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. A person shall not establish or operate a health maintenance organization in this state, nor sell, offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate under this chapter.

[C75, 77, 79, 81, §514B.2]

514B.3 Application for a certificate of authority.

1. An application for a certificate of authority shall be verified by an officer or authorized representative of the health maintenance organization, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

a. A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all of its amendments.

b. A copy of the bylaws, rules or similar document, if any, regulating the conduct of the internal affairs of the applicant.

c. A list of the names, addresses and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.

d. A copy of any contract made or to be made between any providers or persons listed in paragraph "*c*" and the applicant.

e. A statement generally describing the health maintenance organization including, but not limited to, a description of its facilities and personnel.

f. A copy of the form of evidence of coverage.

g. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.

h. Financial statements showing the applicant's assets, liabilities and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement shall satisfy this requirement unless the commissioner directs that additional financial information is required for the proper administration of this chapter.

i. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.

j. A power of attorney executed by any applicant appointing the commissioner, the commissioner's successors in office, and deputies to receive process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state.

k. A statement reasonably describing the geographic area to be served.

l. A description of the complaint procedures to be utilized as required under section 514B.14.

m. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the director of public health under section 514B.4.

n. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by section 514B.7.

o. Other information the commissioner finds reasonably necessary to make the determinations required in section 514B.5.

2. A health maintenance organization shall, unless otherwise provided for in this chapter, file notice with the commissioner and receive approval from the commissioner before modifying the operations described in the information required by this section.

3. Upon receipt of an application for a certificate of authority, the commissioner shall immediately transmit copies of the application and accompanying documents to the director of public health and the affected regional health planning council, as authorized by Pub. L. No. 89-749, 42 U.S.C. § 246(b)2b, for their nonbinding consultation and advice.

[C75, 77, 79, 81, §514B.3]

2003 Acts, ch 91, §28; 2006 Acts, ch 1010, §140; 2012 Acts, ch 1023, §116

Referred to in §514B.5, 514B.12

[T] Section amended

514B.3A Articles — approval — bylaws.

The articles of incorporation, and any subsequent amendments, of a corporation shall be filed with and approved by the commissioner of insurance before filing with the secretary of state. A corporation shall file bylaws and subsequent amendments to the bylaws with the commissioner within thirty days of adoption of the bylaws and amendments.

2000 Acts, ch 1023, §24; 2009 Acts, ch 145, §10

514B.3B Certificate of authority — renewal.

A certificate of authority of a health maintenance organization formed under this chapter expires on June 1 succeeding its issue and shall be renewed annually so long as the organization transacts its business in accordance with all legal requirements. A health maintenance organization shall submit annually, on or before March 1, a completed application for renewal of its certificate of authority. A health maintenance organization that fails to timely file an application for renewal shall pay an administrative penalty of five hundred dollars to the treasurer of state for deposit as provided in section 505.7. A duly certified copy or duplicate of the certificate is admissible in evidence for or against the organization with the same effect as the original.

2006 Acts, ch 1117, §58; 2009 Acts, ch 181, §73

Referred to in §514B.33

514B.4 Applicant for certificate of authority.

1. The commissioner shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

a. Has demonstrated the willingness and potential ability to assure the availability, accessibility, and continuity of service through adequate personnel and facilities.

b. Has arrangements established in accordance with rules adopted by the commissioner for a continuous review of health care processes and outcomes. If a health maintenance organization is accredited by the national committee on quality assurance, or another accreditation entity approved by the commissioner, an external peer review under rules of the commissioner shall not be applicable. However, at the discretion of the commissioner, an on-site inspection of the health maintenance organization may be conducted.

c. Has a procedure established in accordance with rules adopted by the commissioner to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and other matters as may be reasonably required by the commissioner.

2. The commissioner, in administering this section and sections 514B.25 and 514B.26, may contract with qualified persons to make recommendations concerning the determinations

required to be made by the commissioner. Such recommendations may be accepted in full or in part by the commissioner.

[C75, 77, 79, 81, §514B.4]

92 Acts, ch 1162, §21; 99 Acts, ch 165, §11; 2012 Acts, ch 1023, §157

Referred to in §514B.3, 514B.5

[T] Code editor directive applied

514B.4A Direct provision of health care services.

1. An application for a certificate of authority to provide health care services, directly, shall be forwarded by the commissioner to the director of public health for review, comment, and recommendation, with respect to the health care services to be provided directly, to assure that the applicant has demonstrated the willingness and potential ability to provide the health care services through adequate personnel and facilities.

2. Rules proposed by the commissioner for adoption for the direct provision of health care services by a health maintenance organization, shall be forwarded by the commissioner to the director of public health for review, comment, and recommendation, prior to submission to the administrative rules coordinator pursuant to section 17A.4.

3. The director of public health shall respond to the commissioner, with respect to an application or proposed rule, with any comments or recommendations within thirty days of the forwarding of the application or proposed rules to the director of public health.

92 Acts, ch 1237, §12

514B.5 Issuance and denial of a certificate of authority.

1. The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section 514B.3 within a reasonable period of time. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in section 514B.22 if the commissioner is satisfied that the following conditions are met:

a. The persons responsible for the conduct of the affairs of the applicant are competent and trustworthy.

b. The commissioner finds that the health maintenance organization's proposed plan of operation meets the requirements of section 514B.4.

c. The health maintenance organization provides or arranges for the provision of basic health care services on a prepaid basis, except that the health maintenance organization may impose deductible and coinsurance charges subject to approval by the commissioner. The commissioner has the authority to promulgate rules pursuant to chapter 17A establishing reasonable maximum deductible and coinsurance charges which may be imposed by health maintenance organizations.

d. The health maintenance organization is fiscally sound and may reasonably be expected to meet its obligations to enrollees. In making this determination, the commissioner may consider:

(1) The financial soundness of the health maintenance organization's arrangements for health care services in relation to its schedule of charges.

(2) The adequacy of the health maintenance organization's working capital.

(3) Any agreement made by the health maintenance organization with an insurer, a corporation authorized under chapter 514 or any other organization for insuring the payment of the cost of health care services or for providing immediate alternative coverage in the event of discontinuance of the health maintenance organization.

(4) Any agreement made with providers for the provision of health care services.

(5) Any surety bond or deposit of cash or securities submitted in accordance with section 514B.16.

e. The enrollees may participate in matters of policy and operation pursuant to section 514B.7.

f. Nothing in the proposed method of operation as shown by the information submitted pursuant to section 514B.3 or by independent investigation is contrary to the public interest.

2. A certificate of authority shall be denied only after compliance with the requirements of section 514B.26.

[C75, 77, 79, 81, §514B.5]

92 Acts, ch 1162, §22, 23; 2012 Acts, ch 1023, §117

Referred to in §513C.4, 514B.3, 514B.9

[T] Section amended

514B.6 Powers of health maintenance organizations.

1. The powers of a health maintenance organization include, but are not limited to, the following:

a. The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for transacting the business of the organization.

b. The making of loans to a medical group under contract with it or to a corporation under its control for the purpose of acquiring or constructing medical facilities and hospitals or in furtherance of a program providing health care services to enrollees.

c. The furnishing of health care services to the public through providers which are under contract with or employed by the health maintenance organization.

d. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration.

e. The contracting with an insurance company authorized to insure groups or individuals in this state for the cost of health care or with a corporation authorized under chapter 514 for the provision of insurance, indemnity, or reimbursement against the cost of health care services provided by the health maintenance organization.

f. The offering, in addition to basic health care services, of health care services and indemnity benefits to enrollees or groups of enrollees.

g. The acceptance from any person of payments covering all or part of the charges made to enrollees of the health maintenance organization.

2. A health maintenance organization shall file notice with the commissioner before the exercise of any power granted in subsection 1, paragraphs "*a*" and "*b*". The commissioner shall disapprove the exercise of power if in the commissioner's opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. The commissioner may adopt rules exempting from the filing requirement of this section those activities having a minimum effect.

[C75, 77, 79, 81, §514B.6]

92 Acts, ch 1162, §24; 2012 Acts, ch 1023, §118

Referred to in §514B.15

[T] Section amended

514B.7 Governing body.

The governing body of a health maintenance organization may include providers, other individuals, or both, but it shall establish a mechanism to allow a reasonable representation of enrollees to participate in matters of policy and operation. The commissioner shall establish guidelines to implement this section.

[C75, 77, 79, 81, §514B.7]

86 Acts, ch 1180, §8

Referred to in §514B.3, 514B.5

514B.8 Fiduciary responsibilities.

Any director, officer or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of a health maintenance organization shall be responsible for these funds in a fiduciary relationship to the enrollees.

[C75, 77, 79, 81, §514B.8]

514B.9 Evidence of coverage.

1. Every enrollee shall receive an evidence of coverage and any amendments. If the enrollee obtains coverage through an insurance policy or a contract issued by a corporation authorized under chapter 514, the insurer or the corporation shall issue the evidence of

coverage. No evidence of coverage or amendment shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment has been filed with and approved by the commissioner.

2. An evidence of coverage shall contain a clear and complete statement of:

a. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled in the total context of the organizational structure of the health maintenance organization.

b. Any limitations on the services or benefits to be provided, including any deductible or coinsurance charges permitted under section 514B.5, subsection 1, paragraph "*c*".

c. The manner in which information is available on the method of obtaining health care services.

d. The total amount of payment for health care services and indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to individual contracts, or an indication whether the plan offered through the health maintenance organization is contributory or noncontributory with respect to group contracts.

e. The health maintenance organization's method for resolving enrollee complaints.

f. The mechanism by which enrollees shall be allowed to participate in matters of policy and operation.

3. A copy of the form of the evidence of coverage to be used in this state and any amendment shall be subject to the filing and approval requirements of this section unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance or corporations authorized under chapter 514 in which event the filing and approval provisions of such laws apply. To the extent, however, that those provisions are less strict than those provided under this section, then the requirements of this section shall apply.

4. Enrollees shall be entitled to receive the most recent annual statement of the financial condition of the health maintenance organization in which they are enrolled, which statement shall include a balance sheet and summary of receipts and disbursements.

[C75, 77, 79, 81, §514B.9]

2012 Acts, ch 1023, §119

Referred to in §514B.11

[T] Section amended

514B.9A Coverage of children — continuation or reenrollment.

A health maintenance organization which provides health care coverage pursuant to an individual or group health maintenance organization contract regulated under this chapter for children of an enrollee shall permit continuation of existing coverage or reenrollment in previously existing coverage for an individual who meets the requirements of section 513B.2, subsection 14, paragraph "*a*", "*b*", "*c*", "*d*", or "*e*", and who is an unmarried child of an enrollee who so elects, at least through the policy anniversary date on or after the date the child marries, ceases to be a resident of this state, or attains the age of twenty-five years old, whichever occurs first, or so long as the unmarried child maintains full-time status as a student in an accredited institution of postsecondary education.

2009 Acts, ch 118, §10, 11

[SP] Section applies to policies, contracts, or plans of accident and health insurance delivered, issued for delivery, continued, or renewed in this state on or after July 1, 2009; 2009 Acts, ch 118, §11

514B.10 Charges.

Charges to enrollees may be established in accordance with actuarial principles for various categories of enrollees, but the charges shall not be determined according to the status of an individual enrollee's health or sex and shall not be excessive, inadequate, or unfairly discriminatory.

[C75, 77, 79, 81, §514B.10]

95 Acts, ch 185, §10

Referred to in §514B.11, 514B.17

514B.11 Disapproval of filings.

If the commissioner disapproves a filing made pursuant to sections 514B.9 and 514B.10, the commissioner shall notify the filer and in the notice specify the reasons for the disapproval.

A hearing shall be granted by the commissioner within a reasonable period of time from the request for the hearing, which request must be made within thirty days after receipt by the filer of the notice of disapproval. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to disapprove a filing.

[C75, 77, 79, 81, §514B.11]

514B.12 Annual report.

1. A health maintenance organization shall annually on or before the first day of March file with the commissioner or a depository designated by the commissioner a report verified by at least two of the principal officers of the health maintenance organization and covering the preceding calendar year. The report shall be on forms prescribed by the commissioner and shall include:

a. Financial statements of the organization including a balance sheet as of the end of the preceding calendar year and statement of profit and loss for the year then ended, certified by a certified public accountant or an independent public accountant.

b. Any material changes in the information submitted pursuant to section 514B.3.

c. The number of persons enrolled during the year, the number of enrollees as of the end of the year and the number of enrollments terminated during the year.

d. Other information relating to the performance of the health maintenance organization as is necessary to enable the commissioner to carry out the commissioner's duties under this chapter.

2. The commissioner shall refuse to renew a certificate of authority of a health maintenance organization that fails to comply with the provisions of this section and the organization's right to transact new business in this state shall immediately cease until the organization has so complied.

3. A health maintenance organization that fails to timely file the report required under subsection 1 is in violation of this section and shall pay an administrative penalty of five hundred dollars to the treasurer of state for deposit as provided in section 505.7.

4. The commissioner may give notice to a health maintenance organization that the organization has not timely filed the report required under subsection 1 and is in violation of this section. If the organization fails to file the required report and comply with this section within ten days of the date of the notice, the organization shall pay an additional administrative penalty of one hundred dollars for each day that the failure continues to the treasurer of state for deposit as provided in section 505.7.

[C75, 77, 79, 81, §514B.12]

92 Acts, ch 1162, §25; 2003 Acts, ch 91, §29; 2004 Acts, ch 1101, §73; 2006 Acts, ch 1117, §59; 2009 Acts, ch 181, §74

Referred to in §514B.33

514B.13 Open enrollment.

After a health maintenance organization has been in operation twenty-four months, it shall have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the commissioner for authorization to impose such underwriting restrictions upon enrollment as are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner shall approve or deny the application made pursuant to this section within a reasonable period of time from the receipt of the application.

Health maintenance organizations providing services exclusively on a group contract basis may limit the open enrollment provided for in this section to all members of the group covered by the contract, including those members of the group who previously waived coverage.

[C75, 77, 79, 81, §514B.13]

2005 Acts, ch 70, §13

514B.14 Complaint system.

1. A health maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner and which shall provide for the resolution of written complaints initiated by enrollees concerning health care services. A health maintenance organization shall submit to the commissioner an annual report in a form prescribed by the commissioner which shall include:

a. A description of the procedures of the complaint system.

b. The total number of complaints handled through the complaint system and a compilation of causes underlying the complaints filed.

c. The number, amount and disposition of malpractice claims settled during the year by the health maintenance organization and any of its providers.

2. The health maintenance organization shall maintain statistical information of written complaints filed with it concerning benefits over which the health maintenance organization does not have control and shall submit to the commissioner a summary report at the time and in the format that the commissioner may require. Complaints involving other persons shall be referred to those persons and a copy of the complaint sent to the commissioner.

[C75, 77, 79, 81, §514B.14]

92 Acts, ch 1162, §26; 2012 Acts, ch 1023, §157

Referred to in §514B.3

[T] Code editor directive applied

514B.15 Investments.

With the exception of investments made in accordance with section 514B.6, the investable funds of a health maintenance organization shall be invested only in securities or other investments permitted by section 511.8 for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner may permit. For purposes of this section, investable funds of a health maintenance organization are all moneys held in trust for the purpose of fulfilling the obligations incurred by a health maintenance organization in providing health care services to enrollees.

[C75, 77, 79, 81, §514B.15]

514B.16 Protection against insolvency.

A health maintenance organization shall furnish a surety bond in an amount satisfactory to the commissioner, or deposit with the commissioner cash or securities acceptable to the commissioner in at least the same amount, as a guarantee that its obligations to enrollees will be performed. The commissioner may waive this requirement when satisfied that the assets of the organization or its contracts with other organizations are sufficient to reasonably assure the performance of its obligations.

[C75, 77, 79, 81, §514B.16]

Referred to in §514B.5

514B.17 Cancellation of enrollees.

1. An enrollee enrolled in a prepaid individual plan shall not be canceled except for the failure to pay the charges permitted under section 514B.10 or for other reasons stated in the rules adopted by the commissioner and subject to review in accordance with chapter 17A. Except as provided in subsection 2 concerning prepaid group plans, notice of cancellation to an enrollee shall not be effective unless delivered to the enrollee by the health maintenance organization in a manner prescribed by the commissioner and at least thirty days before the effective date of cancellation and unless accompanied by a statement of reason for cancellation. At any time before cancellation of the policy for nonpayment, the enrollee may pay to the health maintenance organization the full amount due, including court costs if any, and from the date of payment by the enrollee or the collection of the judgment, coverage shall revive and be in full force and effect.

2. The effect of cancellation of a prepaid group plan providing health care services to enrollees, and the duty to provide notice and liability for benefits, is the same as provided

under section 509B.5, subsection 2, for the termination of accident or health insurance for employees or members.

[C75, 77, 79, 81, §514B.17]

95 Acts, ch 185, §11

514B.17A Recision.

1. A health maintenance organization may rescind an enrollee's membership in the health maintenance organization if the enrollee makes a material false statement or misrepresentation in the enrollee's application for membership. A written notice of recision shall be sent to the enrollee by certified mail addressed to the enrollee and sent to the enrollee's last address known to the health maintenance organization and shall state the reason for the recision. The enrollee may appeal the recision to the commissioner as provided by the commissioner by rules adopted under chapter 17A.

2. An enrollee's membership in a health maintenance organization shall not be rescinded as provided in subsection 1 more than two years after the date of the enrollee's enrollment in the health maintenance organization.

2008 Acts, ch 1123, §24

514B.18 False representation.

A health maintenance organization, unless licensed as an insurer, shall not use in its name, contracts, or literature any words descriptive of an insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state. No health maintenance organization or any person on its behalf shall advertise or merchandise its services in a manner to misrepresent its services or capacity for service, nor shall it engage in misleading, deceptive or unfair practices with respect to advertising or merchandising. This section does not exempt health maintenance organizations which are engaged in the business of insurance from regulation under the provisions of chapter 507B.

[C75, 77, 79, 81, §514B.18]

514B.19 Regulation of insurance producers.

The commissioner may, after notice and hearing, promulgate such reasonable rules under the provisions of chapter 522B that are necessary to provide for the licensing of insurance producers who engage in solicitation or enrollment for a health maintenance organization.

[C75, 77, 79, 81, §514B.19]

2001 Acts, ch 16, §14, 37

514B.20 Powers of insurers and hospital and medical service corporations.

1. An insurance company authorized to engage in insuring individuals or groups for the cost of health care in this state or a corporation authorized under chapter 514 may either directly or through a subsidiary or affiliate do one or more of the following:

a. Organize and operate a health maintenance organization under the provisions of this chapter.

b. Contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through the health maintenance organization.

c. Contract with a health maintenance organization to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

2. Any two or more insurance companies, corporations, or their subsidiaries or affiliates may jointly organize and operate a health maintenance organization.

[C75, 77, 79, 81, §514B.20]

2012 Acts, ch 1023, §157

[T] Code editor directive applied

514B.21 Public employees included.

Any employee of the state, political subdivision of the state, or of any institution supported in whole or in part by public funds may authorize the deduction from the employee's salary

or wages of the amount charged to the employee for any health care services provided through health maintenance organizations under this chapter in the manner provided in section 514.16.

[C75, 77, 79, 81, §514B.21]

514B.22 Fees.

When not otherwise provided, a foreign or domestic health maintenance organization doing business in this state shall pay the commissioner of insurance the fees as required in section 511.24.

[C75, 77, 79, 81, §514B.22]

2006 Acts, ch 1117, §60

Referred to in §514B.5

514B.23 Rules.

The commissioner shall adopt rules, pursuant to chapter 17A, as are necessary to administer this chapter.

[C75, 77, 79, 81, §514B.23]

92 Acts, ch 1162, §27

514B.24 Examinations permitted.

The commissioner shall make an examination of the affairs of a health maintenance organization and its providers as often as the commissioner deems necessary for the protection of the interests of the people of this state, but not less frequently than once every five years.

Every health maintenance organization and provider shall submit its books and records to the commissioner and in every way facilitate the examination. For the purpose of examinations, the commissioner may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of its providers concerning their business. The expenses of examinations under this section shall be assessed against the organization being examined and remitted to the commissioner.

In lieu of the examination required by this section, the commissioner may accept the report of an examination made by the appropriate departments in other states.

[C75, 77, 79, 81, §514B.24]

92 Acts, ch 1162, §28; 2000 Acts, ch 1023, §25

Referred to in §514B.30

514B.25 Financially impaired or insolvent health maintenance organizations.

The provisions of chapter 507C shall apply to health maintenance organizations, which shall be considered insurers for the purposes of chapter 507C.

[C75, 77, 79, 81, §514B.25]

91 Acts, ch 26, §39

Referred to in §514B.4

514B.25A Insolvency protection — assessment.

1. Upon a health maintenance organization or organized delivery system authorized to do business in this state and licensed by the director of public health being declared insolvent by the district court, the commissioner may levy an assessment on each health maintenance organization or organized delivery system doing business in this state and licensed by the director of public health, as applicable, to pay claims for uncovered expenditures for enrollees. The commissioner shall not assess an amount in any one calendar year which is more than two percent of the aggregate premium written by each health maintenance organization or organized delivery system.

2. The commissioner may use funds obtained through an assessment under subsection 1 to pay claims for uncovered expenditures for enrollees of an insolvent health maintenance organization or organized delivery system and administrative costs. The commissioner, by rule, may prescribe the time, manner, and form for filing claims under this section. The

commissioner may require claims to be allowed by an ancillary receiver or the domestic receiver or liquidator.

3. *a.* A receiver or liquidator of an insolvent health maintenance organization or organized delivery system shall allow a claim in the proceeding in an amount equal to uncovered expenditures and administrative costs paid under this section.

b. A person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the commissioner to the extent of the benefits received. The commissioner may require an assignment of such rights by a payee, enrollee, or beneficiary, to the commissioner as a condition precedent to the receipt of such benefits. The commissioner is subrogated to these rights against the assets of the insolvent health maintenance organization or organized delivery system that are held by a receiver or liquidator of a foreign jurisdiction.

c. The assigned subrogation rights of the commissioner and allowed claims under this subsection have the same priority against the assets of the insolvent health maintenance organization or organized delivery system as those claims of persons entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

4. If funds assessed under subsection 1 are unused following the completion of the liquidation of an insolvent health maintenance organization or organized delivery system, the commissioner shall distribute the remaining amounts, if such amounts are not de minimis, to the health maintenance organizations or organized delivery systems that were assessed.

5. The aggregate coverage of uncovered expenditures under this section shall not exceed three hundred thousand dollars with respect to one individual. Continuation of coverage shall cease after the lesser of one year after the health maintenance organization or organized delivery system is terminated by insolvency or the remaining term of the contract. The commissioner may provide continuation of coverage on a reasonable basis, including, but not limited to, continuation of the health maintenance organization or organized delivery system contract or substitution of indemnity coverage in a form as determined by the commissioner.

6. The commissioner may waive an assessment of a health maintenance organization or organized delivery system if such organization or system is impaired financially or would be impaired financially as a result of such assessment. A health maintenance organization or organized delivery system that fails to pay an assessment within thirty days after notice of the assessment is subject to a civil forfeiture of not more than one thousand dollars for each day the failure continues, and suspension or revocation of its certificate of authority. An action taken by the commissioner to enforce an assessment under this section may be appealed by the health maintenance organization or organized delivery system pursuant to chapter 17A.

2000 Acts, ch 1023, §26

514B.26 Administrative procedures.

When the commissioner has cause to believe that grounds for the denial, suspension, or revocation of a certificate of authority exist, the commissioner shall notify the health maintenance organization in writing of the particular grounds for denial, suspension, or revocation and shall issue a notice of a time fixed for a hearing, which shall be held not less than ten days after the receipt by the health maintenance organization of the notice.

At the time and place fixed for a hearing, the person charged shall have an opportunity to be heard and to show cause why the order should not be made by the commissioner. Upon good cause shown, the commissioner may permit any person to intervene, appear and be heard at the hearing by counsel or in person. Nothing contained in this chapter shall require the observance at any hearing of formal rules of pleading or evidence. The provisions of section 507B.6, subsections 4 and 5, relating to the powers and duties of the commissioner in relation to the hearing and relating to the rights and obligations of persons upon whom the commissioner has served notice shall apply to this chapter.

After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take action as the commissioner deems advisable and which is permitted by the commissioner under the provisions of this chapter and shall

reduce the findings to writing. Copies of the written findings shall be mailed to the health maintenance organization charged with violation of this chapter.

[C75, 77, 79, 81, §514B.26]

92 Acts, ch 1162 §29

Referred to in §514B.4, 514B.5, 514B.27

514B.27 Judicial review.

The action of the commissioner under section 514B.26 is subject to judicial review in accordance with chapter 17A.

[C75, 77, 79, 81, §514B.27]

92 Acts, ch 1162, §30

514B.28 Injunction.

The commissioner may, in the manner provided by law, maintain an action in the name of the state for injunction or other process against the person violating any provision of this chapter.

[C75, 77, 79, 81, §514B.28]

514B.29 Penalty. Repealed by 2004 Acts, ch 1110, § 71.

514B.30 Communications in professional confidence.

An officer, director, trustee, partner, or employee of a health maintenance organization shall not testify as to or make other public disclosure of any communication made to a provider and deemed privileged under section 622.10, and which communication has come into the knowledge or possession of such officer, director, trustee, partner, or employee by reason of employment with the health maintenance organization. To the extent necessary to effectuate the examinations provided in section 514B.24 only, the commissioner may examine medical or hospital records of a person receiving basic health care services under the provisions of this chapter but shall not testify as to such confidential communications or make other public disclosure thereof without the express consent of the person or the person's legal representative, if the person is deceased or incompetent. The provisions of section 622.10 respecting waiver shall apply to this section.

A health maintenance organization is hereby prohibited from releasing the names of its membership list of enrollees, whether or not for value or consideration, except to the extent necessary to effectuate the provisions of this chapter or to conduct research or analyses regarding cost or quality issues.

[C75, 77, 79, 81, §514B.30]

92 Acts, ch 1162, §31; 92 Acts, ch 1206, §6

514B.31 Taxation.

Payments received by a health maintenance organization for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through a health maintenance organization authorized under this chapter and payments by a health maintenance organization to providers for health care services, to insurers, or corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under this chapter are not premiums received and taxable under the provisions of section 432.1 for the first five years of the existence of the health maintenance organization, its successors or assigns. After the first five years, the payments received shall be considered premiums received and shall be taxable under the provisions of section 432.1, subsection 1. However, payments made by the United States secretary of health and human services under contracts issued under section 1833 or 1876 of the federal Social Security Act, section 4015 of the federal Omnibus Budget Reconciliation Act of 1987, or chapter 249A for enrolled members shall not be considered premiums received and shall not be taxable under section 432.1.

[C75, 77, 79, 81, §514B.31]

90 Acts, ch 1173, §1; 2002 Acts, ch 1158, §8

Referred to in §505.32, 514E.1

514B.32 Construction.

1. Except as otherwise provided in this chapter, laws regulating the insurance business in this state and the operations of corporations authorized under chapter 514 shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives does not violate any provision of law prohibiting solicitation or advertising by health professionals. Upon a prospective enrollee's request, a list of locations of services and a list of providers who have current agreements with the health maintenance organization shall be made available.

3. Any health maintenance organization authorized under this chapter is not practicing medicine and shall not be subject to the limitations provided in section 135B.26 on types of contracts entered into between doctors and hospitals.

4. A health maintenance organization authorized under this chapter shall be considered a person for purposes of chapter 507B.

[C75, 77, 79, 81, §514B.32]

83 Acts, ch 28, §1; 93 Acts, ch 88, §16

514B.33 Establishment of limited service organizations.

1. A person may apply to the commissioner for and obtain a certificate of authority to establish and operate a limited service organization in compliance with this chapter. A person shall not establish or operate a limited service organization in this state, or sell, offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a limited service organization without obtaining a certificate of authority under this chapter.

2. When not otherwise provided, a foreign or domestic limited service organization doing business in this state shall pay the commissioner the fees as required in section 511.24.

3. The commissioner shall adopt rules pursuant to chapter 17A establishing a certification process for limited service organizations.

4. Sections 514B.3B and 514B.12 apply to all foreign and domestic limited service organizations authorized to do business in this state.

5. *a.* For purposes of this section, *"limited service organization"* means an organization providing dental care services, vision care services, mental health services, substance abuse services, pharmaceutical services, podiatric care services, or such other services as may be determined by the commissioner.

b. *"Limited service organization"* does not include an organization providing hospital, medical, surgical, or emergency services, except as such services are provided incident to those services identified in paragraph *"a"*.

97 Acts, ch 186, §9; 2003 Acts, ch 91, §30; 2006 Acts, ch 1117, §61