507B.4 Unfair methods of competition and unfair or deceptive acts or practices defined.

1. For purposes of subsection 3, paragraph *"p"*, *"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, a nonprofit health service corporation, a plan established pursuant to 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 insurance.

2. *a.* For purposes of subsection 3, paragraphs *"k"*, *"l"*, and *"m"*, *"personal lines property and casualty insurance"* means insurance sold to individuals and families primarily for noncommercial purposes as provided in chapter 522B.

b. For purposes of subsection 3, paragraph *"i"*, subparagraph (2), subparagraph division (d), *"customer"* means a policyholder, potential policyholder, certificate holder, potential certificate holder, an insured, potential insured, or an applicant.

3. The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

a. Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison which does any of the following:

(1) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy.

(2) Misrepresents the dividends or share of the surplus to be received on any insurance policy.

(3) Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy.

(4) Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates.

(5) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof.

(6) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy.

(7) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy.

(8) Misrepresents any insurance policy as being shares of stock.

(9) Misrepresents any insurance policy to consumers by using the terms "burial insurance", "funeral insurance", "burial plan", or "funeral plan" in its names or titles, unless the policy is made with a funeral provider as beneficiary who specifies and fixes a price under contract with an insurance company. This subparagraph does not prevent insurers from stating or advertising that insurance benefits may provide cash for funeral or burial expenses.

(10) Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase of an insurance policy.

b. False information and advertising.

(1) *Generally.* Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(2) *False statement of assets.* In the case of a company transacting the business of fire insurance within the state, stating or representing by advertisement in any newspaper, magazine, or periodical, or by any sign, circular, card, policy of insurance, or renewal certificate thereof or otherwise, that any funds or assets are in its possession and held available for the protection of holders of its policies unless so held, except the policy of

insurance or certificate of renewal thereof may state, as a single item, the amount of capital set forth in the charter, or articles of incorporation, or association, or deed of settlement under which it is authorized to transact business.

(3) *Statement of capital and surplus.*

(a) In the case of a foreign company transacting the business of casualty insurance in the state, or an officer, producer, or representative of such a company, issuing or publishing an advertisement, public announcement, sign, circular, or card that purports to disclose the company's financial standing and fails to exhibit the following:

(i) The capital actually paid in cash, and the amount of net surplus of assets over all the company's liabilities actually held and available for the payment of losses by fire and for the protection of holders of fire policies.

(ii) The amount of net surplus of assets over all liabilities in the United States actually available for the payment of losses by fire and held in the United States for the protection of holders of fire policies in the United States, including in such liabilities the fund reserved for reinsurance of outstanding risks.

(b) The amounts stated for capital and net surplus shall correspond with the latest verified statement made by the company or association to the commissioner of insurance.

c. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

d. Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

e. False statements and entries.

(1) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(2) Knowingly making any false entry of a material fact in any book, report or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

f. Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

g. Unfair discrimination.

(1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) Making or permitting any unfair discrimination between insureds of the same class for essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance other than life or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(3) Making or permitting any discrimination in the sale of insurance solely on the basis of domestic abuse as defined in section 236.2 or sexual abuse as defined in section 236A.2.

h. Release or use of genetic information. Failure of a person to comply with section 729.6, subsection 4.

i. Rebates.

(1) Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, life annuity or accident and health insurance, or agreement as to such contract other than as plainly expressed in the contract

issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or any thing of value whatsoever not specified in the contract.

(2) Subparagraphs (1) and (3), and paragraph *"g"*, shall not be construed to include any of the following practices in the definition of unfair discrimination or rebates:

(a) In the case of any contract of life insurance or life annuity, paying bonuses to policyholders or otherwise rebating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or rebatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders.

(b) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses.

(c) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

(d) The offer or provision, at no or reduced cost, by an insurer or producer by or through an employee, affiliate, or third-party representative, of a value-added product or service that is not specified in the policy of insurance if the value-added product or service that is offered or provided meets all of the following criteria:

(i) The product or service relates to the policy of insurance.

(ii) The product or service is designed primarily to accomplish at least one of the following:

(A) Provide loss mitigation or loss control.

(B) Reduce the customer's claim costs or claim settlement costs.

(C) Provide the customer with education regarding liability risks, or the risk of loss to persons or property.

(D) Monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing risk.

(E) Enhance the customer's health.

(F) Enhance the customer's financial wellness through education or financial planning services.

(G) Provide the customer with post-loss services.

(H) Incentivize behavioral changes to improve the health of, or to reduce the risk of death or disability of, a customer.

(I) Assist in the administration of employee or retiree benefit insurance coverage.

(iii) The cost to the insurer or producer offering or providing the product or service to a customer must be reasonable in comparison to the customer's premiums and insurance coverage for the policy class.

(iv) If the insurer or producer provides the product or service offered, the insurer or producer shall ensure that the customer is provided with contact information for customer service or technical support personnel who can assist the customer with questions regarding the product or service.

(v) The availability of the value-added product or service shall be based on documented objective criteria and the value-added product or service must be offered to all customers in a nondiscriminatory manner. The documented objective criteria shall be maintained by the insurer or producer and provided to the commissioner upon request. If an insurer or producer does not have sufficient documented objective criteria, but has a good-faith belief that the product or service meets the criteria under subparagraph subdivision (ii), the insurer or producer may offer or provide the product or service in a nondiscriminatory manner to

customers as part of a pilot program or a test program for up to one year. Prior to launching the pilot program or test program, the insurer or producer must notify the commissioner. If the commissioner does not object to the pilot program or test program within twenty-one calendar days from the date of notice, the insurer or producer may proceed with the pilot program or test program.

(vi) The commissioner may adopt rules pursuant to chapter 17A to administer this subparagraph division.

(3) (a) Paying, allowing, or giving, or offering to pay, allow, or give, directly or indirectly, as an inducement to purchase or acquire insurance other than life insurance, life annuity, or accident and health insurance, or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue on the policy, or any valuable consideration or inducement, not specified in the policy, except to the extent provided for in an applicable filing. An insured named in a policy, or an employee of the insured, shall not knowingly receive or accept, directly or indirectly, any rebate, discount, abatement, credit, or reduction of premium, or any such special favor or advantage or valuable consideration or inducement.

(b) This subparagraph (3) shall not be construed to prohibit the payment of commissions or other compensation to duly licensed producers, or to prohibit any insurer from allowing or returning to its participating policyholders, members, or subscribers, dividends, savings, or unabsorbed premium deposits. As used in this subparagraph (3), *"insurance"* includes suretyship and *"policy"* includes bond.

j. Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(1) Misrepresenting pertinent facts or insurance policy provisions relating to coverages of issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(4) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(6) 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 paragraph *"p"* or section 511.38.

(7) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds.

(8) Attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured.

(10) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

(11) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(12) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(13) Failing to promptly settle claims, where liability has become reasonably clear, under

one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(14) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(15) Failing to comply with the procedures for auditing claims submitted by health care providers as set forth by rule of the commissioner. However, this subparagraph 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.

k. Use of inquiries. Considering either of the following events for purposes of surcharging, declining, nonrenewing, or canceling personal lines property and casualty insurance coverage or a binder for personal lines property and casualty insurance coverage:

(1) An applicant's or insured's inquiry into the type or level of coverage of a policy, or an inquiry into whether a policy will cover a loss.

(2) An insured's inquiry regarding coverage of a policy for a loss if the insured does not file a claim.

l. History of a property. Declining to insure a property not previously owned by an applicant for personal lines property and casualty insurance, based solely on the loss history of a previous owner of the property, unless the insurer can provide evidence that the previous owner did not repair damage to the property.

m. Disclosure of use of claims history. Failing to inform an applicant at the time that an application for personal lines property and casualty insurance is made, in writing or in the same medium as the application is made, that the insurer will consider the applicant's or insured's claims history in determining whether to decline, cancel, nonrenew, or surcharge such a policy, and that a claim made by an insured will be reported to an insurance support organization.

n. Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

o. Omission from insurance application. Failing to designate on an insurance policy application the licensee who has solicited and written the policy.

p. 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 2, paragraph "*d*". Interest shall accrue commencing on the thirty-first day after receipt of all properly completed proof of loss forms.

q. Rating organizations. Any violation of section 515F.16.

r. Minor traffic violations. Failure of a person to comply with section 516B.3.

s. Information. Failing or refusing to furnish any policyholder or applicant, upon reasonable request, information to which that individual is entitled.

t. Pharmacy benefits managers. Any violation of chapter 510B by a pharmacy benefits manager.

u. 340B drug program. Any violation of chapter 510D by a group health plan, a health carrier that offers group or individual health insurance coverage, a third-party administrator, or a pharmacy benefits manager.

v. Post-loss assignment of benefits. Any violation of section 515.137A by a residential contractor.

[C97, §1782; S13, §1782, 1820-b; SS15, §1758-f; C24, 27, 31, 35, 39, §**8666, 8759, 9022;** C46, 50, 54, §508.23, 511.20, 515.144; C58, 62, 66, 71, 73, 75, 77, 79, 81, §507B.4]

85 Acts, ch 229, §1; 87 Acts, ch 65, §2; 87 Acts, ch 120, §7; 89 Acts, ch 321, §32; 90 Acts, ch 1234, §64; 92 Acts, ch 1162, §3; 93 Acts, ch 88, §4; 95 Acts, ch 185, §6; 2001 Acts, ch 69, §5 – 7, 39; 2001 Acts, ch 118, §15, 56; 2006 Acts, ch 1117, §23, 24; 2007 Acts, ch 152, §53, 54; 2008 Acts, ch 1074, §1; 2010 Acts, ch 1153, §1; 2012 Acts, ch 1023, §101; 2016 Acts, ch 1073, §145;

2017 Acts, ch 121, §25; 2017 Acts, ch 148, §32; 2018 Acts, ch 1012, §1; 2022 Acts, ch 1113, §1, 16, 23; 2023 Acts, ch 22, §1 – 3; 2023 Acts, ch 43, §1; 2025 Acts, ch 28, §27

Referred to in §231.77, 507B.6, 507B.7, 507B.12, 510B.10, 510D.3, 515E.4, 515K.5, 729.6

Subsection 3, paragraph t applies to pharmacy benefits managers that manage a prescription drug benefit in the state on or after June 13, 2022; 2022 Acts, ch 1113, §16

Subsection 3, NEW paragraph v