CHAPTER 514G

LONG-TERM CARE INSURANCE ACT

Referred to in §87.4, 296.7, 331.301, 364.4, 505.28, 505.29, 669.14, 670.7

514G.1 through 514G.8 Repealed by 2008 Acts, ch 1175, §16.

514G.9 Reserved.

514G.10 Long-term care consumer guide. Repealed by 2008 Acts, ch 1175, §16.

514G.101 Title and purpose.

This chapter may be known and cited as the *"Long-term Care Insurance Act"*. The purpose of this chapter is to promote the public interest, to promote the availability of long-term care insurance, to protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

2008 Acts, ch 1175, §2

514G.102 Scope.

The requirements of this chapter apply to policies delivered or issued for delivery in this state on or after July 1, 2008. The requirements of this chapter related to independent review of benefit trigger determinations apply to all claims made on or after January 1, 2009. The requirements of this chapter related to prompt payment of claims and the payment of interest apply to all long-term care insurance policies. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable insurance laws not in conflict with this chapter, except that laws and regulations designed and intended to apply to Medicare supplement insurance policies shall not be applied to long-term care insurance.

2008 Acts, ch 1175, §3; 2009 Acts, ch 145, §11, 55; 2015 Acts, ch 128, §21, 50, 51

514G.103 Definitions.

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

1. *"Activities of daily living"* means at least bathing, continence, dressing, eating, toileting, and transferring.
2. *"Applicant"* means either of the following:

a. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

b. In the case of a group long-term care insurance policy, the proposed certificate holder.

3. *"Benefit trigger"* means a contractual provision in a policy of long-term care insurance that conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment, or on other conditions of the insured as

specified in the policy. For purposes of a qualified long-term care insurance contract, *"benefit trigger"* means a determination by a licensed health care practitioner that an insured is a chronically ill individual. For purposes of this definition, *"licensed health care practitioner"* means the same as defined in section 7702B(c)(4) of the Internal Revenue Code.

4. *"Certificate"* means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

5. *"Chronically ill individual"* means the same as defined in section 7702B(c)(2) of the Internal Revenue Code.

6. *"Claim"* means a request for payment of benefits under an in-force long-term care insurance policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

7. *"Cognitive impairment"* means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

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

9. *"Group long-term care insurance"* means a long-term care insurance policy that is delivered or issued for delivery in this state to any of the following:

a. One or more employers or labor organizations, or to a trust or to the trustee or trustees of a fund established, created, or maintained by one or more employers or labor organizations or a combination thereof, for the benefit of employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the employers or labor organizations.

b. Any professional, trade, or occupational association for its members or former or retired members, or a combination thereof, if the association meets both of the following requirements:

(1) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation.

(2) Has been maintained in good faith for purposes other than obtaining insurance.

c. (1) An association or associations, or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations, which files evidence with the commissioner prior to advertising, marketing, or offering a policy within this state by the association or associations, or their insurer, that the following organizational requirements have been met:

(a) At the outset, there is a minimum of one hundred members of the association or associations.

(b) The association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance.

(c) The association or associations have been in active existence for at least one year at the time of filing.

(d) The association or associations have a constitution and bylaws that require all of the following:

(i) The association or associations have regular meetings, not less than annually, to further the purposes of the members.

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members.

(iii) The members have voting privileges and representation on a governing board and committees.

(2) Thirty days after the required evidentiary filings have been made, the association or associations shall be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those requirements.

d. A group other than those described in paragraphs *"a"* through *"c"*, subject to a finding by the commissioner that all of the following are true:

(1) The issuance of the group policy is not contrary to the best interests of the public.

(2) The issuance of the group policy would result in economies of acquisition or administration.

(3) The benefits are reasonable in relation to the premiums charged.

10. *"Independent review organization"* means a review organization certified by the commissioner pursuant to section 514G.110, subsection 4.

11. *"Insurer"* means an entity qualified and licensed by the insurance division to transact the business of insurance in this state by a certificate issued pursuant to chapter 508, 512B, 514, or 514B.

12. *"Licensed health care professional"* means a qualified professional in an appropriate field for determining an insured's functional or cognitive impairment as it relates to the insured's specific diagnosis. Licensed health care professionals include but are not limited to physical therapists, occupational therapists, neurologists, physical medicine specialists, and rehabilitation medicine specialists.

13. *a. "Long-term care insurance"* means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital. *"Long-term care insurance"* includes group and individual annuities and life insurance policies or riders that directly provide or supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term also includes a qualified long-term care insurance contract. Long-term care insurance may be issued by an insurer.

b. "Long-term care insurance" does not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, *"long-term care insurance"* does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits, where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

c. Notwithstanding any other provision of this chapter, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this chapter.

14. *"Policy"* means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; or health maintenance organization or any similar organization.

15. *"Preexisting condition"* means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six months preceding the effective date of coverage of an individual.

16. *"Qualified long-term care insurance contract"* or *"federally tax-qualified long-term care insurance contract"* means any of the following:

a. An individual or group insurance contract that meets the requirements of section 7702B(b) of the Internal Revenue Code, as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract does not fail to satisfy the requirements of this subparagraph because payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Tit. XVIII of the federal Social Security Act, as amended, or would be reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Tit. XVIII of the federal Social Security Act only as a secondary payor. A contract does not fail to satisfy the requirements of this subparagraph because

payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(3) The contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code.

(4) The contract does not provide for a cash surrender value or for other money that can be paid, assigned or pledged as collateral for a loan, or borrowed except as provided in subparagraph (5).

(5) All refunds of premiums and all policyholder dividends or similar accounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund in the event of the death of the insured or a complete surrender or cancellation of the contract shall not exceed the aggregate premiums paid under the contract.

(6) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code.

b. The portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the Internal Revenue Code.

2008 Acts, ch 1175, §4; 2012 Acts, ch 1023, §80; 2021 Acts, ch 181, §13
Referred to in §508C.3, 514G.104, 514G.105, 514G.107, 514G.110, 514H.1
Subsection 10 amended

514G.104 Extraterritorial jurisdiction — group long-term care insurance.

Group long-term care insurance coverage shall not be offered to a resident of this state under a group policy issued in another state unless either this state or another state with statutory and regulatory requirements for long-term care insurance that are substantially similar to those adopted in this state has made a determination that the group to which the policy is issued meets the requirements of section 514G.103, subsection 9, paragraph *"d"*.

2008 Acts, ch 1175, §5; 2009 Acts, ch 145, §12

514G.105 Disclosure and performance standards for long-term care insurance.

1. *Prohibited policy practices.* A long-term care insurance policy shall not:

a. Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or deterioration of the mental or physical health of the insured individual or certificate holder.

b. Contain a provision establishing a new waiting period in the event that existing coverage is converted to or replaced by a new or other policy form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual, the certificate holder, or the group policyholder.

c. Provide coverage for skilled nursing care only, or provide significantly more coverage for skilled nursing care in a facility than coverage for lower levels of care.

2. *Preexisting conditions.*

a. A long-term care insurance policy or certificate, other than a policy or certificate issued to a group as described in section 514G.103, subsection 9, shall not use a definition of "preexisting condition" that is more restrictive than the definition contained in section 514G.103, subsection 15.

b. A long-term care insurance policy or certificate, other than a policy or certificate issued to a group as described in section 514G.103, subsection 9, shall not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured individual.

c. The commissioner may extend the limitation periods set forth in paragraphs *"a"* and *"b"* as to specific age group categories in specific policy forms upon finding that such an extension is in the best interest of the public.

d. The requirements of paragraph *"a"* do not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and on the basis of the answers on that application, underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, is not required to be covered until the waiting period described in paragraph *"b"* expires. A long-term care

insurance policy or certificate shall not exclude, or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph *"b"*.

3. *Prior hospitalization or institutionalization.*

a. A long-term care insurance policy shall not be delivered or issued for delivery in this state if the policy does any of the following:

(1) Conditions eligibility for any benefits on a prior hospitalization requirement.

(2) Conditions eligibility for any benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(3) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care, or recuperative benefits on a prior institutionalization requirement.

b. A long-term care insurance policy that contains post-confinement, post-acute care, or recuperative benefits shall contain, in a clearly visible, separate paragraph or the policy or certificate entitled "limitations or conditions on eligibility for benefits", a description of such limitations or conditions, including any required number of days of confinement.

c. A long-term care insurance policy or rider that conditions eligibility for noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than thirty days.

d. A long-term care insurance policy or rider that provides benefits only following institutionalization shall not condition such benefits upon admission to a facility for the same or related conditions within a period of less than thirty days after discharge from the institution.

4. *Right to return — free look — refund.*

a. A long-term care insurance applicant shall have the right to return the long-term care insurance policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

b. A long-term care insurance policy or certificate delivered or issued for delivery in this state shall have a notice prominently displayed on the first page of the policy or certificate, or attached thereto, which states in substance that the applicant has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group as described in section 514G.103, subsection 9, paragraph *"a"*, the applicant is not satisfied for any reason.

c. Any premium refund shall be made to the applicant within thirty days of the return.

5. *Denials — refund.* If an application is denied by an insurer, any premium refund shall be made to the applicant within thirty days of the denial.

6. *Outline of coverage.*

a. A written outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of the initial solicitation for coverage which prominently directs the attention of the applicant to the document and its purpose.

b. The commissioner shall prescribe, by rule, a standard format, including style, arrangement, and overall appearance, and content of the outline of coverage.

c. In the case of producer solicitations, a producer shall deliver the outline of coverage to a prospective applicant prior to the presentation of an application or enrollment form.

d. In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

e. In the case of a policy issued to a group as described in section 514G.103, subsection 9, paragraph *"a"*, an outline of coverage is not required to be delivered to the applicant, provided that the information described in subsection 7 of this section, paragraphs *"a"* through *"f"*, is contained in other enrollment materials provided. Upon request, such other enrollment materials shall be made available to the commissioner.

7. *Contents of outline of coverage.* An outline of coverage of long-term care insurance shall include all of the following:

a. A description of the principal benefits and coverage provided in the policy.

b. A statement of the principal exclusions, reductions, and limitations contained in the policy.

c. A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change the premium. Continuation or conversion provisions of group coverage shall be specifically described.

d. A statement that the outline of coverage is a summary of coverage only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions.

e. A description of the terms under which the policy or certificate may be returned and the premium refunded.

f. A brief description of the relationship of cost of care and benefits.

g. A statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified long-term care insurance contract under section 7702B(b) of the Internal Revenue Code.

8. *Contents of group certificate.* A certificate issued pursuant to a group long-term care insurance policy which policy is delivered or issued for delivery in this state shall include all of the following:

a. A description of the principal benefits and coverage provided in the policy.

b. A statement of the principal exclusions, reductions, and limitations contained in the policy.

c. A statement that the group master policy determines governing contractual provisions.

9. *Time for delivery.* If an application for a long-term care insurance policy or certificate is approved, the issuer shall deliver the policy or certificate of insurance to the applicant no later than thirty days after the date of approval.

10. *Individual life insurance — policy summary.*

a. A written policy summary shall accompany the delivery of an individual life insurance policy that provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver a policy summary upon the applicant's request or at the time of policy delivery, whichever occurs first.

b. A policy summary shall include all of the following:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits.

(2) An illustration of the amount of benefits, the length of benefits, and the guaranteed lifetime benefits if any, for each covered person.

(3) Any exclusions, reductions, or limitations on long-term care benefits.

(4) A statement that a long-term care inflation protection option required by 191 IAC 39.10 is not available under this policy.

(5) If applicable to the policy type, the summary shall also include all of the following:

(a) A disclosure of the effect of exercising other rights under the policy.

(b) A disclosure of guarantees related to long-term care costs of insurance charges.

(c) Current and projected maximum lifetime benefits.

c. The requirements of a policy summary set forth in paragraph *"b"* may be incorporated into the basic illustration required to be delivered in accordance with 191 IAC ch. 14, or into the life insurance policy summary required to be delivered in accordance with 191 IAC 15.4.

11. *Monthly report.* If a long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include all of the following:

a. Any long-term care benefits paid out during the month.

b. An explanation of any changes in the policy, including but not limited to changes in death benefits or cash values due to long-term care benefits being paid out.

c. The amount of long-term care benefits existing or remaining.

12. *Claim denial.* If a claim made under a long-term care insurance policy is denied, the issuer, within sixty days of the date of receipt of a written request by the policyholder, certificate holder, or a representative thereof, shall provide a written explanation of the

reasons for the denial, and shall make all information directly related to the denial available to the requestor.

13. *Compliance.* Any policy or rider advertised, marketed, or offered as long-term care insurance or nursing home insurance shall comply with the provisions of this chapter.

2008 Acts, ch 1175, §6; 2011 Acts, ch 34, §117; 2015 Acts, ch 29, §74
Referred to in §514H.1

514G.106 Incontestability period.

1. An insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the policy or certificate has been in force for less than six months upon a showing of misrepresentation that is material to the insurer's acceptance for coverage.

2. An insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim if the policy or certificate has been in force for at least six months but less than two years, upon a showing of misrepresentation that is both material to the acceptance for coverage and pertains to the condition for which benefits are sought.

3. An insurer shall not contest a long-term care insurance policy or certificate that has been in force for two or more years solely upon the grounds of misrepresentation. Such a policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

4. A long-term care insurance policy or certificate may be field-issued if the compensation paid to the field issuer is not based on the number of policies or certificates issued. For the purposes of this subsection, a *"field-issued"* policy means a policy or certificate issued by a producer or third-party administrator pursuant to the underwriting authority granted to the producer or third-party administrator by an insurer and using the insurer's underwriting guidelines.

5. An insurer that has paid benefits under a long-term care insurance policy or certificate shall not recover such benefit payments if the policy or certificate is rescinded.

6. The provisions of this section are applicable to life insurance policies or certificates that accelerate benefits for long-term care. However, if an insured dies, the remaining death benefits of a life insurance policy that accelerates benefits for long-term care are not governed by this section but by the provisions of section 508.28. In all other situations, this section shall apply to life insurance policies that accelerate benefits for long-term care.

2008 Acts, ch 1175, §7

514G.107 Nonforfeiture benefits.

1. Except as otherwise provided in subsection 2, a long-term care insurance policy or certificate shall not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate that includes a nonforfeiture benefit. A nonforfeiture benefit may be offered in the form of a rider that is attached to the policy or certificate. If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premium rates.

2. When a group long-term care insurance policy or certificate is delivered or issued for delivery in this state, an offer of benefits shall be made to the group policyholder that meets the requirements of subsection 1. However, if the policy is delivered or issued for delivery to a group as described in section 514G.103, subsection 9, paragraph *"d"*, that is not a continuing care retirement community or other similar entity, the offer of benefits shall be made to each proposed certificate holder.

3. The commissioner shall, by rule, specify the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for such nonforfeiture benefits, and the standards for contingent benefit upon lapse including a specified period of time during which a contingent benefit upon lapse will be available and

what constitutes a substantial premium rate increase that will trigger a contingent benefit upon lapse as provided in subsection 1.

2008 Acts, ch 1175, §8

514G.108 Prompt payment of claims — requirements.

1. An insurer providing long-term care insurance under this chapter and subject to state insurance regulation shall either accept and pay or deny a clean claim. For the purposes of this section, *"clean claim"* means a properly completed paper or electronic request for payment that contains all necessary information for the insurer to timely adjudicate and pay claims for long-term care benefits under the policy, does not involve coordination of benefits for third-party liability or subrogation, and does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

2. The commissioner shall adopt rules establishing processes for timely adjudication and payment of claims for long-term care benefits by insurers.

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

2008 Acts, ch 1175, §9

514G.109 Benefit trigger determinations — notice — appeals.

1. *Notice.* When a long-term care insurer determines that the benefit trigger in an insured's long-term care insurance policy has not been met, the insurer shall provide a clear, written notice to the insured of all of the following:

a. The reason that the insurer determined that the insured's benefit trigger has not been met.

b. The insurer's internal appeal process provided under the insured's long-term care insurance policy.

c. The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process set forth in section 514G.110.

2. *Internal appeal.*

a. An insured may request an internal appeal of a benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within sixty days after the insured receives the notice described in subsection 1. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision shall not be the same individual or individuals who made the initial benefit trigger determination. All internal appeals shall be completed and written notice of the internal appeal decision sent to the insured within sixty days of the insurer's receipt of all necessary information upon which a final determination can be made.

b. If the determination that the benefit trigger was not met is upheld upon internal appeal, the notice of the appeal decision shall describe additional internal appeal rights that are offered by the insurer, if any. Nothing in this paragraph shall require an insurer to offer any internal appeal rights other than those described in paragraph *"a"*.

c. If the determination that the benefit trigger was not met is upheld after the internal appeal process has been exhausted and there is no new information not previously provided to the insurer for consideration, the insurer shall provide the insured with a written description of the insured's right to request an independent review of the benefit trigger determination.

3. *Receipt of notice.* Notices required by this section shall be deemed received within five days after the date of mailing.

2008 Acts, ch 1175, §10, 18
Referred to in §514G.110

514G.110 Independent review of benefit trigger determinations.

1. *Request.* An insured may file a written request for independent review of a benefit

trigger determination with the commissioner after the internal appeal process has been exhausted. The request shall be filed within sixty days after the insured receives written notice of the insurer's internal appeal decision.

2. *Eligibility for review.* The commissioner shall certify that the request is eligible for independent review if all of the following criteria are satisfied:

a. The insured was covered by a long-term care insurance policy issued by the insurer at the time the benefit trigger determination was made.

b. The sole reason for requesting an independent review is to review the insurer's determination that the benefit trigger was not met.

c. The insured has exhausted all internal appeal procedures provided under the insured's long-term care insurance policy.

d. The written request for independent review was filed by the insured within sixty days from the date of receipt of the insurer's internal appeal decision.

3. *Notice of eligibility.* The commissioner shall provide written notice regarding eligibility of a request for independent review to the insured and the insurer within two business days from the date of receipt of the request.

a. If the commissioner decides that the request is not eligible for independent review, the written notice shall indicate the reasons for that decision.

b. If the commissioner certifies that the request is eligible for independent review, the insurer may appeal that certification by filing a written notice of appeal with the commissioner within three business days from the date of receipt of the notice of certification. If upon further review, the commissioner upholds the certification, the commissioner shall promptly notify the insured and the insurer in writing of the reasons for that decision.

4. *Qualifications of independent review organizations.* The commissioner shall maintain a list of qualified independent review organizations that are certified by the commissioner. Independent review organizations shall be recertified by the commissioner every two years in order to remain on the list. In order to be certified, an independent review organization shall meet all of the following criteria:

a. Have on staff, or contract with, a qualified, licensed health care professional in an appropriate field for determining an insured's functional or cognitive impairment who can conduct an independent review.

(1) In order to be qualified, a licensed health care professional who is a physician shall hold a current certification by a recognized American medical specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

(2) In order to be qualified, a licensed health care professional who is not a physician shall hold a current certification in the specialty in which that person is licensed, by a recognized American specialty board in a specialty appropriate for determining an insured's functional or cognitive impairment.

b. Ensure that any licensed health care professional who conducts an independent review has no history of disciplinary actions or sanctions, including but not limited to the loss of staff privileges or any participation restrictions taken or pending by any hospital or state or federal government regulatory agency.

c. Ensure that the independent review organization or any of its employees, agents, or licensed health care professionals utilized does not receive compensation of any type that is dependent on the outcome of a review.

d. Ensure that the independent review organization or any of its employees, agents, or licensed health care professionals utilized are not in any manner related to, employed by, or affiliated with the insured or with a person who previously provided medical care to the insured.

e. Ensure that an independent review organization or any of its employees, agents, or licensed health care professionals utilized is not a subsidiary of, or owned or controlled by, an insurer or by a trade association of insurers of which the insurer is a member.

f. Have a quality assurance program on file with the commissioner that ensures the timeliness and quality of reviews performed, the qualifications and independence of the licensed health care professionals who perform the reviews, and the confidentiality of the review process.

g. Have on staff or contract with a licensed health care practitioner, as defined in section 514G.103, subsection 3, who is qualified to certify that an individual is chronically ill for purposes of a qualified long-term care insurance contract.

5. *Independent review process.* The independent review process shall be conducted as follows:

a. Within three business days of receiving a notice from the commissioner of the certification of a request for independent review or receipt of a denial of an insurer's appeal from such a certification, the insurer shall do all of the following:

(1) Select an independent review organization from the list certified by the commissioner and notify the insured in writing of the name, address, and telephone number of the selected independent review organization. The selected independent review organization shall utilize a licensed health care professional with qualifications appropriate to the benefit trigger determination that is under review.

(2) Notify the independent review organization that it has been selected to conduct an independent review of a benefit trigger determination and provide sufficient descriptive information to enable the independent review organization to provide licensed health care professionals who will be qualified to conduct the review.

(3) Provide the commissioner with a copy of the notices sent to the insured and to the selected independent review organization.

b. Within three business days of receiving a notice from an insurer that it has been selected to conduct an independent review, the independent review organization shall do one of the following:

(1) Accept its selection as the independent review organization, designate a qualified licensed health care professional to perform the independent review, and provide notice of that designation to the insured and the insurer, including a brief description of the health care professional's qualifications and the reasons that person is qualified to determine whether the insured's benefit trigger has been met. A copy of this notice shall be sent to the commissioner via facsimile. The independent review organization is not required to disclose the name of the health care professional selected.

(2) Decline its selection as the independent review organization or, if the independent review organization does not have a licensed health care professional who is qualified to conduct the independent review available, request additional time from the commissioner to have a qualified licensed health care professional certified, and provide notice to the insured, the insurer, and the commissioner. The commissioner shall notify the independent review organization, the insured, and the insurer of how to proceed within three business days of receipt of such notice from the independent review organization.

c. An insured may object to the independent review organization selected by the insurer or to the licensed health care professional designated by the independent review organization to conduct the review by filing a notice of objection along with reasons for the objection, with the commissioner within ten days of receipt of a notice sent by the independent review organization pursuant to paragraph *"b"*. The commissioner shall consider the insured's objection and shall notify the insured, the insurer, and the independent review organization of the commissioner's decision to sustain or deny the objection within two business days of receipt of the objection.

d. Within five business days of receiving a notice from the independent review organization accepting its selection or within five business days of receiving a denial of an objection to the independent review organization selected, whichever is later, the insured may submit any information or documentation in support of the insured's claim to both the independent review organization and the insurer.

e. Within fifteen days of receiving a notice from the independent review organization accepting its selection or within three business days of receipt of a denial of an objection to the independent review organization selected, whichever is later, an insurer shall do all of the following:

(1) Provide the independent review organization with any information submitted to the insurer by the insured in support of the insured's internal appeal of the insurer's benefit trigger determination.

(2) Provide the independent review organization with any other relevant documents used by the insurer in making its benefit trigger determination.

(3) Provide the insured and the commissioner with confirmation that the information required under subparagraphs (1) and (2) has been provided to the independent review organization, including the date the information was provided.

f. The independent review organization shall not commence its review until fifteen days after the selection of the independent review organization is final including the resolution of any objection made pursuant to paragraph "*c*". During this time period, the insurer may consider any information provided by the insured pursuant to paragraph "*d*" and overturn or affirm the insurer's benefit trigger determination based on such information. If the insurer overturns its benefit trigger determination, the independent review process shall immediately cease.

g. In conducting a review, the independent review organization shall consider only the information and documentation provided to the independent review organization pursuant to paragraphs "*d*" and "*e*".

h. The independent review organization shall submit its decision as soon as possible, but not later than thirty days from the date the independent review organization receives the information required under paragraphs "*d*" and "*e*", whichever is received later. The decision shall include a description of the basis for the decision and the date of the benefit trigger determination to which the decision relates. The independent review organization, for good cause, may request an extension of time from the commissioner to file its decision. A copy of the decision shall be mailed to the insured, the insurer, and the commissioner.

i. All medical records submitted for use by the independent review organization shall be maintained as confidential records as required by applicable state and federal laws. The commissioner shall keep all information obtained during the independent review process confidential pursuant to section 505.8, subsection 8, except that the commissioner may share some information obtained as provided under section 505.8, subsection 8, and as required by this chapter and rules adopted pursuant to this chapter.

j. If an insured dies before completion of the independent review, the review shall continue to completion if there is potential liability of an insurer to the estate of the insured or to a provider for rendering qualified long-term care services to the insured.

6. *Costs.* All reasonable fees and costs of the independent review organization in conducting an independent review under this section shall be paid by the insurer.

7. *Immunity.* An independent review organization that conducts a review under this section is not liable for damages arising from determinations made during the review. Immunity does not apply to any act or omission made by an independent review organization in bad faith or that involves gross negligence.

8. *Effect of independent review decision.*

a. The review decision by the independent review organization conducting the review is binding on the insurer.

b. The independent review process set forth in this section shall not be considered a contested case under chapter 17A.

c. An insured may appeal the review decision by the independent review organization conducting the review by filing a petition for judicial review in the district court in the county in which the insured resides. The petition for judicial review shall be filed within fifteen business days after the issuance of the review decision by the independent review organization. The petition shall name the insured as the petitioner and the insurer as the respondent. The petitioner shall not name the independent review organization as a party. The commissioner shall not be named as a respondent unless the insured alleges action or inaction by the commissioner under the standards articulated under section 17A.19, subsection 10. Allegations made against the commissioner under section 17A.19, subsection 10, must be stated with particularity. The commissioner may, upon motion, intervene in a judicial review proceeding brought pursuant to this paragraph. The findings of fact by the independent review organization conducting the review are conclusive and binding on appeal.

d. An insurer shall not be subject to any penalties, sanctions, or damages for complying in

good faith with a review decision rendered by an independent review organization pursuant to this section.

e. Nothing contained in this section or in section 514G.109 shall be construed to limit the right of an insurer to assert any rights an insurer may have under a long-term care insurance policy related to:

(1) An insured's misrepresentation.

(2) Changes in the insured's benefit eligibility.

(3) Terms, conditions, and exclusions contained in the policy, other than failure to meet the benefit trigger.

f. The requirements of this section and section 514G.109 are not applicable to a group long-term care insurance policy that is governed by the federal Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. §1001 et seq.

g. The provisions of this section and section 514G.109 are in lieu of and supersede any other third-party review requirement contained in chapter 514J or in any other provision of law.

h. The insured may bring an action in the district court in the county in which the insured resides to enforce the review decision of the independent review organization conducting the review or the decision of the court on appeal.

9. *Receipt of notice.* Notice required by this section shall be deemed received within five days after the date of mailing.

2008 Acts, ch 1175, §11, 18; 2011 Acts, ch 34, §118; 2017 Acts, ch 105, §1; 2021 Acts, ch 181, §14

Referred to in §514G.103, 514G.109
Subsections 4 – 8 amended

514G.111 Authority to promulgate rules.

The commissioner may adopt rules pursuant to chapter 17A related to long-term care insurance and to the administration and enforcement of this chapter, including but not limited to the following:

1. Promoting adequate premiums and protecting policyholders in the event of substantial rate increases.

2. Establishing minimum standards for producer education, compensation, and testing; marketing practices; reporting practices; and penalties related to the sale of long-term care insurance in this state.

3. Establishing loss ratio standards for long-term care insurance policies with specific reference to such policies.

4. Providing standards for full and fair disclosure by setting forth the manner and content of disclosures required for the sale of long-term care insurance policies including terms of renewability; initial and subsequent conditions of eligibility; nonduplication of coverage provisions; coverage of dependents; effect of preexisting conditions; termination, continuation, or conversion of policies; probationary periods; limitations, exceptions, and reductions; elimination periods; requirements for replacement; recurrent conditions; and definitions of terms.

5. Requiring certain remedial actions necessitated by changes in the long-term care insurance market to provide fair and reasonable protections for long-term care insurance purchasers and beneficiaries.

6. Ensuring the prompt payment of clean claims.

7. Administering the independent review process of insurers' benefit trigger determinations.

2008 Acts, ch 1175, §12

514G.112 Severability.

If any provision of this chapter or the application of this chapter to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of the provision to other persons or circumstances shall not be affected.

2008 Acts, ch 1175, §13

514G.113 Penalties.

In addition to any other penalties provided by the laws of this state, any insurer or any producer found to have violated a provision of this chapter or any other requirement of this state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a fine of up to three times the amount of any commission paid for each policy involved in the violation, or up to ten thousand dollars, whichever is greater. A fine collected under this section shall be deposited as provided in section 505.7.

2008 Acts, ch 1175, §14; 2009 Acts, ch 181, §75