TERRY E. BRANSTAD
GOVERNOR

OFFICE OF THE GOVERNOR

KIM REYNOLDS
LT. GOVERNOR

April 19, 2011

The Honorable Matthew Schultz
Secretary of State of Iowa
State Capitol Building
LOCAL

Dear Mr. Secretary:

I hereby transmit:

Senate File 406, an Act relating to various matters under the purview of the insurance division of the Department of Commerce and including effective date provisions.

The above Senate File is hereby approved this date.

Sincerely,

Terry E. Branstad
Governor

cc: Secretary of the Senate
Clerk of the House

Senate File 406

AN ACT

RELATING TO VARIOUS MATTERS UNDER THE PURVIEW OF THE INSURANCE DIVISION OF THE DEPARTMENT OF COMMERCE AND INCLUDING EFFECTIVE DATE PROVISIONS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. Section 502.604, subsections 2 and 4, Code 2011, are amended to read as follows:

2. *Summary process.* An order under subsection 1 is effective on the date of issuance. Upon issuance of the order, the administrator shall promptly serve each person subject to the order with a copy of the order and a notice that the order has been entered. The order must include a statement of any restitution order, civil penalty, or costs of investigation the administrator will seek, a statement of the reasons for the order, and notice that, within thirty days after receipt of a request in a record from the person, the matter will be scheduled for a hearing. If a person subject to the order does not request a hearing and none is ordered by the administrator within thirty days after the date of service of the order, the order, including an order for restitution, the imposition of a civil penalty, or a requirement for payment of costs of investigation sought in the order, becomes final as to that person by operation of law. If a hearing is requested or ordered, the administrator, after notice of and opportunity for hearing to each person subject to the order, may modify or vacate the order or extend it until final determination.

4. *Civil penalty — restitution — corrective action.* In a final order under subsection 3, the administrator may impose a civil penalty up to an amount not to exceed a maximum of five thousand dollars for a single violation or

five hundred thousand dollars for more than one violation, order restitution, or take other corrective action as the administrator deems necessary and appropriate to accomplish compliance with the laws of the state relating to all securities business transacted in the state.

Sec. 2. Section 505.8, subsections 1 and 10, Code 2011, are amended to read as follows:

1. The commissioner of insurance shall be the head of the division, and shall have general control, supervision, and direction over all insurance business transacted in the state, and shall enforce all the laws of the state relating to ~~such~~ federal and state insurance business transacted in the state.

10. The commissioner may, after a hearing conducted pursuant to chapter 17A, assess fines or penalties, assess costs of an investigation or proceeding, order restitution, or take other corrective action as the commissioner deems necessary and appropriate to accomplish compliance with the laws of the state relating to all insurance business transacted in the state.

Sec. 3. Section 505.8, Code 2011, is amended by adding the following new subsection:

NEW SUBSECTION. 19. The commissioner may propose and promulgate administrative rules to effectuate the insurance provisions of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and any amendments thereto, or other applicable federal law.

Sec. 4. Section 505.18, subsection 2, unnumbered paragraph 1, Code 2011, is amended to read as follows:

The commissioner in collaboration with the consumer advocate shall prepare and deliver a report to the governor and to the general assembly no later than November 15 of each year that provides findings regarding health spending costs for health insurance ~~plans~~ carriers in the state for the previous ~~fiscal~~ calendar year. The commissioner may contract with outside vendors or entities to assist in providing the information contained in the annual report. The report shall provide, at a minimum, the following information:

Sec. 5. Section 505.18, subsection 2, paragraph d, Code 2011, is amended to read as follows:

d. A ranking and quantification of those factors that result in higher costs and those factors that result in lower costs

for each health insurance ~~plan offered~~ carrier in the state.

Sec. 6. Section 505.19, subsections 3 and 4, Code 2011, are amended to read as follows:

3. The consumer advocate shall solicit public comments on each proposed health insurance rate increase application if the increase exceeds the average annual health spending growth rate as provided in subsection 1, and shall post without delay during the normal business hours of the division, all comments received on the insurance division's internet site prior to approval ~~or~~, disapproval, or modification of the proposed rate increase by the commissioner.

4. The consumer advocate shall present the public testimony, if any, and public comments received for consideration by the commissioner in determining whether to approve, ~~or~~ disapprove, or modify such health insurance rate increase proposals.

Sec. 7. Section 507E.8, Code 2011, is amended to read as follows:

507E.8 ~~Peace~~ Law enforcement officer status.

1. Bureau investigators shall have the power and status of ~~peace~~ law enforcement officers who by the nature of their duties may be required to perform the duties of a peace officer when making arrests for criminal violations established as a result of their investigations pursuant to this chapter.

2. The general laws applicable to arrests by ~~peace~~ law enforcement officers of the state also apply to bureau investigators. Bureau investigators shall have the power to execute arrest warrants and search warrants for the same criminal violations, serve subpoenas issued for the examination, investigation, and trial of all offenses identified through their investigations, and arrest upon probable cause without warrant a person found in the act of committing a violation of the provisions of this chapter.

Sec. 8. Section 508C.5, Code 2011, is amended by adding the following new subsections:

NEW SUBSECTION. 2A. *"Authorized assessment"*, or the term *"authorized"* when used in the context of an assessment, means that a resolution has been passed by the board of directors of the association whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

NEW SUBSECTION. 2B. *"Benefit plan"* means a specific

employee, union, or association of natural persons benefit plan.

NEW SUBSECTION. 2C. "*Called assessment*", or the term "*called*" when used in the context of an assessment, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

Sec. 9. Section 508C.5, subsection 5, Code 2011, is amended to read as follows:

5. "*Covered policy*" means a policy or contract ~~within the scope of this chapter as~~ or a portion of a policy or contract for which coverage is provided under section 508C.3.

Sec. 10. Section 508C.5, Code 2011, is amended by adding the following new subsections:

NEW SUBSECTION. 12A. "*Plan sponsor*" means any of the following:

a. The employer in the case of a benefit plan established or maintained by a single employer.

b. The employee organization in the case of a benefit plan established or maintained by an employee organization.

c. In the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

NEW SUBSECTION. 13A. "*Principal place of business*" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function as determined pursuant to section 508C.8A.

NEW SUBSECTION. 13B. "*Receivership court*" means a court in an insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

Sec. 11. Section 508C.5, subsection 14, Code 2011, is amended to read as follows:

14. "*Resident*" means a person to whom a contractual obligation is owed and who resides in a state on the date of entry of a court order that determines a member insurer is an

impaired insurer or a court order that determines a member insurer is an insolvent insurer~~, whichever occurs first~~. A person may be a resident of only one state, which in the case of a person other than a natural person shall be the state of that person's principal place of business. A citizen of the United States who is a resident of a foreign country, or is a resident of a United States possession, territory, or protectorate that does not have an association similar to the association created by this chapter, shall be deemed a resident of the state or domicile of the insurer that issued the policy or contract.

Sec. 12. NEW SECTION. **508C.8A Principal place of business — determination.**

1. The principal place of business of a plan sponsor or a person other than a natural person shall be determined by the association in its reasonable judgment by considering all of the following factors:

a. The state in which the primary executive and administrative headquarters of the entity is located.

b. The state in which the principal office of the chief executive officer of the entity is located.

c. The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.

d. The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.

e. The state from which the management of the overall operations of the entity is directed.

2. In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the principal place of business of the entity shall be deemed to be the state in which the holding company or controlling affiliate has its principal place of business as determined by the association using the factors enumerated in subsection 1. However, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be determined to be the principal place of business of the entity.

3. In the case of a benefit plan established or maintained by two or more employers, or jointly by one or more employers and one or more employee organizations, the principal place of business of the entity shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of

the parties who establish or maintain the benefit plan. In lieu of a specific or clear designation of the principal place of business of the entity under this subsection, the principal place of business of the entity shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

Sec. 13. Section 508C.9, subsections 2 through 6, Code 2011, are amended to read as follows:

2. There are two classes of assessments as follows:

a. Class A assessments shall be ~~made~~ authorized and called for the purpose of meeting administrative and legal costs and other ~~general~~ expenses ~~and examinations conducted under section 508C.12, subsection 5,~~. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

b. Class B assessments shall be ~~made~~ authorized and called to the extent necessary to carry out the powers and duties of the association under section 508C.8 with regard to an impaired ~~domestic insurer~~ or an insolvent ~~domestic, foreign, or alien~~ insurer.

3. *a.* The amount of a class A assessment shall be determined by the board ~~and to the extent that class A assessments do not exceed one hundred dollars per company in any one calendar year may be made on a per capita basis~~ and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the assessment be credited against future class B assessments. The total of all non-pro rata assessments shall not exceed three hundred dollars per member insurer in any one calendar year. The amount of a class B assessment shall be allocated for assessment purposes among the accounts ~~as the liabilities and expenses of the association, either experienced or reasonably expected, are attributable to those accounts, all as determined by the association and on as equitable a basis as is reasonably practical~~ pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or on any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

b. Class ~~A assessments in excess of one hundred dollars per company per calendar year and class~~ B assessments against member insurers for each account shall be in the proportion

that the average of the aggregate premiums received on business in this state by each assessed member insurer on policies or contracts ~~related to that~~ covered by each account for the three most recent calendar years for which information is available, preceding the year in which the insurer became ~~impaired or~~ insolvent, ~~is~~ or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the insurer became impaired, bears to the ~~average of the aggregate~~ premiums received on business in this state for those calendar years by all assessed member insurers ~~on policies related to that account for the three most recent calendar years for which information is available preceding the assessment~~.

c. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be ~~made~~ authorized or called until necessary to implement the purposes of this chapter. Classification of assessments under ~~this~~ subsection 2 and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

4. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused an abatement or deferral have been removed or rectified, the member insurer shall pay all assessments that were abated or deferred pursuant to a repayment plan approved by the association.

5. *a.* (1) ~~The~~ Subject to the provisions of subparagraph (2) of this paragraph "*a*", the total of all assessments ~~upon~~ authorized by the association with respect to a member insurer for each ~~account~~ of the accounts established pursuant to section 508C.6, and designated as the health insurance account, the life insurance account, the annuity account, and the

unallocated annuity contract account, shall not in any one calendar year exceed two percent of ~~the average of the~~ that member insurer's average annual premiums received in this state on the policies and contracts covered by the account during the three ~~most recent~~ calendar years ~~for which information is available,~~ preceding the year in which the insurer becomes impaired or insolvent~~, on the policies related to that account~~.

(2) ~~However, if~~ If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referred to in subparagraph (1) of this paragraph *"a"* shall be equal~~,~~ and limited~~,~~ to the higher of the three-year average annual premiums for the applicable account as calculated pursuant to this section.

(3) If the maximum assessment ~~for an account~~, together with the other assets of the association in the account, does not provide in ~~any~~ one year in ~~the~~ either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed for the account in succeeding years as soon as permitted by this chapter.

b. The board may provide in its plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

~~*b.*~~ *c.* If the maximum assessment ~~under paragraph "a"~~ for ~~any account, other than the health insurance account,~~ either the life insurance account, the annuity account, or the unallocated annuity contract account in one year does not provide an amount sufficient to carry out the responsibilities of the association ~~in any succeeding year~~, the board, pursuant to subsection 3, paragraph ~~"a"~~ *"b"*, shall ~~assess~~ access any of the other said accounts for the necessary additional amount ~~and allocate the amount for assessment among the accounts, other than the health insurance account, in the following sequence: from the life insurance account, to the annuity account, to the unallocated annuity contract account; from the annuity account, to the unallocated annuity contract account, to the life insurance account; from the unallocated annuity contract account, to the annuity account, to the life insurance account; provided that no amount shall be allocated to an account for assessment until the maximum amount has been allocated to the preceding account~~,

subject to the maximum assessments stated in paragraph "a" of this subsection.

6. By an equitable method as established in the plan of operation, the board may refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account, including assets accruing from assignment, subrogation, net realized gains, and income from investments, exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future ~~losses if refunds are impractical~~ claims.

Sec. 14. Section 508C.9, Code 2011, is amended by adding the following new subsections:

NEW SUBSECTION. 9. *a.* A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be made available to meet association obligations during the pendency of the protest or any subsequent appeal. The payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

b. Within sixty days following the payment of an assessment under protest by a member insurer, the association shall either notify the protesting member insurer in writing of its determination with respect to the protest or notify the protesting member insurer that additional time is required to resolve the issues raised by the protest.

c. Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final decision to the commissioner.

d. As an alternative to rendering a final decision with respect to a protest of an assessment, the association may refer the protest to the commissioner for a final decision, with or without a recommendation from the association.

e. If a protest or subsequent appeal of an assessment is upheld in favor of the protesting member insurer, the amount paid in error or the excess shall be refunded to the member insurer. Interest on a refund due a protesting member insurer

shall be paid at the rate actually earned by the association during the pendency of the protest or any subsequent appeal.

NEW SUBSECTION. 10. The association may request information from member insurers in order to aid in the exercise of the association's power under this section, and the member insurers shall promptly comply with such a request.

Sec. 15. Section 508C.11, subsection 1, paragraph c, Code 2011, is amended by striking the paragraph.

Sec. 16. Section 508C.11, subsection 3, Code 2011, is amended to read as follows:

3. ~~An~~ A final action of the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken within ~~thirty~~ sixty days of the member insurer's receipt of notice of the final action being appealed. A final action or order of the commissioner is subject to judicial review pursuant to chapter 17A in a court of competent jurisdiction.

Sec. 17. Section 508C.12, subsection 1, paragraphs b through d, Code 2011, are amended to read as follows:

b. Report to the board of directors when the commissioner has taken any of the actions set forth in paragraph "*a*" or has received a report from any other commissioner indicating that ~~a member insurer is impaired or insolvent~~ such action has been taken in another state. Reports to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

c. Report to the board of directors when there is reasonable cause to believe from an examination, whether completed or in process, of a member ~~company~~ insurer that the ~~company~~ insurer may be an impaired or insolvent insurer.

d. Furnish to the board of directors the national association of insurance commissioners' ~~early warning tests. The~~ insurance regulatory information system ratios, and listing of insurers not included in the ratios, developed by the national association of insurance commissioners, and the board may use the information in carrying out its duties and responsibilities under this section. The report and the information contained in the report shall be kept confidential by the board of directors until such time as it is made public by the commissioner or other lawful authority.

Sec. 18. Section 508C.12, subsection 2, Code 2011, is amended to read as follows:

2. The commissioner may seek the advice and recommendations