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MAR 14 1980

HOUSE FILE 2537

Place On Calendar

By COMMITTEE ON COMMERCE

(Formerly House File 2270)

Passed House, Date 3-19-80 (p.1000) Passed Senate, Date _____
Vote: Ayes 94 Nays 0 Vote: Ayes _____ Nays _____
Approved May 19, 1980

A BILL FOR

1 An Act relating to the sale of individual policies of
2 accident and sickness insurance and subscriber contracts,
3 and providing penalties.

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

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2537

1 Section 1. Title twenty (XX), Code 1979, is amended by
2 adding sections two (2) through nine (9) of this Act as a
3 new chapter five hundred fourteen D (514D) of the Code.

4 Sec. 2. NEW SECTION. PURPOSE. The purpose of this
5 division is to provide reasonable standardization,
6 simplification, and disclosure of the terms and coverages
7 of individual accident and sickness insurance policies issued
8 under chapter five hundred fourteen A (514A) of the Code and
9 subscriber contracts issued under chapter five hundred fourteen
10 (514) of the Code, in order to facilitate public understanding
11 and comparison and to eliminate provisions which may be
12 misleading or unreasonably confusing in connection with the
13 purchase of coverage or the settlement of claims.

14 Sec. 3. NEW SECTION. DEFINITIONS. As used in this
15 division, unless the context otherwise requires:

16 1. "Accident and sickness insurance" means individual
17 accident and sickness insurance within the meaning of section
18 five hundred fourteen A point one (514A.1) of the Code.

19 "Accident and sickness insurance" also means subscriber
20 contracts for hospital service, or medical and surgical
21 service, or pharmaceutical or optometric service issued under
22 chapter five hundred fourteen (514) of the Code, and for
23 purposes of this division, corporations issuing contracts
24 under chapter five hundred fourteen (514) of the Code are
25 deemed to be engaged in the business of insurance.

26 2. "Form" means and includes policies, contracts, riders,
27 endorsements and applications used in connection with the
28 sale of accident and sickness insurance under chapter five
29 hundred fourteen (514) of the Code or chapter five hundred
30 fourteen A (514A) of the Code.

31 3. "Policy" means the entire contract between the insurer
32 and the insured, including the policy riders, endorsements,
33 and the application, if attached, and includes subscriber
34 contracts issued under chapter five hundred fourteen (514)
35 of the Code.

1 4. "Medicare" means the Health Insurance for the Aged
2 Act, title XVIII of the United States Social Security Act
3 added by the amendment of 1965 as amended on or before the
4 effective date of this Act.

5 Sec. 4. NEW SECTION. STANDARDS FOR POLICIES ESTABLISHED.

6 1. The commissioner shall issue rules to establish specific
7 standards, including standards of full and fair disclosure,
8 that set forth the manner, content, and required disclosure
9 for the sale of policies of individual accident and sickness
10 insurance and subscriber contracts which shall be in addition
11 to and in accordance with applicable laws of this state,
12 including but not limited to sections five hundred fourteen
13 A point one (514A.1) through five hundred fourteen A point
14 twelve (514A.12) of the Code. These rules may include, but
15 shall not be limited to, any of the following subjects:

- 16 a. Terms of renewability.
- 17 b. Initial and subsequent conditions of eligibility.
- 18 c. Nonduplication of coverage provisions.
- 19 d. Coverage of dependents.
- 20 e. Coverage of persons eligible for medicare by reason
21 of age.
- 22 f. Preexisting conditions.
- 23 g. Termination of insurance.
- 24 h. Probationary periods.
- 25 i. Limitations.
- 26 j. Exceptions.
- 27 k. Reductions.
- 28 l. Elimination periods.
- 29 m. Requirements for replacement.
- 30 n. Recurrent conditions.
- 31 o. The definition of terms, including but not limited
32 to the following: hospital, accident, sickness, injury,
33 physician, accidental means, total disability, partial
34 disability, nervous disorder, guaranteed renewable, and
35 noncancelable.

1 2. The commissioner may issue rules with respect to
2 policies of individual accident and sickness insurance and
3 subscriber contracts that specify prohibited policies or
4 subscriber contracts, or prohibited policy or contract
5 provisions which the commissioner finds to be unjust, unfair,
6 or unfairly discriminatory to the policyholder or any person
7 insured under the policy or any beneficiary. This subsection
8 does not authorize the commissioner to prohibit a policy or
9 policy provision or subscriber contract or contract provision
10 which is specifically authorized by statute.

11 3. A rule issued by the commissioner under this section
12 shall not apply to a conversion policy issued pursuant to
13 a contractual conversion privilege under a group or individual
14 policy of accident and sickness insurance when such group
15 or individual contract contains provisions that are
16 inconsistent with the requirements of this chapter or any
17 rule issued under this chapter.

18 4. A rule issued by the commissioner under this section
19 shall not apply to policies being issued to employees or
20 members being added to a franchise plan, as defined in section
21 five hundred nine point fourteen (509.14) of the Code, which
22 is in existence on the effective date of the rule.

23 Sec. 5. NEW SECTION. STANDARDS FOR BENEFITS ESTABLISHED.

24 1. The commissioner shall issue rules to establish minimum
25 standards for benefits under each of the following categories
26 of coverage contained in policies of individual accident and
27 sickness insurance or subscriber contracts:

- 28 a. Basic hospital expense coverage.
- 29 b. Basic medical-surgical expense coverage.
- 30 c. Hospital confinement indemnity coverage.
- 31 d. Major medical expense coverage.
- 32 e. Disability income protection coverage.
- 33 f. Accident only coverage.
- 34 g. Specified disease or specified accident coverage.
- 35 h. Medicare supplement coverage.

1 i. Limited benefit health coverage.

2 2. This section does not prohibit the issuance of a policy
3 which combines two or more of the categories of coverage
4 enumerated in paragraphs a through f of subsection one (1)
5 of this section. A category of coverage referred to in
6 paragraph g, h or i of subsection one (1) of this section
7 shall not be combined in a policy or contract either with
8 another category of coverage referred to in paragraph g, h
9 or i of subsection one (1) of this section or with a category
10 of coverage referred to in any of paragraphs a through f of
11 subsection one (1) of this section unless a rule issued by
12 the commissioner specifically authorizes that combination
13 of coverages.

14 3. The commissioner shall prescribe the method of
15 identification of policies and contracts based upon coverages
16 provided.

17 4. A policy of accident and sickness insurance or
18 subscriber contract shall not be delivered or issued for
19 delivery in this state unless the policy or contract meets
20 the minimum standards prescribed under this section.

21 5. The commissioner may upon notice and hearing at any
22 time after the initial filing or approval of any individual
23 accident and sickness policy or subscriber contract form,
24 withdraw approval or suspend further sale of the form if the
25 benefits provided are unreasonable in relation to the premium
26 charge. The commissioner shall establish reasonable and
27 creditable anticipated minimum loss ratios for medicare
28 supplement and other accident and sickness insurance policies.

29 6. A rule issued by the commissioner under this section
30 shall not apply to a conversion policy issued pursuant to
31 a contractual conversion privilege under a group or individual
32 policy of accident and sickness insurance when such group
33 or individual contract contains provisions which are
34 inconsistent with the requirements of this chapter or any
35 rule issued under this chapter.

1 7. A rule issued by the commissioner under this section
2 shall not apply to policies being issued to employees or
3 members being added to a franchise plan, as defined in section
4 five hundred nine point fourteen (509.14) of the Code, which
5 is in existence on the effective date of the rule.

6 Sec. 6. NEW SECTION. DISCLOSURE OF COVERAGE.

7 1. Except as otherwise provided in subsection three (3)
8 of this section, in order to provide for full and fair
9 disclosure in the sale of individual accident and sickness
10 insurance policies or subscriber contracts a policy or contract
11 shall not be delivered or issued for delivery in this state
12 unless the outline of coverage described in subsection two
13 (2) of this section either accompanies the policy or contract
14 or is delivered to the applicant at the time application is
15 made and unless an acknowledgement of receipt or certificate
16 of delivery of the outline is provided the insurer. In the
17 event the policy or contract is issued on a basis other than
18 that applied for, the outline of coverage properly describing
19 the policy or contract must accompany the policy or contract
20 when it is delivered and must clearly state that it is not
21 the policy or contract for which application was made.

22 2. The commissioner shall prescribe the format and content
23 of the outline of coverage required by subsection one (1)
24 of this section. "Format" means style, arrangement, and
25 overall appearance, including such items as the size, color,
26 and prominence of type and the arrangement of text and
27 captions. The outline of coverage shall include all of the
28 following:

29 a. A statement identifying the applicable category or
30 categories of coverage provided by the policy or contract
31 as prescribed in section five (5) of this Act.

32 b. A description of the principal benefits and coverage
33 provided in the policy or contract.

34 c. A statement of the exceptions, reductions and
35 limitations contained in the policy or contract.

1 d. A statement of the renewal provisions including any
2 reservation by the insurer of a right to change premiums.

3 e. A statement that the outline is a summary of the policy
4 or contract issued or applied for and that the policy or
5 contract should be consulted to determine governing contractual
6 provisions.

7 3. The commissioner may prescribe disclosure rules for
8 medicare supplement coverage which are determined to be in
9 the public interest and which are designed to adequately
10 inform the prospective insured of the need for and extent
11 of coverage offered as medicare supplement coverage. For
12 medicare supplement coverage, the outline of coverage required
13 by subsection two (2) of this section shall be furnished to
14 the prospective insured with the application form.

15 4. The commissioner may further prescribe by rule a
16 standard form for and the contents of an informational brochure
17 for persons eligible for medicare by reason of age, which
18 is intended to improve the buyer's ability to select the most
19 appropriate coverage and to improve the buyer's understanding
20 of medicare. Except in the case of direct response insurance
21 policies, the commissioner may require by rule that this
22 informational brochure be provided to prospective insureds
23 eligible for medicare concurrently with delivery of the outline
24 of coverage. With respect to direct response insurance
25 policies, the commissioner may require by rule that this
26 brochure must be provided to prospective insureds eligible
27 for medicare by reason of age upon request, but not later
28 than at the time of delivery of the policy or contract.

29 5. The commissioner shall adopt rules prohibiting the
30 advertising of forms titled as "nursing home" forms or
31 inferring coverage for custodial care in an intermediate care
32 facility as defined in section one hundred thirty-five C point
33 one (135C.1) of the Code unless such forms also provide
34 coverage for custodial as well as convalescent care in an
35 intermediate care facility as defined in section one hundred

1 thirty-five C point one (135C.1) of the Code.

2 Sec. 7. NEW SECTION. LIMITATION ON DEFENSES. Not-
3 withstanding section five hundred fourteen A point three
4 (514A.3), subsection one (1), paragraph b, subparagraph two
5 (2) of the Code, or any contrary provision of chapter five
6 hundred fourteen (514) of the Code, if the issuer of the
7 policy of accident and sickness insurance or subscriber
8 contract elects to use a simplified application form, with
9 or without a question as to the applicant's health at the
10 time of application, but without any questions concerning
11 the insured's health history or medical treatment history,
12 the policy or contract must cover any loss occurring after
13 twelve months from the date of issue of the policy or contract
14 from any preexisting condition not specifically excluded from
15 coverage by terms of the policy or contract, and, except as
16 so provided, the policy or contract shall not include wording
17 that would permit a defense based upon preexisting conditions.

18 Sec. 8. NEW SECTION. EXCLUSIONS. This division does
19 not apply to any of the following:

20 1. A policy of credit accident and health or credit
21 accident and sickness insurance.

22 2. A policy of accident and sickness insurance which is
23 exempt from the provisions of sections five hundred fourteen
24 A point one (514A.1) through five hundred fourteen A point
25 twelve (514A.12) of the Code by virtue of an exemption set
26 forth in section five hundred fourteen A point one (514A.1)
27 or five hundred fourteen A point eight (514A.8) of the Code.

28 3. Any evidence of coverage issued to an enrollee of a
29 health maintenance organization under chapter five hundred
30 fourteen B (514B) of the Code.

31 Sec. 9. NEW SECTION. TITLE AND EFFECTIVE DATE OF CHAPTER.
32 This chapter may be cited as the "Uniform individual accident
33 and health insurance minimum standards Act". This chapter
34 takes effect July 1, 1980. Rules issued by the commissioner
35 of insurance pursuant to this chapter shall be subject to

1 the provisions of chapter seventeen A (17A) of the Code, and
2 all rules issued by the commissioner of insurance shall give
3 the issuers of policies and contracts a reasonable time to
4 achieve compliance.

5 Sec. 10. Chapter five hundred seven B (507B), Code 1979,
6 is amended by adding the following new section:

7 NEW SECTION. SALE OF DUPLICATE COVERAGE PROHIBITED.

8 1. A person shall not knowingly engage in the sale of
9 duplicate medicare supplement insurance coverage, as defined
10 by rule of the commissioner.

11 2. The commissioner of insurance shall adopt rules pursu-
12 ant to chapter seventeen A (17A) of the Code which define
13 the sale of duplicate medicare supplement insurance coverage.

14 Sec. 11. Section five hundred fourteen A point three
15 (514A.3), subsection one (1), paragraph b, Code 1979, is
16 amended to read as follows:

17 b. A provision as follows:

18 Time limit on certain defenses: (1) After ~~three~~ two years
19 from the date of issue of this policy no misstatements, except
20 fraudulent misstatements, made by the applicant in the
21 application for such policy shall be used to void the policy
22 or to deny a claim for loss incurred or disability (as defined
23 in the policy) commencing after the expiration of ~~such-three-~~
24 year this two-year period.

25 (The foregoing policy provision shall not be so construed
26 as to affect any legal requirement for avoidance of a policy
27 or denial of a claim during such initial ~~three-year~~ two-year
28 period, nor to limit the application of subsection 2,
29 paragraphs "a", "b", "c", "d" and "e", in the event of
30 misstatement with respect to age or occupation or other
31 insurance.)

32 (A policy which the insured has the right to continue in
33 force subject to its terms by the timely payment of premium
34 (a) until at least age fifty or, (b) in the case of a policy
35 issued after age forty-four, for at least five years from

1 its date of issue, may contain in lieu of the foregoing the
2 following provision (from which the clause in parentheses
3 may be omitted at the insurer's option) under the caption
4 "incontestable":

5 After this policy has been in force for a period of ~~three~~
6 two years during the lifetime of the insured, (excluding any
7 period during which the insured is disabled), it shall become
8 incontestable as to the statements contained in the
9 application.)

10 (2) No claim for loss incurred or disability (as defined
11 in the policy) commencing after ~~three~~ two years from the date
12 of issue of this policy shall be reduced or denied on the
13 ground that a disease or physical condition not excluded from
14 coverage by name or specific description effective on the
15 date of loss had existed prior to the effective date of
16 coverage of this policy.

17 EXPLANATION

18 This bill relates to the sale of individual insurance
19 contracts which either provide for accident and sickness
20 insurance as defined in section 514A.1 of the Code or which
21 provide for hospital, medical or surgical, pharmaceutical
22 or optometric services under chapter 514 of the Code. It
23 contains the provisions of the "Individual accident and
24 sickness insurance minimum standards Act" promulgated by the
25 national association of insurance commissioners.

26 The purpose of the bill as stated in section 2 is to provide
27 for reasonable standardization, simplification and disclosure
28 of policies and contracts in order to facilitate public
29 understanding and comparison of coverages, and to eliminate
30 provisions which may be misleading or unreasonably confusing
31 in connection with the purchase of coverage or the settlement
32 of claims.

33 Section 3 of the bill contains definitions.

34 Section 4 of the bill authorizes the commissioner of
35 insurance to promulgate rules which establish standards for

1 the various terms found in these contracts, such as those
2 relating to eligibility requirements, preexisting conditions,
3 conditions of termination, and exceptions and limitations
4 to coverage.

5 Section 5 of the bill authorizes the commissioner to
6 establish minimum standards for benefits for the various types
7 of coverage which may be offered, such as basic hospital or
8 medical or surgical expense coverage, disability income
9 protection, and medicare supplement coverage. The section
10 also would allow the commissioner to withdraw approval for
11 the sale of forms of contract if after notice and hearing
12 it is determined that the premium is excessive in relation
13 to the benefits provided.

14 Section 6 of the bill authorizes the commissioner to
15 promulgate rules which require that contract issuers deliver
16 to applicants for coverage a brochure which outlines the
17 coverage under the contract being offered. The brochure is
18 intended to provide uniform disclosure of the essential
19 contents of policies or subscriber contracts. The commissioner
20 also is authorized to require a separate informational brochure
21 for applicants who are eligible for medicare by reason of
22 age.

23 Section 7 of the bill provides for a limitation of the
24 defenses of preexisting condition, fraudulent misstatement,
25 etc., and section 11 is a correlating amendment relating to
26 the same subject.

27 Section 8 of the bill exempts certain types of insurance
28 policies. Basically the new law would not apply to policies
29 which otherwise are exempt from the provisions of existing
30 chapter 514A of the Code, or to credit accident and sickness
31 insurance policies, or to contracts issued by health
32 maintenance organizations.

33 Section 9 contains a title for the new uniform Act, and
34 effective date provisions.

35 Section 10 of the bill adds a new section to chapter 507B

1 of the Code to prohibit the sale of "duplicate medicare
 2 supplement insurance coverage". The commissioner of insurance
 3 would adopt rules in order to implement the section. Viola-
 4 tion of the section is punishable by a fine imposed by the
 5 commissioner and suspension or revocation of license to sell
 6 insurance.

7 The bill would take effect July first after its enactment.
 8 However, the law would not have any substantive effect until
 9 the commissioner of insurance issues rules which establish
 10 the minimum standards and the disclosure requirements.

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 HOUSE FILE 2537

H-5562

1 Amend House File 2537 as follows:

- 2 1. Page 1, line 9, by inserting before the word
- 3 "subscriber" the word "individual".
- 4 2. Page 1, line 19, by inserting after the word
- 5 "means" the word "individual".
- 6 3. Page 1, line 21, by inserting before the word
- 7 "pharmaceutical" the word "individual".
- 8 4. Page 1, line 33, by inserting after the word
- 9 "includes" the word "individual".
- 10 5. Page 2, line 10, by inserting after the word
- 11 "and" the word "individual".
- 12 6. Page 3, line 3, by inserting before the word
- 13 "subscriber" the word "individual".

H-5562 FILED
 MARCH 18, 1980

Adopted 3/17 (p. 1005)

BY POPE of Polk
 BRUNER of Story

 HOUSE FILE 2537

H-5538

1 Amend House File 2537 as follows:

- 2 1. Page 6, line 33, by striking the word
- 3 "also".
- 4 2. Page 6, line 34, by striking the words
- 5 "as well as convalescent".

H-5538 FILED
 MARCH 17, 1980

Adopted 3/14 (p. 1006)

BY BRUNER of Story
 POPE of Polk

S. Committee 3/21
Do Pass 3/27 (p. 137)

HOUSE FILE 2537

By COMMITTEE ON COMMERCE

(As Amended and Passed by the House)

Passed House, Date 4/23/80 (p. 2005) Passed Senate, Date 4/21/80 (p. 1346)

Vote: Ayes 94 Nays 0 Vote: Ayes 49 Nays 0

Approved May 17, 1980

Re-passed Senate 4/25/80 (p. 1702)
48-0

A BILL FOR

1 An Act relating to the sale of individual policies of
2 accident and sickness insurance and subscriber contracts,
3 and providing penalties.

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

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House Amendments _____

Stricken Language *

1 Section 1. Title twenty (XX), Code 1979, is amended by
2 adding sections two (2) through nine (9) of this Act as a
3 new chapter five hundred fourteen D (514D) of the Code.

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5 division is to provide reasonable standardization,
6 simplification, and disclosure of the terms and coverages
7 of individual accident and sickness insurance policies issued
8 under chapter five hundred fourteen A (514A) of the Code and
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19 "Accident and sickness insurance" also means individual
20 subscriber contracts for hospital service, or medical and
21 surgical service, or individual pharmaceutical or optometric
22 service issued under chapter five hundred fourteen (514) of
23 the Code, and for purposes of this division, corporations
24 issuing contracts under chapter five hundred fourteen (514)
25 of the Code are deemed to be engaged in the business of
26 insurance.

27 2. "Form" means and includes policies, contracts, riders,
28 endorsements and applications used in connection with the
29 sale of accident and sickness insurance under chapter five
30 hundred fourteen (514) of the Code or chapter five hundred
31 fourteen A (514A) of the Code.

32 3. "Policy" means the entire contract between the insurer
33 and the insured, including the policy riders, endorsements,
34 and the application, if attached, and includes individual
35 subscriber contracts issued under chapter five hundred fourteen

1 (514) of the Code.

2 4. "Medicare" means the Health Insurance for the Aged
3 Act, title XVIII of the United States Social Security Act
4 added by the amendment of 1965 as amended on or before the
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6 Sec. 4. NEW SECTION. STANDARDS FOR POLICIES ESTABLISHED.

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8 standards, including standards of full and fair disclosure,
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11 insurance and individual subscriber contracts which shall
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14 fourteen A point one (514A.1) through five hundred fourteen
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8 any person insured under the policy or any beneficiary. This
9 subsection does not authorize the commissioner to prohibit
10 a policy or policy provision or subscriber contract or contract
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14 a contractual conversion privilege under a group or individual
15 policy of accident and sickness insurance when such group
16 or individual contract contains provisions that are
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3 2. This section does not prohibit the issuance of a policy
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20 delivery in this state unless the policy or contract meets
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15 the prospective insured with the application form.

16 4. The commissioner may further prescribe by rule a
17 standard form for and the contents of an informational brochure
18 for persons eligible for medicare by reason of age, which
19 is intended to improve the buyer's ability to select the most
20 appropriate coverage and to improve the buyer's understanding
21 of medicare. Except in the case of direct response insurance
22 policies, the commissioner may require by rule that this
23 informational brochure be provided to prospective insureds
24 eligible for medicare concurrently with delivery of the outline
25 of coverage. With respect to direct response insurance
26 policies, the commissioner may require by rule that this
27 brochure must be provided to prospective insureds eligible
28 for medicare by reason of age upon request, but not later
29 than at the time of delivery of the policy or contract.

30 5. The commissioner shall adopt rules prohibiting the
31 advertising of forms titled as "nursing home" forms or
32 inferring coverage for custodial care in an intermediate care
33 facility as defined in section one hundred thirty-five C point
34 one (135C.1) of the Code unless such forms provide coverage
35 for custodial care in an intermediate care facility as defined

1 in section one hundred thirty-five C point one (135C.1) of
2 the Code.

3 Sec. 7. NEW SECTION. LIMITATION ON DEFENSES. Not-
4 withstanding section five hundred fourteen A point three
5 (514A.3), subsection one (1), paragraph b, subparagraph two
6 (2) of the Code, or any contrary provision of chapter five
7 hundred fourteen (514) of the Code, if the issuer of the
8 policy of accident and sickness insurance or subscriber
9 contract elects to use a simplified application form, with
10 or without a question as to the applicant's health at the
11 time of application, but without any questions concerning
12 the insured's health history or medical treatment history,
13 the policy or contract must cover any loss occurring after
14 twelve months from the date of issue of the policy or contract
15 from any preexisting condition not specifically excluded from
16 coverage by terms of the policy or contract, and, except as
17 so provided, the policy or contract shall not include wording
18 that would permit a defense based upon preexisting conditions.

19 Sec. 8. NEW SECTION. EXCLUSIONS. This division does
20 not apply to any of the following:

21 1. A policy of credit accident and health or credit
22 accident and sickness insurance.

23 2. A policy of accident and sickness insurance which is
24 exempt from the provisions of sections five hundred fourteen
25 A point one (514A.1) through five hundred fourteen A point
26 twelve (514A.12) of the Code by virtue of an exemption set
27 forth in section five hundred fourteen A point one (514A.1)
28 or five hundred fourteen A point eight (514A.8) of the Code.

29 3. Any evidence of coverage issued to an enrollee of a
30 health maintenance organization under chapter five hundred
31 fourteen B (514B) of the Code.

32 Sec. 9. NEW SECTION. TITLE AND EFFECTIVE DATE OF CHAPTER.

33 This chapter may be cited as the "Uniform individual accident
34 and health insurance minimum standards Act". This chapter
35 takes effect July 1, 1980. Rules issued by the commissioner

1 of insurance pursuant to this chapter shall be subject to
2 the provisions of chapter seventeen A (17A) of the Code, and
3 all rules issued by the commissioner of insurance shall give
4 the issuers of policies and contracts a reasonable time to
5 achieve compliance.

6 Sec. 10. Chapter five hundred seven B (507B), Code 1979,
7 is amended by adding the following new section:

8 NEW SECTION. SALE OF DUPLICATE COVERAGE PROHIBITED.

9 1. A person shall not knowingly engage in the sale of
10 duplicate medicare supplement insurance coverage, as defined
11 by rule of the commissioner.

12 2. The commissioner of insurance shall adopt rules pursu-
13 ant to chapter seventeen A (17A) of the Code which define
14 the sale of duplicate medicare supplement insurance coverage.

15 Sec. 11. Section five hundred fourteen A point three
16 (514A.3), subsection one (1), paragraph b, Code 1979, is
17 amended to read as follows:

18 b. A provision as follows:

19 Time limit on certain defenses: (1) After ~~three~~ two years
20 from the date of issue of this policy no misstatements, except
21 fraudulent misstatements, made by the applicant in the
22 application for such policy shall be used to void the policy
23 or to deny a claim for loss incurred or disability (as defined
24 in the policy) commencing after the expiration of ~~such-three-~~
25 year this two-year period.

26 (The foregoing policy provision shall not be so construed
27 as to affect any legal requirement for avoidance of a policy
28 or denial of a claim during such initial ~~three-year~~ two-year
29 period, nor to limit the application of subsection 2,
30 paragraphs "a", "b", "c", "d" and "e", in the event of
31 misstatement with respect to age or occupation or other
32 insurance.)

33 (A policy which the insured has the right to continue in
34 force subject to its terms by the timely payment of premium
35 (a) until at least age fifty or, (b) in the case of a policy

1 issued after age forty-four, for at least five years from
2 its date of issue, may contain in lieu of the foregoing the
3 following provision (from which the clause in parentheses
4 may be omitted at the insurer's option) under the caption
5 "incontestable":

6 After this policy has been in force for a period of ~~three~~
7 two years during the lifetime of the insured, (excluding any
8 period during which the insured is disabled), it shall become
9 incontestable as to the statements contained in the
10 application.)

11 (2) No claim for loss incurred or disability (as defined
12 in the policy) commencing after ~~three~~ two years from the date
13 of issue of this policy shall be reduced or denied on the
14 ground that a disease or physical condition not excluded from
15 coverage by name or specific description effective on the
16 date of loss had existed prior to the effective date of
17 coverage of this policy.

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HOUSE FILE 2537

S-5673

1 Amend House File 2537, as amended, passed and
2 reprinted by the House, as follows:
3 1. Page 5, by inserting after line 6 the following:
4 "8. Notwithstanding the provisions of section
5 five hundred fourteen B point five (514B.5), subsection
6 three (3) of the Code, the commissioner may waive
7 the requirement that health maintenance organizations
8 impose those deductible and coinsurance charges
9 contained in federal government contracts. If waived
10 the commissioner shall require that health maintenance
11 organizations impose reasonable deductible and
12 coinsurance charges."

S-5673 FILED

BY EDGAR H. HOLDEN

APRIL 8, 1980

Adopted 4/9/80 (1245)

HOUSE FILE 2537

S-5688

1 Amend House File 2537 as amended, passed and
2 reprinted by the House as follows:
3 1. Page 3, line 1, by inserting after the period
4 the words "Any rule which establishes standards for
5 the definition of "physician" shall require that a
6 policy or contract specifically disclose whether or
7 not coverage for chiropractic services is included."
8 2. Page 6, by inserting after line 7 the following:
9 "____. A statement disclosing whether or not
10 coverage for chiropractic services is included."

S-5688 FILED

BY CHARLES P. MILLER

APRIL 8, 1980

ADOPTED *(p. 1345)*

ROLF CRAFT

BOB CARR

DALE L. TIEDEN

MERLIN D. HULSE

WILLIAM PALMER

GEORGE R. KINLEY

LOWELL JUNKINS

ALVIN V. MILLER

C. W. HUTCHINS

ELIZABETH MILLER

JAMES BRILES

ARNE WALDSTEIN

RICHARD DRAKE

JOHN JENSEN

BERL PRIEBE

JOE BROWN

RAY TAYLOR

JACK W. HESTER

RICHARD COMITO

C. JOSEPH COLEMAN

JAMES GALLAGHER

BASS VAN GILST

BOB RUSH

TOM SLATER

GARY BAUGHER

SUE YENGER

HOUSE FILE 2537

S-5690

- 1 Amend House File 2537 as amended, passed and re-
- 2 printed by the House as follows:
- 3 1. Page 1, line 7, by inserting after the word
- 4 "individual" the words "and group".
- 5 2. Page 1, line 9, by inserting after the word
- 6 "individual" the words "and group".
- 7 3. Page 1, line 16, by inserting after the word
- 8 "individual" the words "and group".
- 9 4. Page 1, line 19, by inserting after the word
- 10 "individual" the words "and group".
- 11 5. Page 1, line 21, by inserting after the word
- 12 "individual" the words "and group".
- 13 6. Page 1, line 34, by inserting after the word
- 14 "individual" the words "and group".
- 15 7. Page 2, line 10, by inserting after the word
- 16 "individual" the words "and group".
- 17 8. Page 2, line 11, by inserting after the word
- 18 "individual" the words "and group".
- 19 9. Page 3, line 3, by inserting after the word
- 20 "individual" the words "and group".
- 21 10. Page 3, line 4, by inserting after the word
- 22 "individual" the words "and group".
- 23 11. Page 3, line 27, by inserting after the word
- 24 "individual" the words "and group".
- 25 12. Page 4, line 23, by inserting after the word
- 26 "individual" the words "and group".
- 27 13. Page 5, line 10, by inserting after the word
- 28 "individual" the words "and group".
- 29 14. Page 7, line 33, by inserting after the word
- 30 "individual" the words "and group".

S-5690 FILED

BY RAY TAYLOR

APRIL 9, 1980

RULED OUT OF ORDER (p. 1345)

HOUSE FILE 2537

S-5691

- 1 Amend House File 2537 as amended, passed and re-
- 2 printed by the House as follows:
- 3 1. Page 9, by inserting after line 17 the following
- 4 new section:
- 5 "Sec. _____. Section five hundred fourteen A point nine, (514A.9)
- 6 Code 1979, is amended to read as follows:
- 7 514A.9 Violation. Any person, partnership or cor-
- 8 poration willfully violating any provision of this
- 9 chapter or order of the commissioner made in accordance
- 10 with this chapter, ~~shall forfeit to the people of the~~
- 11 ~~state a sum not to exceed one hundred dollars for each~~
- 12 ~~such violation, which may be recovered by a civil action~~
- 13 is guilty of a serious misdemeanor. The commissioner
- 14 may also suspend or revoke the license of a insurer
- 15 or agent for any such willfull violation."

S-5691 FILED

BY DICK RAMSEY

APRIL 9, 1980

RULED OUT OF ORDER (p. 1345)

HOUSE AMENDMENT TO SENATE AMENDMENT TO
HOUSE FILE 2537

S-5850

1 Amend the Senate amendment H-6002 to House File
2 2537 as follows:

3 1. Page 1, by striking lines 3 through 20 and
4 inserting in lieu thereof the following:

5 "1. Page 6, by inserting after line 7 the following
6 unnumbered paragraph:

7 If payment will not be made for services performed
8 by a chiropractor acting within the scope of his or
9 her license when those services would be compensable
10 if performed by a medical doctor, then a statement
11 that services performed by a chiropractor are not
12 compensable shall be included in the outline of
13 coverage."

14 2. Page 9, by inserting after line 17 the following
15 new section:

16 "Sec. 12. Section five hundred fourteen B point
17 five (514B.5), subsection three (3), Code 1979, is
18 amended to read as follows:

19 3. The health maintenance organization provides
20 or arranges for the provision of basic health care
21 services on a prepaid basis, except that the health
22 maintenance organization may impose deductible and
23 coinsurance charges subject to approval by the
24 commissioner which might be required to be paid by
25 persons on whose behalf the federal government
26 contracts with the health maintenance organization
27 for health care services. The commissioner has the
28 authority to promulgate rules pursuant to Chapter
29 seventeen A (17A) establishing reasonable maximum
30 deductible and coinsurance charges which may be imposed
31 by health maintenance organizations."

32 3. Title page, by inserting after line 2 the words
33 "relating to deductible and coinsurance provisions
34 of contracts with health maintenance organizations,".

S-5850 FILED
APRIL 24, 1980

RECEIVED FROM THE HOUSE

Senate concurred 4/25/80

SENATE AMENDMENT TO
HOUSE FILE 2537

H-6002

1 Amend House File 2537 as amended, passed and
2 reprinted by the House as follows:

3 1. Page 3, line 1, by inserting after the period
4 the words "Any rule which establishes standards for
5 the definition of "physician" shall require that a
6 policy or contract specifically disclose whether or
7 not coverage for chiropractic services is included."

8 2. Page 5, by inserting after line 6 the following:

9 "8. Notwithstanding the provisions of section
10 five hundred fourteen B point five (514B.5), subsection
11 three (3) of the Code, the commissioner may waive
12 the requirement that health maintenance organizations
13 impose those deductible and coinsurance charges
14 contained in federal government contracts. If waived
15 the commissioner shall require that health maintenance
16 organizations impose reasonable deductible and
17 coinsurance charges."

18 3. Page 6, by inserting after line 7 the following:

19 "____. A statement disclosing whether or not
20 coverage for chiropractic services is included."

H-6002 FILED APRIL 11, 1980

RECEIVED FROM THE SENATE

then amended & consumed 4/22 (of 2005)

H-6198

1 Amend the Senate amendment H-6002 to House File
2 2537 as follows:

3 1. Page 1, by striking lines 3 through 20 and
4 inserting in lieu thereof the following:

5 "1. Page 9, by inserting after line 17 the
6 following new section:

7 "Sec. 12. Section five hundred fourteen B point
8 five (514B.5), subsection three (3), Code 1979, is
9 amended to read as follows:

10 3. The health maintenance organization provides
11 or arranges for the provision of basic health care
12 services on a prepaid basis, except that the health
13 maintenance organization may impose deductible and
14 coinsurance charges subject to approval by the com-
15 ~~missioner which might be required to be paid by~~
16 ~~persons on whose behalf the federal government~~
17 ~~contracts with the health maintenance organization~~
18 ~~for health care services. The commissioner has the~~
19 ~~authority to promulgate rules pursuant to Chapter~~
20 ~~seventeen A (17A) establishing reasonable maximum~~
21 ~~deductible and coinsurance charges which may be~~
22 ~~imposed by health maintenance organizations."~~

23 2. Title Page, by inserting after line 2 the
24 words "relating to deductible and coinsurance pro-
25 visions of contracts with health maintenance organ-
26 izations,"."

BY BRUNER of Story
POPE of Polk
SCHROEDER of Pottawattamie
JOHNSON of Linn
AVENSON of Fayette
HALVORSON of Clayton
CHIODO of Polk

H-6198 FILED

1 APRIL 17, 1980

(Adopted as amended by 6328
4/23 (p. 2005))

HOUSE FILE 2537

H-6328

1 Amend amendment H-6198 to the Senate amendment
2 H-6002 to House File 2537 as amended, passed and
3 reprinted by the House as follows:

4 1. Page 1, by inserting after line 4 the follow-
5 ing:

6 "1. Page 6, by inserting after line 7 the follow-
7 ing unnumbered paragraph:

8 "If payment will not be made for services performed
9 by a chiropractor acting within the scope of his or
10 her license when those services would be compensable
11 if performed by a medical doctor, then a statement
12 that services performed by a chiropractor are not
13 compensable shall be included in the outline of
14 coverage.""

H-6328 FILED APRIL 23, 1980 By BRUNER of Story
ADOPTED (p. 2005) POPE of Polk

HOUSE FILE 2537

AN ACT

RELATING TO THE SALE OF INDIVIDUAL POLICIES OF ACCIDENT AND SICKNESS INSURANCE AND SUBSCRIBER CONTRACTS, RELATING TO DEDUCTIBLE AND COINSURANCE PROVISIONS OF CONTRACTS WITH HEALTH MAINTENANCE ORGANIZATIONS, AND PROVIDING PENALTIES.

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

Section 1. Title twenty (XX), Code 1979, is amended by adding sections two (2) through nine (9) of this Act as a new chapter five hundred fourteen D (514D) of the Code.

Sec. 2. NEW SECTION. PURPOSE. The purpose of this division is to provide reasonable standardization, simplification, and disclosure of the terms and coverages of individual accident and sickness insurance policies issued under chapter five hundred fourteen A (514A) of the Code and individual subscriber contracts issued under chapter five hundred fourteen (514) of the Code, in order to facilitate public understanding and comparison and to eliminate provisions which may be misleading or unreasonably confusing in connection with the purchase of coverage or the settlement of claims.

Sec. 3. NEW SECTION. DEFINITIONS. As used in this division, unless the context otherwise requires:

1. "Accident and sickness insurance" means individual accident and sickness insurance within the meaning of section five hundred fourteen A point one (514A.1) of the Code. "Accident and sickness insurance" also means individual subscriber contracts for hospital service, or medical and surgical service, or individual pharmaceutical or optometric service issued under chapter five hundred fourteen (514) of the Code, and for purposes of this division, corporations issuing contracts under chapter five hundred fourteen (514) of the Code are deemed to be engaged in the business of insurance.

2. "Form" means and includes policies, contracts, riders, endorsements and applications used in connection with the sale of accident and sickness insurance under chapter five hundred fourteen (514) of the Code or chapter five hundred fourteen A (514A) of the Code.

3. "Policy" means the entire contract between the insurer and the insured, including the policy riders, endorsements, and the application, if attached, and includes individual subscriber contracts issued under chapter five hundred fourteen (514) of the Code.

4. "Medicare" means the Health Insurance for the Aged Act, title XVIII of the United States Social Security Act added by the amendment of 1965 as amended on or before the effective date of this Act.

Sec. 4. NEW SECTION. STANDARDS FOR POLICIES ESTABLISHED.

1. The commissioner shall issue rules to establish specific standards, including standards of full and fair disclosure, that set forth the manner, content, and required disclosure for the sale of policies of individual accident and sickness insurance and individual subscriber contracts which shall be in addition to and in accordance with applicable laws of this state, including but not limited to sections five hundred fourteen A point one (514A.1) through five hundred fourteen A point twelve (514A.12) of the Code. These rules may include, but shall not be limited to, any of the following subjects:

- a. Terms of renewability.
- b. Initial and subsequent conditions of eligibility.
- c. Nonduplication of coverage provisions.
- d. Coverage of dependents.
- e. Coverage of persons eligible for medicare by reason of age.
- f. Preexisting conditions.
- g. Termination of insurance.
- h. Probationary periods.

- l. Limitations.
- j. Exceptions.
- k. Reductions.
- l. Elimination periods.
- m. Requirements for replacement.
- n. Recurrent conditions.
- o. The definition of terms, including but not limited to the following: hospital, accident, sickness, injury, physician, accidental means, total disability, partial disability, nervous disorder, guaranteed renewable, and noncancelable.
2. The commissioner may issue rules with respect to policies of individual accident and sickness insurance and individual subscriber contracts that specify prohibited policies or subscriber contracts, or prohibited policy or contract provisions which the commissioner finds to be unjust, unfair, or unfairly discriminatory to the policyholder or any person insured under the policy or any beneficiary. This subsection does not authorize the commissioner to prohibit a policy or policy provision or subscriber contract or contract provision which is specifically authorized by statute.

3. A rule issued by the commissioner under this section shall not apply to a conversion policy issued pursuant to a contractual conversion privilege under a group or individual policy of accident and sickness insurance when such group or individual contract contains provisions that are inconsistent with the requirements of this chapter or any rule issued under this chapter.

4. A rule issued by the commissioner under this section shall not apply to policies being issued to employees or members being added to a franchise plan, as defined in section five hundred nine point fourteen (509.14) of the Code, which is in existence on the effective date of the rule.

Sec. 5. NEW SECTION. STANDARDS FOR BENEFITS ESTABLISHED.

1. The commissioner shall issue rules to establish minimum

standards for benefits under each of the following categories of coverage contained in policies of individual accident and sickness insurance or subscriber contracts:

- a. Basic hospital expense coverage.
- b. Basic medical-surgical expense coverage.
- c. Hospital confinement indemnity coverage.
- d. Major medical expense coverage.
- e. Disability income protection coverage.
- f. Accident only coverage.
- g. Specified disease or specified accident coverage.
- h. Medicare supplement coverage.
- i. Limited benefit health coverage.

2. This section does not prohibit the issuance of a policy which combines two or more of the categories of coverage enumerated in paragraphs a through i of subsection one (1) of this section. A category of coverage referred to in paragraph g, h or i of subsection one (1) of this section shall not be combined in a policy or contract either with another category of coverage referred to in paragraph g, h or i of subsection one (1) of this section or with a category of coverage referred to in any of paragraphs a through f of subsection one (1) of this section unless a rule issued by the commissioner specifically authorizes that combination of coverages.

3. The commissioner shall prescribe the method of identification of policies and contracts based upon coverages provided.

4. A policy of accident and sickness insurance or subscriber contract shall not be delivered or issued for delivery in this state unless the policy or contract meets the minimum standards prescribed under this section.

5. The commissioner may upon notice and hearing at any time after the initial filing or approval of any individual accident and sickness policy or subscriber contract form, withdraw approval or suspend further sale of the form if the

benefits provided are unreasonable in relation to the premium charge. The commissioner shall establish reasonable and creditable anticipated minimum loss ratios for medicare supplement and other accident and sickness insurance policies.

6. A rule issued by the commissioner under this section shall not apply to a conversion policy issued pursuant to a contractual conversion privilege under a group or individual policy of accident and sickness insurance when such group or individual contract contains provisions which are inconsistent with the requirements of this chapter or any rule issued under this chapter.

7. A rule issued by the commissioner under this section shall not apply to policies being issued to employees or members being added to a franchise plan, as defined in section five hundred nine point fourteen (509.14) of the Code, which is in existence on the effective date of the rule.

Sec. 6. NEW SECTION. DISCLOSURE OF COVERAGE.

1. Except as otherwise provided in subsection three (3) of this section, in order to provide for full and fair disclosure in the sale of individual accident and sickness insurance policies or subscriber contracts a policy or contract shall not be delivered or issued for delivery in this state unless the outline of coverage described in subsection two (2) of this section either accompanies the policy or contract or is delivered to the applicant at the time application is made and unless an acknowledgement of receipt or certificate of delivery of the outline is provided the insurer. In the event the policy or contract is issued on a basis other than that applied for, the outline of coverage properly describing the policy or contract must accompany the policy or contract when it is delivered and must clearly state that it is not the policy or contract for which application was made.

2. The commissioner shall prescribe the format and content of the outline of coverage required by subsection one (1) of this section. "Format" means style, arrangement, and

overall appearance, including such items as the size, color, and prominence of type and the arrangement of text and captions. The outline of coverage shall include all of the following:

- a. A statement identifying the applicable category or categories of coverage provided by the policy or contract as prescribed in section five (5) of this Act.
- b. A description of the principal benefits and coverage provided in the policy or contract.
- c. A statement of the exceptions, reductions and limitations contained in the policy or contract.
- d. A statement of the renewal provisions including any reservation by the insurer of a right to change premiums.
- e. A statement that the outline is a summary of the policy or contract issued or applied for and that the policy or contract should be consulted to determine governing contractual provisions.

If payment will not be made for services performed by a chiropractor acting within the scope of his or her license when those services would be compensable if performed by a medical doctor, then a statement that services performed by a chiropractor are not compensable shall be included in the outline of coverage.

3. The commissioner may prescribe disclosure rules for medicare supplement coverage which are determined to be in the public interest and which are designed to adequately inform the prospective insured of the need for and extent of coverage offered as medicare supplement coverage. For medicare supplement coverage, the outline of coverage required by subsection two (2) of this section shall be furnished to the prospective insured with the application form.

4. The commissioner may further prescribe by rule a standard form for and the contents of an informational brochure for persons eligible for medicare by reason of age, which is intended to improve the buyer's ability to select the most

appropriate coverage and to improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that this informational brochure be provided to prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by rule that this brochure must be provided to prospective insureds eligible for medicare by reason of age upon request, but not later than at the time of delivery of the policy or contract.

5. The commissioner shall adopt rules prohibiting the advertising of forms titled as "nursing home" forms or insuring coverage for custodial care in an intermediate care facility as defined in section one hundred thirty-five C point one (135C.1) of the Code unless such forms provide coverage for custodial care in an intermediate care facility as defined in section one hundred thirty-five C point one (135C.1) of the Code.

Sec. 7. NEW SECTION. LIMITATION ON DEFENSES. Notwithstanding section five hundred fourteen A point three (514A.3), subsection one (1), paragraph b, subparagraph two (2) of the Code, or any contrary provision of chapter five hundred fourteen (514) of the Code, if the issuer of the policy of accident and sickness insurance or subscriber contract elects to use a simplified application form, with or without a question as to the applicant's health at the time of application, but without any questions concerning the insured's health history or medical treatment history, the policy or contract must cover any loss occurring after twelve months from the date of issue of the policy or contract from any preexisting condition not specifically excluded from coverage by terms of the policy or contract, and, except as so provided, the policy or contract shall not include wording that would permit a defense based upon preexisting conditions.

Sec. 8. NEW SECTION. EXCLUSIONS. This division does not apply to any of the following:

1. A policy of credit accident and health or credit accident and sickness insurance.

2. A policy of accident and sickness insurance which is exempt from the provisions of sections five hundred fourteen A point one (514A.1) through five hundred fourteen A point twelve (514A.12) of the Code by virtue of an exemption set forth in section five hundred fourteen A point one (514A.1) or five hundred fourteen A point eight (514A.8) of the Code.

3. Any evidence of coverage issued to an enrollee of a health maintenance organization under chapter five hundred fourteen B (514B) of the Code.

Sec. 9. NEW SECTION. TITLE AND EFFECTIVE DATE OF CHAPTER. This chapter may be cited as the "Uniform Individual accident and health insurance minimum standards Act". This chapter takes effect July 1, 1980. Rules issued by the commissioner of insurance pursuant to this chapter shall be subject to the provisions of chapter seventeen A (17A) of the Code, and all rules issued by the commissioner of insurance shall give the issuers of policies and contracts a reasonable time to achieve compliance.

Sec. 10. Chapter five hundred seven B (507B), Code 1979, is amended by adding the following new section:

NEW SECTION. SALE OF DUPLICATE COVERAGE PROHIBITED.

1. A person shall not knowingly engage in the sale of duplicate medicare supplement insurance coverage, as defined by rule of the commissioner.

2. The commissioner of insurance shall adopt rules pursuant to chapter seventeen A (17A) of the Code which define the sale of duplicate medicare supplement insurance coverage.

Sec. 11. Section five hundred fourteen A point three (514A.3), subsection one (1), paragraph b, Code 1979, is amended to read as follows:

b. A provision as follows:

Time limit on certain defenses: (1) After ~~three~~ two years from the date of issue of this policy no misstatements, except

fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of ~~each three-year~~ this two-year period.

(The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial ~~three-year~~ two-year period, nor to limit the application of subsection 2, paragraphs "a", "b", "c", "d" and "e", in the event of misstatement with respect to age or occupation or other insurance.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age fifty or, (b) in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "incontestable":

After this policy has been in force for a period of ~~three~~ two years during the lifetime of the insured, (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application.)

(2) No claim for loss incurred or disability (as defined in the policy) commencing after ~~three two~~ years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

Sec. 12. Section five hundred fourteen B point five (514B.5), subsection three (3), Code 1979, is amended to read as follows:

3. The health maintenance organization provides or arranges for the provision of basic health care services on a prepaid basis, except that the health maintenance organization may impose deductible and coinsurance charges subject to approval by the commissioner which might be required to be paid by persons on whose behalf the federal government contracts with the health maintenance organization for health care services. The commissioner has the authority to promulgate rules pursuant to chapter seventeen A (17A) establishing reasonable maximum deductible and coinsurance charges which may be imposed by health maintenance organizations.

WILLIAM H. HARBOR
Speaker of the House

TERRY E. BRANSTAD
President of the Senate

I hereby certify that this bill originated in the House and is known as House File 2537, Sixty-eighth General Assembly.

BRUCE GRAHAM
Assistant Chief Clerk of the House

Approved May 19, 1980

ROBERT D. RAY
Governor