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SSB-1128
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SENATE/HOUSE FILE ___ (SF) / HF 500
BY (PROPOSED DEPARTMENT OF COMMERCE/
INSURANCE DIVISION BILL)

Passed Senate, Date _____ Passed House, Date _____
Vote: Ayes _____ Nays _____ Vote: Ayes _____ Nays _____
Approved _____

A BILL FOR

An Act relating to insurance, by addressing the operation and regulation of insurance companies, mutual insurance associations, the Iowa insurance guaranty association, and other insurance or risk-assuming entities, including the rights and duties of such entities and the powers and authority of the insurance commissioner; by establishing jurisdiction and venue requirements for actions against the Iowa insurance guaranty association; and by setting forth a prohibition on intentional motor vehicle collisions, and providing penalties, repeals, and effective dates.

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

TLSB 1073DP 79
jj/cls/14

S.F. _____ H.F. _____

Section 1. Section 87.11, unnumbered paragraph 1, Code 2001, is amended to read as follows:

When an employer coming under this chapter furnishes satisfactory proofs to the insurance commissioner of such employer's solvency and financial ability to pay the compensation and benefits as by law provided and to make such payments to the parties when entitled thereto, or when such employer deposits with the insurance commissioner security satisfactory to the insurance commissioner and the workers' compensation commissioner as guaranty for the payment of such compensation, such employer shall be relieved of the provisions of this chapter requiring insurance; but such employer shall, from time to time, furnish such additional proof of solvency and financial ability to pay as may be required by such insurance commissioner or workers' compensation commissioner. A political subdivision, including a city, county, community college, or school corporation, that is self-insured for workers' compensation is not required to submit a plan or program to the insurance commissioner for review and approval.

Sec. 2. NEW SECTION. 321.276 INTENTIONAL VEHICLE COLLISION.

1. It is unlawful to cause or attempt to cause a vehicle collision that is likely to result in bodily injury, or to aid, abet, or conspire with any person to knowingly cause or participate in or attempt to cause a vehicle collision that is likely to result in bodily injury.

2. A person guilty of a violation of subsection 1 commits a class "D" felony.

Sec. 3. Section 505.11, Code 2001, is amended to read as follows:

505.11 REFUNDS.

Whenever it appears to the satisfaction of the commissioner of insurance that because of error, mistake, or erroneous interpretation of statute that a foreign or domestic insurance

corporation has paid to the state of Iowa taxes, fines, penalties, or license fees in excess of the amount legally chargeable against it, the commissioner of insurance shall have power to refund to such corporation any such excess by applying the amount ~~thereof~~ of the excess payment toward the payment of taxes, fines, penalties, or license fees already due or which may ~~hereafter~~ become due, until such excess payments have been fully refunded. ~~The commissioner shall certify to the department of revenue and finance the amount of any such credit to be applied to future taxes due and notify the insurance company affected of the amount thereof.~~

Sec. 4. Section 507.10, subsection 2, Code 2001, is amended to read as follows:

2. FILING OF EXAMINATION REPORT. No later than sixty days following completion of the examination, the examiner in charge shall file with the division a verified written report of examination ~~under oath~~. Upon receipt of the verified report and after administrative review, the division shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

Sec. 5. Section 507B.4, subsection 9, paragraphs b and e, Code 2001, are amended by striking the paragraphs.

Sec. 6. Section 507B.4, subsection 9, paragraph f, Code 2001, is amended to read as follows:

f. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear, or failing to include interest on the payment of claims when required under section 511.38 or subsection 10B.

Sec. 7. Section 507B.4, subsection 9, Code 2001, is amended by adding the following new paragraph:

NEW PARAGRAPH. o. Failing to comply with the procedures

for auditing claims submitted by health care providers as set forth by rule of the commissioner.

Sec. 8. Section 507B.4, Code 2001, is amended by adding the following new subsection:

NEW SUBSECTION. 10B. PAYMENT OF INTEREST. Failure of an insurer to pay interest at the rate of ten percent per annum on all health insurance claims that the insurer fails to timely accept and pay pursuant to section 507B.4A, subsection 1, paragraph "e". Interest shall accrue commencing on the thirty-first day after receipt of all properly completed proof of loss forms.

For purposes of this subsection, "insurer" means an entity providing a plan of health insurance, health care benefits, or health care services, or an entity subject to the jurisdiction of the commissioner performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services.

Sec. 9. NEW SECTION. 507B.4A DUTY TO PROMPTLY INVESTIGATE CLAIMS AND RESPOND TO INQUIRIES.

1. A person shall promptly respond to inquiries from the commissioner, a policyholder, or a claimant. A person shall promptly take action to investigate and settle a claim. A person's actions are deemed untimely if that person fails to do any of the following:

a. Provide all forms necessary to file a claim within ten days of receipt of notification of a claim.

b. Acknowledge a completed proof of loss or other claim form within ten days of its receipt by the person.

c. Initiate investigation of a claim within ten days of receipt of a completed proof of loss or claim form.

d. Provide a substantive reply to an inquiry from the

commissioner, a policyholder, or a claimant within thirty days of receipt of the inquiry, unless good cause exists for delay.

e. Either accept and pay or deny a clean claim within thirty days of receipt of all reasonably completed proof of loss or claim forms. If a person needs additional time to determine whether a claim should be accepted or denied, the person shall notify the claimant of the additional time needed within thirty days of receipt of settlement information or proof of loss or claim forms. The notice shall state the reason the additional time is needed and the amount of additional time needed to process the claim.

2. For purposes of this section, "clean claim" means a claim that the insurer has received all reasonably necessary information and no particular circumstance exists requiring special treatment that prevents prompt payment from being made.

Sec. 10. Section 507B.6, subsection 1, Code 2001, is amended to read as follows:

1. Whenever the commissioner ~~shall have reason to believe~~ believes that any ~~such~~ person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in section 507B.4, 507B.4A, or 507B.5 and that a proceeding by the commissioner in respect ~~thereto~~ to such method of competition or unfair or deceptive act or practice would be ~~to the interest of~~ in the public interest, the commissioner shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing ~~thereon~~ on such charges to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service ~~thereof~~ of such notice.

Sec. 11. Section 507B.7, subsection 1, Code 2001, is amended to read as follows:

1. If, after such hearing, the commissioner ~~shall determine~~ determines that the person charged has engaged in an

unfair method of competition or an unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings, an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of section 507B.4, 507B.4A, or 507B.5, the commissioner may at the commissioner's discretion order any one or more of the following:

a. Payment of a civil penalty of not more than one thousand dollars for each act or violation, but not to exceed an aggregate of ten thousand dollars, unless the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or 507B.5, in which case the penalty shall be not more than five thousand dollars for each act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any one six-month period. ~~The commissioner shall, if~~ If the commissioner finds ~~the violations~~ that a violation of section 507B.4, 507B.4A, or 507B.5 ~~were~~ was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer.

b. Suspension or revocation of the license of a person as defined in section 507B.2, subsection 1, if the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or ~~section~~ 507B.5.

c. Payment of interest at the rate of ten percent per annum if the commissioner finds that the insurer failed to pay interest as required under section 507B.4, subsection 10B.

Sec. 12. Section 507B.12, unnumbered paragraph 1, Code 2001, is amended to read as follows:

The commissioner may, after notice and hearing, promulgate reasonable rules, as are necessary or proper to identify specific methods of competition or acts or practices which are

prohibited by section 507B.4, 507B.4A, or 507B.5, but the rules shall not enlarge upon or extend the provisions of such sections. Such rules shall be subject to review in accordance with chapter 17A.

Sec. 13. Section 511.4, Code 2001, is amended to read as follows:

511.4 ADVERTISEMENTS -- WHO DEEMED AGENT.

The provisions of sections ~~515.122~~ 515.123 to 515.126 shall apply to life insurance companies and associations.

Sec. 14. Section 513B.2, subsections 3 and 20, Code 2001, are amended to read as follows:

3. "Basic health benefit plan" means a plan ~~which is~~ offered established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

20. "Standard health benefit plan" means a plan ~~which is~~ offered established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

Sec. 15. Section 513B.4, subsection 1, paragraphs d and e, Code 2001, are amended by striking the paragraphs.

Sec. 16. Section 513B.4, subsection 2, Code 2001, is amended by striking the subsection.

Sec. 17. Section 513B.10, subsection 1, paragraph a, Code 2001, is amended to read as follows:

a. A carrier or an organized delivery system that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter. ~~A carrier or organized delivery system shall offer health insurance~~

coverage which constitutes a basic health benefit plan and which constitutes a standard health benefit plan.

Sec. 18. Section 513B.10, subsection 3, Code 2001, is amended by striking the subsection.

Sec. 19. Section 513B.13, subsection 3, paragraph c, Code 2001, is amended by striking the paragraph.

Sec. 20. Section 513B.13, subsection 3, paragraph d, Code 2001, is amended to read as follows:

d. Subsequent members Members shall be appointed for terms of three years. A board member's term shall continue until the member's successor is appointed.

Sec. 21. Section 513B.13, subsections 4 and 5, Code 2001, are amended to read as follows:

4. The board, within one hundred eighty days after the initial appointments, shall may submit a plan of operation to the commissioner. The commissioner, after notice and hearing, may approve the a plan of operation if the commissioner determines that the plan is suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains and losses on an equitable and proportionate basis in accordance with the provisions of this section. The A plan of operation is effective upon written approval of the commissioner. After the initial plan of operation is submitted and approved by the commissioner, the

5. The board may submit to the commissioner any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program.

5. If the board fails to submit a plan of operation within one hundred eighty days after the board's appointment, the commissioner, after notice and hearing, shall establish and adopt a temporary plan of operation. The commissioner shall may amend or rescind a plan adopted pursuant to this subsection at the time a plan is submitted by the board and approved by the commissioner subsection 4.

Sec. 22. Section 513B.13, subsection 8, paragraph a, Code 2001, is amended to read as follows:

a. ~~With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans,~~ the The program shall reinsure up to the level of coverage provided in either a basic health benefit plan or standard health benefit plan established by the board.

Sec. 23. Section 513B.13, subsection 13, Code 2001, is amended by striking the subsection.

Sec. 24. Section 514E.1, subsection 15, paragraph a, Code 2001, is amended to read as follows:

a. "Health insurance coverage" means health insurance coverage offered to individuals, ~~but does not include short-term limited duration insurance.~~

Sec. 25. NEW SECTION. 514J.3A NOTICE.

When a claim is denied in whole or in part based on medical necessity, the carrier or organized delivery system shall provide a notice in writing to the enrollee of the internal appeal mechanism provided under the carrier or organized delivery system's plan or policy.

At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

Sec. 26. Section 514J.4, subsection 1, Code 2001, is amended by striking the subsection.

Sec. 27. Section 514J.5, Code 2001, is amended to read as follows:

514J.5 CERTIFICATION OF REQUEST -- ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized

delivery system at the time the service or treatment was proposed or received.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed or received service or treatment does not meet the definition of medical necessity as defined in the ~~enrollee's evidence of coverage~~ carrier's or organized delivery system's plan or policy.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's ~~contract~~ plan or policy.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the ~~decision~~ certification.

3. The carrier or organized delivery system has three business days to contest ~~the eligibility of the request for external review with the commissioner~~ the commissioner's certification decision. If the commissioner finds that the request for external review is not eligible for ~~full review~~ certification, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for ~~full review~~ certification.

4. If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the carrier or organized delivery system, the commissioner shall notify the carrier or organized delivery system in writing of the reasons for upholding the certification.

Sec. 28. Section 514J.7, Code 2001, is amended by striking

the section and inserting in lieu thereof the following:

514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, or within three business days of receipt of the commissioner's denial of the carrier's or organized delivery system's contest of the certification of the request under section 514J.5, subsection 3, whichever is later, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and telephone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information.

c. Notify the selected independent review entity by facsimile that the carrier or organized delivery system has chosen it to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review and a detailed description and necessary documentation of the treatment of the medical condition to be reviewed.

d. Provide to the commissioner by facsimile a copy of the notices sent to the enrollee and to the selected independent review entity.

2. The independent review entity, within three business

days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the enrollee of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner. If the independent review entity does not have a person who is an expert in the treatment of the medical condition under review and certified by the commissioner to conduct an independent review, the independent review entity may either decline the review request or may request from the commissioner additional time to have such an expert certified. The independent review entity shall notify the commissioner by facsimile of its choice between these options within three business days of receipt of the notice from the carrier or organized delivery system. The commissioner shall provide a notice to the enrollee of the independent review entity's decision and of the commissioner's decision as to how to proceed with the external review process within three business days of receipt of the independent review entity's decision.

3. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the independent review entity selected by the carrier or organized delivery system or to the person selected as the reviewer by the independent review entity by notifying the commissioner within ten days of the mailing of the notice by the independent review entity. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

4. The carrier or organized delivery system, within

fifteen days of the mailing of the notice by the independent review entity, or within three business days of a receipt of notice by the commissioner following an objection by the enrollee, whichever is later, shall do all of the following:

a. Provide to the independent review entity any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

b. Provide to the independent review entity any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

c. Provide to the commissioner a confirmation that the information required in paragraphs "a" and "b" has been provided to the independent review entity, including the date the information was provided.

5. The enrollee, or the enrollee's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the carrier's or organized delivery system's evidence of coverage, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the ten-day period.

6. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 4. The enrollee or the enrollee's

treating health care provider shall provide the requested information to the independent review entity within five days after receipt of the notification requesting additional medical information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the carrier or organized delivery system of this request.

7. The independent review entity shall submit its external review decision as soon as possible, but not later than thirty days from the date the independent review entity received the information required under subsection 4 from the carrier or organized delivery system. The independent review entity, for good cause, may request an extension of time from the commissioner. The independent review entity's external review decision shall be mailed to the enrollee or the treating health care provider acting on behalf of the enrollee, the carrier or organized delivery system, and the commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 29. NEW SECTION. 514J.15 PENALTIES.

A carrier who fails to comply with this chapter or with rules adopted pursuant to this chapter is subject to the penalties provided under chapter 507B.

Sec. 30. Section 515.35, subsection 4, paragraph n, subparagraph (1), Code 2001, is amended to read as follows:

(1) A company organized under this chapter may invest up to ~~two~~ five percent of its admitted assets in securities or property of any kind, without restrictions or limitations except those imposed on business corporations in general.

Sec. 31. Section 515B.1, subsection 2, Code 2001, is amended to read as follows:

2. Mortgage guaranty, financial guaranty, residual value,

or other forms of insurance offering protection against investment risks.

Sec. 32. Section 515B.5, subsection 1, paragraph b, Code 2001, is amended to read as follows:

b. Be obligated to pay covered claims subject to a limitation as established by the rights, duties, and obligations under the policy of the insolvent insurer. However, the association is not obligated to pay a claimant an amount in excess of the obligation under the policy of the insolvent insurer, regardless of whether such claim is based on contract or tort.

Sec. 33. Section 515B.16, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

515B.16 ACTIONS AGAINST THE ASSOCIATION.

Any action against the association shall be brought against the association in the association's own name. The Polk county district court shall have exclusive jurisdiction and venue of such actions. Service of the original notice in actions against the association may be made on any officer of the association or upon the commissioner of insurance on behalf of the association. The commissioner shall promptly transmit any notice so served upon the commissioner to the association.

Sec. 34. NEW SECTION. 515F.4A REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGE.

Benefits provided by credit personal property insurance policies shall be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than sixty-five percent to afford a reasonable allowance for actual and expected loss experience including a reasonable catastrophe provision, general and administrative expenses, reasonable acquisition expenses, reasonable creditor compensation, investment income, premium

taxes, licenses, fees, assessments, and reasonable insurer profit.

Sec. 35. Section 518.23, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded to the insured upon the surrender of the policy to the association at its home office.

Sec. 36. Section 518A.29, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded upon the surrender of the policy to the association at its home office.

Sec. 37. Section 707.6A, subsection 2, Code 2001, is amended by adding the following new paragraph:

NEW PARAGRAPH. c. Causing or attempting to cause a vehicle collision likely to result in bodily injury, or aiding, abetting, or conspiring to cause or attempt to cause a

collision, in violation of section 321.276.

Sec. 38. Section 515.122, Code 2001, is repealed.

Sec. 39. Sections 432.12, 513B.14, 513B.16, 513B.17A, 513B.18, and 513B.31 through 513B.43, Code 2001, are repealed.

Sec. 40. EFFECTIVE DATE. Sections 14 through 23 and section 39 of this Act take effect January 1, 2002.

EXPLANATION

This bill makes changes to various insurance-related provisions throughout the Code.

The bill amends Code section 87.11 to provide that a political subdivision, including a city, county, community college, or school corporation, that is self-insured for workers' compensation is not required to submit a plan or program to the commissioner of insurance (the commissioner) for review and approval. The current Code language requires employers to furnish certain proof of solvency and ability to pay to be exempted from workers' compensation insurance requirements.

The bill creates new Code section 321.276, which punishes intentional vehicle collisions likely to result in bodily injury as a class "D" felony. Attempts to cause vehicle collisions or aiding, abetting, or conspiring to knowingly cause such collisions are also punishable as class "D" felonies. If a death unintentionally results from such a violation, the act is punishable as a class "C" felony under Code section 707.6A.

The bill deletes the requirement in Code section 505.11 for the commissioner to certify to the department of revenue and finance the amount of credit to be applied on future taxes due from a company that has overpaid amounts due to the state, and to notify the company of the amount. The current Code language gives the commissioner the power to refund the overpayment or apply it to current or future amounts due.

Code section 507.10 is amended regarding the filing by the examiner of a verified written report of examination, to

delete the words "under oath".

The bill deletes certain acts designated in Code section 507B.4 as unfair claim settlement practices: failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies, and failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. The bill amends another unfair claim settlement practice to expressly include a reference to another Code subsection added by this bill, and adds an additional unfair claim settlement practice relating to the audit of health care claims.

The bill adds an unfair practice relating to the payment of interest on health insurance claims an insurer fails to accept timely.

The bill adds new Code section 507B.4A, specifying certain actions that are within a person's duty to respond timely to inquiries from the commissioner, a policyholder, or a claimant; and to investigate and settle a claim timely. Several other Code sections are amended in the bill to include a reference to this new Code section.

The bill corrects certain Code references in Code sections 511.4 and 513B.2 due to Code section repeals made by the bill.

The bill strikes paragraphs in Code section 513B.4 related to certain outdated restrictions on premiums, and strikes a subsection pertaining to premium rates variances for certain plans.

The bill deletes the requirement in Code section 513B.10 for a carrier or organized delivery system to offer health insurance coverage which constitutes a basic health benefit plan and a standard health benefit plan. The bill also deletes a subsection of Code section 513B.10 dealing with such plans.

The bill strikes a paragraph from Code section 513B.13 dealing with initial appointments to the board for the small

employer carrier reinsurance program. The bill also updates other language in the section.

Changes to Code chapter 513B, regarding small group health coverage in sections 14 through 23 of the bill are effective January 1, 2002.

The bill modifies the language used in Code section 514E.1 for the definition of "health insurance coverage".

The bill adds new Code section 514J.3A, which requires notice of the availability of the internal appeal mechanism to be provided when a claim is denied, and notice of the external review process when a coverage decision is made. The bill also deletes a subsection of Code section 514J.4 that was moved to new Code section 514J.3A.

The bill amends terms used in Code section 514J.5 relating to certification of a request for external review, and adds a paragraph relating to written notification of reasons for certification.

The bill strikes the existing Code section 514J.7, relating to criteria for the external review process, and inserts a new criteria section that reorganizes certain current provisions and contains more details regarding the process.

The bill adds language to Code section 514J.12 to address the standard of review when a health care claim has been denied under a property or casualty insurance policy.

The bill adds new Code section 514J.15 to provide that a carrier who fails to comply with the provisions of Code chapter 514J, relating to the external review process, or related rules adopted pursuant to the chapter, is subject to penalties provided under Code chapter 507B, relating to insurance trade practices.

The bill amends Code section 515.35, to permit investments of up to 5 percent of the admitted assets of an insurance company other than a life insurance company, instead of 2 percent.

The bill adds residual value as a type of insurance

coverage excluded from the scope of Code chapter 515B, the insurance guaranty association chapter.

The bill amends Code section 515B.5 to specify that the insurance guaranty association is not obligated to pay an amount in excess of the policy limitations of the insolvent insurer, regardless of whether the claim is based in contract or tort.

The bill strikes current Code section 515B.16 regarding actions against the insurance guaranty association, and inserts revised language, including a provision that specifies that Polk county district court has exclusive jurisdiction and venue of such actions.

The bill creates new Code section 515F.4A to provide a standard for judging the reasonableness of premiums charged to benefits provided under a casualty insurance policy.

The bill amends Code sections 518.23 and 518A.29 by deleting references to certified or registered mail, and specifying that a certificate of mailing constitutes proof of receipt of cancellation or nonrenewal of policies by a county mutual insurance association or a state mutual insurance association, respectively.

The bill repeals Code section 515.122, relating to required components of advertising by agents for insurance other than life insurance, effective July 1, 2001.

Effective January 1, 2002, the bill also repeals Code section 432.12, regarding the premium tax credit for employer-sponsored health plan premium credit; Code section 513B.14, regarding basic and standard health benefit plan standards; Code sections 513B.16 and 513B.18, applicability provisions relating to basic and standard health benefit plans; Code section 513B.17A, regarding adoption of rules relating to restoration of small group health coverage; and Code sections 513B.31 through 513B.43, relating to basic benefit coverage for small groups.

STATE OF IOWA

THOMAS J VILSACK
GOVERNOR

SALLY J PEDERSON
LT GOVERNOR

Therese M. Vaughan, Commissioner
INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

January 30, 2001

Re: Proposed Omnibus Bill/Iowa Insurance Division

Dear Senators and Representatives:

The Iowa Insurance Division submits its Omnibus Bill for your consideration during the 2001 Legislative Session. This bill addresses a number of issues that have come to our attention during the past year. Through many of the sections of this proposed legislation we are attempting to streamline procedures, clarify requirements and addresses concerns brought to us by industry, consumers and other interested parties that we believe would be beneficial in our regulatory framework. Briefly, they are as follows:

The first section exempts political subdivisions that self-insure for workers' compensation from submitting their plan to the Division for approval. The Division currently possesses no regulatory authority over these plans other than to receive the plan.

The next section addresses an issue that our Fraud Bureau has watched develop through their investigations of staged automobile accidents. Currently, there is no penalty for intentionally causing a vehicle collision that is likely to result in bodily injury. This section and a subsequent section would create such a criminal penalty.

The following section strikes a requirement that the commissioner certify to the Department of Revenue the amount of a credit to be applied to future taxes due. The Division believes this is unnecessary under the current system and is additional paperwork that can be streamlined.

We are also eliminating the requirement that a Division field examiner verify the written report of a carrier examination under oath. Additional staff reviews all examination reports for verification.

The next group of sections amends the Insurance Trade Practices chapter. The Division is adding a section requiring carriers and producers to respond timely to inquiries from the Division and for a health insurance carrier to promptly pay a clean claim within 30 days of receipt. Failure to pay the clean claim within 30 days will cause payment of interest at the rate of 10% per annum. The Division also proposes that failure to comply with procedures for auditing claims submitted by health care provider, as set forth by rule is an unfair trade practice.

The amendment to Iowa Code chapter 511 is correcting an internal reference.

The next group of sections amends the small group health coverage chapter, 513B. With the passage of the federal Health Insurance Portability and Accountability Act in 1996 (HIPAA) that provided guaranteed access to all small group policies, the need for a guaranteed basic or standard policy is no

SSB 1123

longer necessary. Both the basic and standard health benefit plans are rarely sold now. The costs of maintaining these policies and regulating by the Division are not justified by the federal law addressing guaranteed issue. The changes would maintain the small employer carrier reinsurance program to provide a reinsurance mechanism for carriers.

The change to Iowa Code chapter 514E, the Iowa Comprehensive Health Association chapter, provides for the inclusion of short term limited duration insurance as creditable coverage. This type of coverage is required to be included as creditable coverage for purposes of portability as provided in HIPAA.

We are also addressing changes to the external review process that was enacted in 2000. These changes are proposed following review of the current process and issues that have arisen during the first year of the review process. The purposes of the amendments to section 514J are to ensure that an enrollee is aware of his or her ability under a plan to appeal a denial decision. Because the external review mechanism does not go into effect until an enrollee has exhausted all internal appeal mechanisms, it is important that an enrollee is aware of the existence and procedure of such mechanisms. The section is made separate from the prior 514J.4 to clarify that the notice requirements are placed on the carrier, while the requirements for making an external review request are placed on the enrollee.

The purposes of the amendments to section 514J.7 are to clarify the time frames in which each participant in the external review process must perform each respective duty. In addition, this section clarifies how the objection and appeal times fit into the time framework of the external review process and allows the enrollee enough information to be able to make a reasoned decision as to whether to object to the selection of the specific person conducting the external review. The section all provides notice to the commissioner of what is occurring in the external review process so that the commissioner can determine whether notice and time requirements are being met and to allow the independent review entity to decline a request to be an independent reviewer or to request an extension of time from the commissioner for good cause. And finally, the section clarifies the penalty for failure to comply with the law.

The Division is also addressing issues of the insurance guaranty association. The Guaranty Fund should not be required to pay a claimant for an amount in excess of the obligation under the policy regardless of whether a claim is based upon a contract or a tort. Actions brought against the Association shall be brought in Polk County with notice served upon the Commissioner. Claims against the Association shall not include residual value protection against investment risks.

The Division is also requiring that benefits provided by credit personal property insurance policies shall be reasonable in relation to the premium charged. The loss ratio shall not be less than 65%.

The Division requests that the sections relating to the small employer coverage benefits and certain related sections that are being rescinded should be effective January 1, 2002 to allow for appropriate implementation.

Thank you for your consideration of these proposals.

Sincerely,

Susan E. Voss

Susan E. Voss
1st Deputy Commissioner

H 3/29/01 Commerce & Rg.

AMENDED

FILED MAR 19 '01

SENATE FILE 500

BY COMMITTEE ON COMMERCE

(SUCCESSOR TO SSB 1123)

Passed Senate, Date 3-28-01 (p.901) Passed House, Date 4/16/01 (p.1114)

Vote: Ayes 49 Nays 0 Vote: Ayes 98 Nays 0

Approved 4-24-01

A BILL FOR

An Act relating to insurance, by addressing the operation and regulation of insurance companies, mutual insurance associations, the Iowa insurance guaranty association, and other insurance or risk-assuming entities, including the rights and duties of such entities and the powers and authority of the insurance commissioner; by establishing jurisdiction and venue requirements for actions against the Iowa insurance guaranty association; and providing penalties, repeals, and effective dates.

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

SF 500

SENATE FILE 500

S-3274

Amend Senate File 500 as follows:

1. Page 4, line 19, by inserting before the word "claim" the following: "clean".

By DONALD B. REDFERN

S-3274 FILED MARCH 28, 2001

ADOPTED (p. 901)

TLSB 1073SV 79

jj/cls/14

S.F. 500 H.F. _____

Section 1. Section 87.11, unnumbered paragraph 1, Code 2001, is amended to read as follows:

When an employer coming under this chapter furnishes satisfactory proofs to the insurance commissioner of such employer's solvency and financial ability to pay the compensation and benefits as by law provided and to make such payments to the parties when entitled thereto, or when such employer deposits with the insurance commissioner security satisfactory to the insurance commissioner and the workers' compensation commissioner as guaranty for the payment of such compensation, such employer shall be relieved of the provisions of this chapter requiring insurance; but such employer shall, from time to time, furnish such additional proof of solvency and financial ability to pay as may be required by such insurance commissioner or workers' compensation commissioner. A political subdivision, including a city, county, community college, or school corporation, that is self-insured for workers' compensation is not required to submit a plan or program to the insurance commissioner for review and approval.

Sec. 2. Section 505.11, Code 2001, is amended to read as follows:

505.11 REFUNDS.

Whenever it appears to the satisfaction of the commissioner of insurance that because of error, mistake, or erroneous interpretation of statute that a foreign or domestic insurance corporation has paid to the state of Iowa taxes, fines, penalties, or license fees in excess of the amount legally chargeable against it, the commissioner of insurance shall have power to refund to such corporation any such excess by applying the amount ~~thereof~~ of the excess payment toward the payment of taxes, fines, penalties, or license fees already due or which may ~~hereafter~~ become due, until such excess payments have been fully refunded. ~~The commissioner shall certify to the department of revenue and finance the amount of~~

~~any-such-credit-to-be-applied-to-future-taxes-due-and-notify the-insurance-company-affected-of-the-amount-thereof.~~

Sec. 3. Section 507.10, subsection 2, Code 2001, is amended to read as follows:

2. FILING OF EXAMINATION REPORT. No later than sixty days following completion of the examination, the examiner in charge shall file with the division a verified written report of examination ~~under-oath~~. Upon receipt of the verified report and after administrative review, the division shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

Sec. 4. Section 507A.4, subsection 7, Code 2001, is amended by striking the subsection.

Sec. 5. Section 507B.4, subsection 9, paragraph f, Code 2001, is amended to read as follows:

f. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear, or failing to include interest on the payment of claims when required under section 511.38 or subsection 10B.

Sec. 6. Section 507B.4, subsection 9, Code 2001, is amended by adding the following new paragraph:

NEW PARAGRAPH. o. Failing to comply with the procedures for auditing claims submitted by health care providers as set forth by rule of the commissioner. However, this paragraph shall have no applicability to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 7. Section 507B.4, Code 2001, is amended by adding the following new subsection:

NEW SUBSECTION. 10B. PAYMENT OF INTEREST. Failure of an

insurer to pay interest at the rate of ten percent per annum on all health insurance claims that the insurer fails to timely accept and pay pursuant to section 507B.4A, subsection 1, paragraph "e". Interest shall accrue commencing on the thirty-first day after receipt of all properly completed proof of loss forms.

For purposes of this subsection, "insurer" means an entity providing a plan of health insurance, health care benefits, or health care services, or an entity subject to the jurisdiction of the commissioner performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the department of public health, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. However, "insurer" does not include an entity that sells disability income or long-term care insurance.

Sec. 8. NEW SECTION. 507B.4A DUTY TO RESPOND TO INQUIRIES AND PROMPT PAYMENT OF CLAIM.

1. A person shall promptly respond to inquiries from the commissioner.

a. A person's actions are deemed untimely under this subsection if the person fails to respond to an inquiry from the commissioner within thirty days of the receipt of the inquiry, unless good cause exists for delay.

b. Failure to respond to inquiries from the commissioner pursuant to this subsection with such frequency as to indicate a general business practice shall subject the person to penalty under this chapter.

2. a. An insurer providing accident and sickness insurance under chapter 509, 514, or 514A; a health maintenance organization; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by

the department of public health; or another entity providing health insurance or health benefits subject to state insurance regulation shall either accept and pay or deny a clean claim.

b. For purposes of this subsection, "clean claim" means a properly completed paper or electronic billing instrument containing all reasonably necessary information, that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

c. The commissioner shall adopt rules establishing processes for timely adjudication and payment of claims by insurers for health care benefits. The rules shall be consistent with the time frames and other procedural standards for claims decisions by group health plans established by the United States department of labor pursuant to 29 C.F.R. pt. 2560 in effect at the time of passage of this Act.

d. Payment of a claim shall include interest at the rate of ten percent per annum when an insurer or other entity as defined in this subsection that administers or processes claims on behalf of the insurer or other entity fails to timely pay a claim.

e. This subsection shall not apply to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 9. Section 507B.6, subsection 1, Code 2001, is amended to read as follows:

1. Whenever the commissioner ~~shall have reason to believe~~ believes that any ~~such~~ person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in section 507B.4, 507B.4A, or 507B.5 and that a proceeding by the commissioner in respect ~~thereto~~ to such method of

competition or unfair or deceptive act or practice would be ~~to the interest of~~ in the public interest, the commissioner shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing ~~thereon~~ on such charges to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service ~~thereof~~ of such notice.

Sec. 10. Section 507B.7, subsection 1, Code 2001, is amended to read as follows:

1. If, after such hearing, the commissioner ~~shall determine~~ determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings, an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of section 507B.4, 507B.4A, or 507B.5, the commissioner may at the commissioner's discretion order any one or more of the following:

a. Payment of a civil penalty of not more than one thousand dollars for each act or violation, but not to exceed an aggregate of ten thousand dollars, unless the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or 507B.5, in which case the penalty shall be not more than five thousand dollars for each act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any one six-month period. ~~The commissioner shall, if~~ If the commissioner finds ~~the violations~~ that a violation of section 507B.4, 507B.4A, or 507B.5 ~~were~~ was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer.

b. Suspension or revocation of the license of a person as

defined in section 507B.2, subsection 1, if the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or ~~section~~ 507B.5.

c. Payment of interest at the rate of ten percent per annum if the commissioner finds that the insurer failed to pay interest as required under section 507B.4, subsection 10B.

Sec. 11. Section 507B.12, unnumbered paragraph 1, Code 2001, is amended to read as follows:

The commissioner may, after notice and hearing, promulgate reasonable rules, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by section 507B.4, 507B.4A, or 507B.5, but the rules shall not enlarge upon or extend the provisions of such sections. Such rules shall be subject to review in accordance with chapter 17A.

Sec. 12. Section 511.4, Code 2001, is amended to read as follows:

511.4 ADVERTISEMENTS -- WHO DEEMED AGENT.

The provisions of sections ~~515.122~~ 515.123 to 515.126 shall apply to life insurance companies and associations.

Sec. 13. Section 513B.2, subsections 3 and 20, Code 2001, are amended to read as follows:

3. "Basic health benefit plan" means a plan ~~which is~~ offered established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

20. "Standard health benefit plan" means a plan ~~which is~~ offered established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

Sec. 14. Section 513B.4, subsection 1, paragraphs d and e, Code 2001, are amended by striking the paragraphs.

Sec. 15. Section 513B.4, subsection 2, Code 2001, is amended by striking the subsection.

Sec. 16. Section 513B.10, subsection 1, paragraph a, Code

2001, is amended to read as follows:

a. A carrier or an organized delivery system that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter. ~~A carrier or organized delivery system shall offer health insurance coverage which constitutes a basic health benefit plan and which constitutes a standard health benefit plan.~~

Sec. 17. Section 513B.10, subsection 3, Code 2001, is amended by striking the subsection.

Sec. 18. Section 513B.13, subsection 3, paragraph c, Code 2001, is amended by striking the paragraph.

Sec. 19. Section 513B.13, subsection 3, paragraph d, Code 2001, is amended to read as follows:

d. ~~Subsequent members~~ Members shall be appointed for terms of three years. A board member's term shall continue until the member's successor is appointed.

Sec. 20. Section 513B.13, subsections 4 and 5, Code 2001, are amended to read as follows:

4. The board~~, within one hundred eighty days after the initial appointments, shall~~ may submit a plan of operation to the commissioner. The commissioner, after notice and hearing, may approve ~~the~~ a plan of operation if the commissioner determines that the plan is suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains and losses on an equitable and proportionate basis in accordance with the provisions of this section. ~~The~~ A plan of operation is effective upon written approval of the commissioner. ~~After the initial plan of operation is submitted and approved by the~~

~~commissioner,-the~~

5. The board may submit to the commissioner any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The amendments shall be effective upon the written approval of the commissioner.

~~5.--If-the-board-fails-to-submit-a-plan-of-operation-within one-hundred-eighty-days-after-the-board's-appointment,-the commissioner,-after-notice-and-hearing,-shall-establish-and adopt-a-temporary-plan-of-operation.--The-commissioner-shall amend-or-rescind-a-plan-adopted-pursuant-to-this-subsection-at the-time-a-plan-is-submitted-by-the-board-and-approved-by-the commissioner.~~

Sec. 21. Section 513B.13, subsection 8, paragraph a, Code 2001, is amended to read as follows:

a. ~~With-respect-to-a-basic-health-benefit-plan-or-a standard-health-benefit-plan,-the-program-shall-reinsure-the level-of-coverage-provided-and,-with-respect-to-other-plans,~~ the The program shall reinsure up to the level of coverage provided in either a basic health benefit plan or standard health benefit plan established by the board.

Sec. 22. Section 513B.13, subsection 13, Code 2001, is amended by striking the subsection.

Sec. 23. Section 514E.1, subsection 15, paragraph a, Code 2001, is amended to read as follows:

a. "Health insurance coverage" means health insurance coverage offered to individuals~~,-but-does-not-include-short-term-limited-duration-insurance~~.

Sec. 24. NEW SECTION. 514J.3A NOTICE.

When a claim is denied in whole or in part based on medical necessity, the carrier or organized delivery system shall provide a notice in writing to the enrollee of the internal appeal mechanism provided under the carrier or organized delivery system's plan or policy.

At the time of a coverage decision, the carrier or

organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

Sec. 25. Section 514J.4, subsection 1, Code 2001, is amended by striking the subsection.

Sec. 26. Section 514J.5, Code 2001, is amended to read as follows:

514J.5 CERTIFICATION OF REQUEST -- ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed or received.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed or received service or treatment does not meet the definition of medical necessity as defined in the ~~enrollee's evidence of coverage~~ carrier's or organized delivery system's plan or policy.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's ~~contract~~ plan or policy.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the ~~decision~~ certification.

3. The carrier or organized delivery system has three business days to contest ~~the eligibility of the request for external review with the commissioner~~ the commissioner's certification decision. If the commissioner finds that the

request for external review is not eligible for ~~full-review~~ certification, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for ~~full-review~~ certification.

4. If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the carrier or organized delivery system, the commissioner shall notify the carrier or organized delivery system in writing of the reasons for upholding the certification.

Sec. 27. Section 514J.7, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, or within three business days of receipt of the commissioner's denial of the carrier's or organized delivery system's contest of the certification of the request under section 514J.5, subsection 3, whichever is later, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and telephone number of the independent review entity and of the enrollee's and

treating health care provider's right to submit additional information.

c. Notify the selected independent review entity by facsimile that the carrier or organized delivery system has chosen it to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.

d. Provide to the commissioner by facsimile a copy of the notices sent to the enrollee and to the selected independent review entity.

2. The independent review entity, within three business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the enrollee of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner. If the independent review entity does not have a person who is an expert in the treatment of the medical condition under review and certified by the commissioner to conduct an independent review, the independent review entity may either decline the review request or may request from the commissioner additional time to have such an expert certified. The independent review entity shall notify the commissioner by facsimile of its choice between these options within three business days of receipt of the notice from the carrier or organized delivery system. The commissioner shall provide a notice to the enrollee and carrier or organized delivery system of the independent review entity's decision and of the commissioner's decision as to how to proceed with the external review process within three business days of receipt of the independent review entity's decision.

3. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the

independent review entity selected by the carrier or organized delivery system or to the person selected as the reviewer by the independent review entity by notifying the commissioner and carrier or organized delivery system within ten days of the mailing of the notice by the independent review entity. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

4. The carrier or organized delivery system, within fifteen days of the mailing of the notice by the independent review entity, or within three business days of a receipt of notice by the commissioner following an objection by the enrollee, whichever is later, shall do all of the following:

a. Provide to the independent review entity any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

b. Provide to the independent review entity any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

c. Provide to the commissioner a confirmation that the information required in paragraphs "a" and "b" has been provided to the independent review entity, including the date the information was provided.

5. The enrollee, or the enrollee's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the carrier's or organized delivery system's

evidence of coverage, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the ten-day period.

6. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 4. The enrollee or the enrollee's treating health care provider shall provide the requested information to the independent review entity within five days after receipt of the notification requesting additional medical information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the carrier or organized delivery system of this request.

7. The independent review entity shall submit its external review decision as soon as possible, but not later than thirty days from the date the independent review entity received the information required under subsection 4 from the carrier or organized delivery system. The independent review entity, for good cause, may request an extension of time from the commissioner. The independent review entity's external review decision shall be mailed to the enrollee or the treating health care provider acting on behalf of the enrollee, the carrier or organized delivery system, and the commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 28. NEW SECTION. 514J.15 PENALTIES.

A carrier who fails to comply with this chapter or with rules adopted pursuant to this chapter is subject to the penalties provided under chapter 507B.

Sec. 29. Section 515.35, subsection 4, paragraph n, subparagraph (1), Code 2001, is amended to read as follows:

(1) A company organized under this chapter may invest up to ~~two~~ five percent of its admitted assets in securities or property of any kind, without restrictions or limitations except those imposed on business corporations in general.

Sec. 30. Section 515.51, Code 2001, is amended to read as follows:

515.51 POLICIES -- EXECUTION -- REQUIREMENTS.

All policies or contracts of insurance except surety bonds made or entered into by the company may be made either with or without the seal of the company, but shall be subscribed by the president, or such other officer as may be designated by the directors for that purpose, and be attested to by the secretary or the secretary's designee of the company. A group motor vehicle or group homeowners policy shall not be written or delivered within this state unless such policy is an individual policy or contract form.

Sec. 31. Section 515B.1, subsection 2, Code 2001, is amended to read as follows:

2. Mortgage guaranty, financial guaranty, residual value, or other forms of insurance offering protection against investment risks.

Sec. 32. Section 515B.5, subsection 1, paragraph b, Code 2001, is amended to read as follows:

b. Be obligated to pay covered claims subject to a limitation as established by the rights, duties, and obligations under the policy of the insolvent insurer. However, the association is not obligated to pay a claimant an amount in excess of the obligation under the policy of the insolvent insurer, regardless of whether such claim is based

on contract or tort.

Sec. 33. Section 515B.16, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

515B.16 ACTIONS AGAINST THE ASSOCIATION.

Any action against the association shall be brought against the association in the association's own name. The Polk county district court shall have exclusive jurisdiction and venue of such actions. Service of the original notice in actions against the association may be made on any officer of the association or upon the commissioner of insurance on behalf of the association. The commissioner shall promptly transmit any notice so served upon the commissioner to the association.

Sec. 34. NEW SECTION. 515F.4A REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGED.

Benefits provided by credit personal property insurance shall be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than fifty percent or such lower loss ratio as designated by the commissioner to afford a reasonable allowance for actual and expected loss experience including a reasonable catastrophe provision, general and administrative expenses, reasonable acquisition expenses, reasonable creditor compensation, investment income, premium taxes, licenses, fees, assessments, and reasonable insurer profit.

Sec. 35. Section 518.23, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A

post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded to the insured upon the surrender of the policy to the association at its home office.

Sec. 36. Section 518A.29, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded upon the surrender of the policy to the association at its home office.

Sec. 37. Section 515.122, Code 2001, is repealed.

Sec. 38. Sections 432.12, 513B.14, 513B.16, 513B.17A, 513B.18, and 513B.31 through 513B.43, Code 2001, are repealed.

Sec. 39. EFFECTIVE DATE. Sections 4, 7 through 11, 13 through 22, 34, and 38 of this Act take effect January 1, 2002.

EXPLANATION

This bill makes changes to various insurance-related provisions throughout the Code. Specific provisions are effective January 1, 2002, as noted.

The bill amends Code section 87.11 to provide that a political subdivision, including a city, county, community college, or school corporation, that is self-insured for workers' compensation is not required to submit a plan or program to the commissioner of insurance (the commissioner)

for review and approval. The current Code language requires employers to furnish certain proof of solvency and ability to pay to be exempted from workers' compensation insurance requirements.

The bill deletes the requirement in Code section 505.11 for the commissioner to certify to the department of revenue and finance the amount of credit to be applied on future taxes due from a company that has overpaid amounts due to the state, and to notify the company of the amount. The current Code language gives the commissioner the power to refund the overpayment or apply it to current or future amounts due.

Code section 507.10 is amended regarding the filing by the examiner of a verified written report of examination, to delete the words "under oath".

The bill deletes a provision in Code section 507A.4 that exempts from the Code chapter on unauthorized insurers any life insurance company organized and operated for the purpose of aiding educational or scientific institutions organized and operated without profit to any private shareholder or individual by issuing insurance and annuity contracts. This provision takes effect January 1, 2002.

The bill amends an unfair claim settlement practice in Code section 507B.4 to expressly include a reference to another Code subsection on the payment of interest added by this bill, and adds an additional unfair claim settlement practice relating to the audit of health care claims.

The bill adds an unfair practice relating to the payment of interest on health insurance claims an insurer fails to accept timely. This provision takes effect January 1, 2002.

The bill adds new Code section 507B.4A, specifying a person's duty to respond timely to inquiries from the commissioner and a health insurer's duty to accept and pay or deny a clean claim, as defined by the new Code section. These provisions, and Code sections that are amended to refer to this new Code section, take effect January 1, 2002.

The bill corrects certain Code references in Code sections 511.4 and 513B.2 due to Code section repeals made by the bill.

The bill strikes paragraphs in Code section 513B.4 related to certain outdated restrictions on premiums, and strikes a subsection pertaining to premium rates variances for certain plans.

The bill deletes the requirement in Code section 513B.10 for a carrier or organized delivery system to offer health insurance coverage that constitutes a basic health benefit plan and a standard health benefit plan. The bill also deletes a subsection of Code section 513B.10 dealing with such plans.

The bill strikes a paragraph from Code section 513B.13 dealing with initial appointments to the board for the small employer carrier reinsurance program. The bill also updates other language in the section.

Changes to Code chapter 513B, regarding small group health coverage in sections 14 through 23 of the bill are effective January 1, 2002.

The bill modifies the language used in Code section 514E.1 for the definition of "health insurance coverage".

The bill adds new Code section 514J.3A, which requires notice of the availability of the internal appeal mechanism to be provided when a claim is denied, and notice of the external review process when a coverage decision is made. The bill also deletes a subsection of Code section 514J.4 that was moved to new Code section 514J.3A.

The bill amends terms used in Code section 514J.5 relating to certification of a request for external review, and adds a paragraph relating to written notification of reasons for certification.

The bill strikes the existing Code section 514J.7, relating to criteria for the external review process, and inserts a new criteria section that reorganizes certain current provisions and contains more details regarding the process.

The bill adds language to Code section 514J.12 to address the standard of review when a health care claim has been denied under a property or casualty insurance policy.

The bill adds new Code section 514J.15 to provide that a carrier who fails to comply with the provisions of Code chapter 514J, relating to the external review process, or related rules adopted pursuant to the chapter, is subject to penalties provided under Code chapter 507B, relating to insurance trade practices.

The bill amends Code section 515.35, to permit investments of up to 5 percent of the admitted assets of an insurance company other than a life insurance company, instead of 2 percent.

The bill amends Code section 515.51 to provide that all policies or contracts of insurance except surety bonds may be entered into with or without the seal of the company.

The bill adds residual value as a type of insurance coverage excluded from the scope of Code chapter 515B, the insurance guaranty association chapter.

The bill amends Code section 515B.5 to specify that the insurance guaranty association is not obligated to pay an amount in excess of the policy limitations of the insolvent insurer, regardless of whether the claim is based in contract or tort.

The bill strikes current Code section 515B.16 regarding actions against the insurance guaranty association, and inserts revised language, including a provision that specifies that Polk county district court has exclusive jurisdiction and venue of such actions.

The bill creates new Code section 515F.4A to provide a standard for judging the reasonableness of premiums charged to benefits provided under a credit personal property insurance policy. This provision takes effect January 1, 2002.

The bill amends Code sections 518.23 and 518A.29 by deleting references to certified or registered mail, and

specifying that a certificate of mailing constitutes proof of receipt of cancellation or nonrenewal of policies by a county mutual insurance association or a state mutual insurance association, respectively.

The bill repeals Code section 515.122, relating to required components of advertising by agents for insurance other than life insurance, effective July 1, 2001.

Effective January 1, 2002, the bill also repeals Code section 432.12, regarding the premium tax credit for employer-sponsored health plan premium credit; Code section 513B.14, regarding basic and standard health benefit plan standards; Code sections 513B.16 and 513B.18, applicability provisions relating to basic and standard health benefit plans; Code section 513B.17A, regarding adoption of rules relating to restoration of small group health coverage; and Code sections 513B.31 through 513B.43, relating to basic benefit coverage for small groups.

H 3/29/01 Commerce Rpt.
H. 4/4/01 Do Pass
H 4/12/01 UNFINISHED BUSINESS CALENDAR

SENATE FILE 500
BY COMMITTEE ON COMMERCE

(SUCCESSOR TO SSB 1123)

(AS AMENDED AND PASSED BY THE SENATE MARCH 28, 2001)

[redacted] - New Language by the Senate

Passed Senate, Date _____ Passed House, Date 4-16-01 (P. 1185)
Vote: Ayes _____ Nays _____ Vote: Ayes 98 Nays 0
Approved April 24, 2001

A BILL FOR

An Act relating to insurance, by addressing the operation and regulation of insurance companies, mutual insurance associations, the Iowa insurance guaranty association, and other insurance or risk-assuming entities, including the rights and duties of such entities and the powers and authority of the insurance commissioner; by establishing jurisdiction and venue requirements for actions against the Iowa insurance guaranty association; and providing penalties, repeals, and effective dates.

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

S.F. 500

SF 500
jj/cc/26

S.F. 500 H.F. _____

Section 1. Section 87.11, unnumbered paragraph 1, Code 2001, is amended to read as follows:

When an employer coming under this chapter furnishes satisfactory proofs to the insurance commissioner of such employer's solvency and financial ability to pay the compensation and benefits as by law provided and to make such payments to the parties when entitled thereto, or when such employer deposits with the insurance commissioner security satisfactory to the insurance commissioner and the workers' compensation commissioner as guaranty for the payment of such compensation, such employer shall be relieved of the provisions of this chapter requiring insurance; but such employer shall, from time to time, furnish such additional proof of solvency and financial ability to pay as may be required by such insurance commissioner or workers' compensation commissioner. A political subdivision, including a city, county, community college, or school corporation, that is self-insured for workers' compensation is not required to submit a plan or program to the insurance commissioner for review and approval.

Sec. 2. Section 505.11, Code 2001, is amended to read as follows:

505.11 *REFUNDS.*

Whenever it appears to the satisfaction of the commissioner of insurance that because of error, mistake, or erroneous interpretation of statute that a foreign or domestic insurance corporation has paid to the state of Iowa taxes, fines, penalties, or license fees in excess of the amount legally chargeable against it, the commissioner of insurance shall have power to refund to such corporation any such excess by applying the amount ~~thereof~~ of the excess payment toward the payment of taxes, fines, penalties, or license fees already due or which may ~~hereafter~~ become due, until such excess payments have been fully refunded. ~~The commissioner shall certify to the department of revenue and finance the amount of~~

~~any-such-credit-to-be-applied-to-future-taxes-due-and-notify the-insurance-company-affected-of-the-amount-thereof.~~

Sec. 3. Section 507.10, subsection 2, Code 2001, is amended to read as follows:

2. FILING OF EXAMINATION REPORT. No later than sixty days following completion of the examination, the examiner in charge shall file with the division a verified written report of examination ~~under-oath~~. Upon receipt of the verified report and after administrative review, the division shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

Sec. 4. Section 507A.4, subsection 7, Code 2001, is amended by striking the subsection.

Sec. 5. Section 507B.4, subsection 9, paragraph f, Code 2001, is amended to read as follows:

f. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear, or failing to include interest on the payment of claims when required under section 511.38 or subsection 10B.

Sec. 6. Section 507B.4, subsection 9, Code 2001, is amended by adding the following new paragraph:

NEW PARAGRAPH. o. Failing to comply with the procedures for auditing claims submitted by health care providers as set forth by rule of the commissioner. However, this paragraph shall have no applicability to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 7. Section 507B.4, Code 2001, is amended by adding the following new subsection:

NEW SUBSECTION. 10B. PAYMENT OF INTEREST. Failure of an

insurer to pay interest at the rate of ten percent per annum on all health insurance claims that the insurer fails to timely accept and pay pursuant to section 507B.4A, subsection 1, paragraph "e". Interest shall accrue commencing on the thirty-first day after receipt of all properly completed proof of loss forms.

For purposes of this subsection, "insurer" means an entity providing a plan of health insurance, health care benefits, or health care services, or an entity subject to the jurisdiction of the commissioner performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the department of public health, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. However, "insurer" does not include an entity that sells disability income or long-term care insurance.

Sec. 8. NEW SECTION. 507B.4A DUTY TO RESPOND TO INQUIRIES AND PROMPT PAYMENT OF CLAIM.

1. A person shall promptly respond to inquiries from the commissioner.

a. A person's actions are deemed untimely under this subsection if the person fails to respond to an inquiry from the commissioner within thirty days of the receipt of the inquiry, unless good cause exists for delay.

b. Failure to respond to inquiries from the commissioner pursuant to this subsection with such frequency as to indicate a general business practice shall subject the person to penalty under this chapter.

2. a. An insurer providing accident and sickness insurance under chapter 509, 514, or 514A; a health maintenance organization; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by

the department of public health; or another entity providing health insurance or health benefits subject to state insurance regulation shall either accept and pay or deny a clean claim.

b. For purposes of this subsection, "clean claim" means a properly completed paper or electronic billing instrument containing all reasonably necessary information, that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

c. The commissioner shall adopt rules establishing processes for timely adjudication and payment of claims by insurers for health care benefits. The rules shall be consistent with the time frames and other procedural standards for claims decisions by group health plans established by the United States department of labor pursuant to 29 C.F.R. pt. 2560 in effect at the time of passage of this Act.

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

e. This subsection shall not apply to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 9. Section 507B.6, subsection 1, Code 2001, is amended to read as follows:

1. Whenever the commissioner ~~shall have reason to believe~~ believes that any ~~such~~ person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in section 507B.4, 507B.4A, or 507B.5 and that a proceeding by the commissioner in respect ~~thereto~~ to such method of

competition or unfair or deceptive act or practice would be ~~to the interest of~~ in the public interest, the commissioner shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing ~~thereon~~ on such charges to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service ~~thereof~~ of such notice.

Sec. 10. Section 507B.7, subsection 1, Code 2001, is amended to read as follows:

1. If, after such hearing, the commissioner ~~shall determine~~ determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings, an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of section 507B.4, 507B.4A, or 507B.5, the commissioner may at the commissioner's discretion order any one or more of the following:

a. Payment of a civil penalty of not more than one thousand dollars for each act or violation, but not to exceed an aggregate of ten thousand dollars, unless the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or 507B.5, in which case the penalty shall be not more than five thousand dollars for each act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any one six-month period. ~~The commissioner shall, if~~ If the commissioner finds ~~the violations~~ that a violation of section 507B.4, 507B.4A, or 507B.5 ~~were~~ was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer.

b. Suspension or revocation of the license of a person as

defined in section 507B.2, subsection 1, if the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or ~~section~~ 507B.5.

c. Payment of interest at the rate of ten percent per annum if the commissioner finds that the insurer failed to pay interest as required under section 507B.4, subsection 10B.

Sec. 11. Section 507B.12, unnumbered paragraph 1, Code 2001, is amended to read as follows:

The commissioner may, after notice and hearing, promulgate reasonable rules, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by section 507B.4, 507B.4A, or 507B.5, but the rules shall not enlarge upon or extend the provisions of such sections. Such rules shall be subject to review in accordance with chapter 17A.

Sec. 12. Section 511.4, Code 2001, is amended to read as follows:

511.4 ADVERTISEMENTS -- WHO DEEMED AGENT.

The provisions of sections ~~515.122~~ 515.123 to 515.126 shall apply to life insurance companies and associations.

Sec. 13. Section 513B.2, subsections 3 and 20, Code 2001, are amended to read as follows:

3. "Basic health benefit plan" means a plan ~~which is offered~~ established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

20. "Standard health benefit plan" means a plan ~~which is offered~~ established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

Sec. 14. Section 513B.4, subsection 1, paragraphs d and e, Code 2001, are amended by striking the paragraphs.

Sec. 15. Section 513B.4, subsection 2, Code 2001, is amended by striking the subsection.

Sec. 16. Section 513B.10, subsection 1, paragraph a, Code

2001, is amended to read as follows:

a. A carrier or an organized delivery system that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter. ~~A carrier or organized delivery system shall offer health insurance coverage which constitutes a basic health benefit plan and which constitutes a standard health benefit plan.~~

Sec. 17. Section 513B.10, subsection 3, Code 2001, is amended by striking the subsection.

Sec. 18. Section 513B.13, subsection 3, paragraph c, Code 2001, is amended by striking the paragraph.

Sec. 19. Section 513B.13, subsection 3, paragraph d, Code 2001, is amended to read as follows:

d. ~~Subsequent members~~ Members shall be appointed for terms of three years. A board member's term shall continue until the member's successor is appointed.

Sec. 20. Section 513B.13, subsections 4 and 5, Code 2001, are amended to read as follows:

4. The board~~, within one hundred eighty days after the initial appointments, shall~~ may submit a plan of operation to the commissioner. The commissioner, after notice and hearing, may approve ~~the~~ a plan of operation if the commissioner determines that the plan is suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains and losses on an equitable and proportionate basis in accordance with the provisions of this section. ~~The~~ A plan of operation is effective upon written approval of the commissioner. ~~After the initial plan of operation is submitted and approved by the~~

~~commissioner,-the~~

5. The board may submit to the commissioner any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The amendments shall be effective upon the written approval of the commissioner.

~~5.--If-the-board-fails-to-submit-a-plan-of-operation-within one-hundred-eighty-days-after-the-board's-appointment,-the commissioner,-after-notice-and-hearing,-shall-establish-and adopt-a-temporary-plan-of-operation.--The-commissioner-shall amend-or-rescind-a-plan-adopted-pursuant-to-this-subsection-at the-time-a-plan-is-submitted-by-the-board-and-approved-by-the commissioner.~~

Sec. 21. Section 513B.13, subsection 8, paragraph a, Code 2001, is amended to read as follows:

~~a. With-respect-to-a-basic-health-benefit-plan-or-a standard-health-benefit-plan,-the-program-shall-reinsure-the level-of-coverage-provided-and,-with-respect-to-other-plans,~~ the The program shall reinsure up to the level of coverage provided in either a basic health benefit plan or standard health benefit plan established by the board.

Sec. 22. Section 513B.13, subsection 13, Code 2001, is amended by striking the subsection.

Sec. 23. Section 514E.1, subsection 15, paragraph a, Code 2001, is amended to read as follows:

a. "Health insurance coverage" means health insurance coverage offered to individuals~~,-but-does-not-include-short-term-limited-duration-insurance~~.

Sec. 24. NEW SECTION. 514J.3A NOTICE.

When a claim is denied in whole or in part based on medical necessity, the carrier or organized delivery system shall provide a notice in writing to the enrollee of the internal appeal mechanism provided under the carrier or organized delivery system's plan or policy.

At the time of a coverage decision, the carrier or

organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

Sec. 25. Section 514J.4, subsection 1, Code 2001, is amended by striking the subsection.

Sec. 26. Section 514J.5, Code 2001, is amended to read as follows:

514J.5 CERTIFICATION OF REQUEST -- ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed or received.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that the proposed or received service or treatment does not meet the definition of medical necessity as defined in the ~~enrollee's evidence of coverage~~ carrier's or organized delivery system's plan or policy.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's ~~contract~~ plan or policy.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the ~~decision~~ certification.

3. The carrier or organized delivery system has three business days to contest ~~the eligibility of the request for external review with the commissioner~~ the commissioner's certification decision. If the commissioner finds that the

request for external review is not eligible for ~~full-review~~ certification, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for ~~full-review~~ certification.

4. If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the carrier or organized delivery system, the commissioner shall notify the carrier or organized delivery system in writing of the reasons for upholding the certification.

Sec. 27. Section 514J.7, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, or within three business days of receipt of the commissioner's denial of the carrier's or organized delivery system's contest of the certification of the request under section 514J.5, subsection 3, whichever is later, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and telephone number of the independent review entity and of the enrollee's and

treating health care provider's right to submit additional information.

c. Notify the selected independent review entity by facsimile that the carrier or organized delivery system has chosen it to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.

d. Provide to the commissioner by facsimile a copy of the notices sent to the enrollee and to the selected independent review entity.

2. The independent review entity, within three business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the enrollee of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner. If the independent review entity does not have a person who is an expert in the treatment of the medical condition under review and certified by the commissioner to conduct an independent review, the independent review entity may either decline the review request or may request from the commissioner additional time to have such an expert certified. The independent review entity shall notify the commissioner by facsimile of its choice between these options within three business days of receipt of the notice from the carrier or organized delivery system. The commissioner shall provide a notice to the enrollee and carrier or organized delivery system of the independent review entity's decision and of the commissioner's decision as to how to proceed with the external review process within three business days of receipt of the independent review entity's decision.

3. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the

independent review entity selected by the carrier or organized delivery system or to the person selected as the reviewer by the independent review entity by notifying the commissioner and carrier or organized delivery system within ten days of the mailing of the notice by the independent review entity. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

4. The carrier or organized delivery system, within fifteen days of the mailing of the notice by the independent review entity, or within three business days of a receipt of notice by the commissioner following an objection by the enrollee, whichever is later, shall do all of the following:

a. Provide to the independent review entity any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

b. Provide to the independent review entity any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

c. Provide to the commissioner a confirmation that the information required in paragraphs "a" and "b" has been provided to the independent review entity, including the date the information was provided.

5. The enrollee, or the enrollee's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the carrier's or organized delivery system's

evidence of coverage, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the ten-day period.

6. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 4. The enrollee or the enrollee's treating health care provider shall provide the requested information to the independent review entity within five days after receipt of the notification requesting additional medical information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the carrier or organized delivery system of this request.

7. The independent review entity shall submit its external review decision as soon as possible, but not later than thirty days from the date the independent review entity received the information required under subsection 4 from the carrier or organized delivery system. The independent review entity, for good cause, may request an extension of time from the commissioner. The independent review entity's external review decision shall be mailed to the enrollee or the treating health care provider acting on behalf of the enrollee, the carrier or organized delivery system, and the commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 28. NEW SECTION. 514J.15 PENALTIES.

A carrier who fails to comply with this chapter or with rules adopted pursuant to this chapter is subject to the penalties provided under chapter 507B.

Sec. 29. Section 515.35, subsection 4, paragraph n, subparagraph (1), Code 2001, is amended to read as follows:

(1) A company organized under this chapter may invest up to ~~two~~ five percent of its admitted assets in securities or property of any kind, without restrictions or limitations except those imposed on business corporations in general.

Sec. 30. Section 515.51, Code 2001, is amended to read as follows:

515.51 POLICIES -- EXECUTION -- REQUIREMENTS.

All policies or contracts of insurance except surety bonds made or entered into by the company may be made either with or without the seal of the company, but shall be subscribed by the president, or such other officer as may be designated by the directors for that purpose, and be attested to by the secretary or the secretary's designee of the company. A group motor vehicle or group homeowners policy shall not be written or delivered within this state unless such policy is an individual policy or contract form.

Sec. 31. Section 515B.1, subsection 2, Code 2001, is amended to read as follows:

2. Mortgage guaranty, financial guaranty, residual value, or other forms of insurance offering protection against investment risks.

Sec. 32. Section 515B.5, subsection 1, paragraph b, Code 2001, is amended to read as follows:

b. Be obligated to pay covered claims subject to a limitation as established by the rights, duties, and obligations under the policy of the insolvent insurer. However, the association is not obligated to pay a claimant an amount in excess of the obligation under the policy of the insolvent insurer, regardless of whether such claim is based

on contract or tort.

Sec. 33. Section 515B.16, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

515B.16 ACTIONS AGAINST THE ASSOCIATION.

Any action against the association shall be brought against the association in the association's own name. The Polk county district court shall have exclusive jurisdiction and venue of such actions. Service of the original notice in actions against the association may be made on any officer of the association or upon the commissioner of insurance on behalf of the association. The commissioner shall promptly transmit any notice so served upon the commissioner to the association.

Sec. 34. NEW SECTION. 515F.4A REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGED.

Benefits provided by credit personal property insurance shall be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than fifty percent or such lower loss ratio as designated by the commissioner to afford a reasonable allowance for actual and expected loss experience including a reasonable catastrophe provision, general and administrative expenses, reasonable acquisition expenses, reasonable creditor compensation, investment income, premium taxes, licenses, fees, assessments, and reasonable insurer profit.

Sec. 35. Section 518.23, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A

post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded to the insured upon the surrender of the policy to the association at its home office.

Sec. 36. Section 518A.29, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded upon the surrender of the policy to the association at its home office.

Sec. 37. Section 515.122, Code 2001, is repealed.

Sec. 38. Sections 432.12, 513B.14, 513B.16, 513B.17A, 513B.18, and 513B.31 through 513B.43, Code 2001, are repealed.

Sec. 39. EFFECTIVE DATE. Sections 4, 7 through 11, 13 through 22, 34, and 38 of this Act take effect January 1, 2002.

SENATE FILE 500

AN ACT

RELATING TO INSURANCE, BY ADDRESSING THE OPERATION AND REGULATION OF INSURANCE COMPANIES, MUTUAL INSURANCE ASSOCIATIONS, THE IOWA INSURANCE GUARANTY ASSOCIATION, AND OTHER INSURANCE OR RISK-ASSUMING ENTITIES, INCLUDING THE RIGHTS AND DUTIES OF SUCH ENTITIES AND THE POWERS AND AUTHORITY OF THE INSURANCE COMMISSIONER; BY ESTABLISHING JURISDICTION AND VENUE REQUIREMENTS FOR ACTIONS AGAINST THE IOWA INSURANCE GUARANTY ASSOCIATION; AND PROVIDING PENALTIES, REPEALS, AND EFFECTIVE DATES.

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

Section 1. Section 87.11, unnumbered paragraph 1, Code 2001, is amended to read as follows:

When an employer coming under this chapter furnishes satisfactory proofs to the insurance commissioner of such employer's solvency and financial ability to pay the compensation and benefits as by law provided and to make such payments to the parties when entitled thereto, or when such employer deposits with the insurance commissioner security satisfactory to the insurance commissioner and the workers' compensation commissioner as guaranty for the payment of such compensation, such employer shall be relieved of the provisions of this chapter requiring insurance; but such employer shall, from time to time, furnish such additional proof of solvency and financial ability to pay as may be required by such insurance commissioner or workers' compensation commissioner. A political subdivision, including a city, county, community college, or school corporation, that is self-insured for workers' compensation is not required to submit a plan or program to the insurance commissioner for review and approval.

Sec. 2. Section 505.11, Code 2001, is amended to read as follows:

505.11 REFUNDS.

Whenever it appears to the satisfaction of the commissioner of insurance that because of error, mistake, or erroneous interpretation of statute that a foreign or domestic insurance corporation has paid to the state of Iowa taxes, fines, penalties, or license fees in excess of the amount legally chargeable against it, the commissioner of insurance shall have power to refund to such corporation any such excess by applying the amount thereof of the excess payment toward the payment of taxes, fines, penalties, or license fees already due or which may hereafter become due, until such excess payments have been fully refunded. ~~The commissioner shall certify to the department of revenue and finance the amount of any such credit to be applied to future taxes due and notify the insurance company affected of the amount thereof.~~

Sec. 3. Section 507.10, subsection 2, Code 2001, is amended to read as follows:

2. FILING OF EXAMINATION REPORT. No later than sixty days following completion of the examination, the examiner in charge shall file with the division a verified written report of examination under oath. Upon receipt of the verified report and after administrative review, the division shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty days to make a written submission or rebuttal with respect to any matters contained in the examination report.

Sec. 4. Section 507A.4, subsection 7, Code 2001, is amended by striking the subsection.

Sec. 5. Section 507B.4, subsection 9, paragraph f, Code 2001, is amended to read as follows:

f. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability

has become reasonably clear, or failing to include interest on the payment of claims when required under section 511.38 or subsection 10B.

Sec. 6. Section 507B.4, subsection 9, Code 2001, is amended by adding the following new paragraph:

NEW PARAGRAPH. o. Failing to comply with the procedures for auditing claims submitted by health care providers as set forth by rule of the commissioner. However, this paragraph shall have no applicability to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 7. Section 507B.4, Code 2001, is amended by adding the following new subsection:

NEW SUBSECTION. 10B. PAYMENT OF INTEREST. Failure of an insurer to pay interest at the rate of ten percent per annum on all health insurance claims that the insurer fails to timely accept and pay pursuant to section 507B.4A, subsection 1, paragraph "e". Interest shall accrue commencing on the thirty-first day after receipt of all properly completed proof of loss forms.

For purposes of this subsection, "insurer" means an entity providing a plan of health insurance, health care benefits, or health care services, or an entity subject to the jurisdiction of the commissioner performing utilization review, including an insurance company offering sickness and accident plans, a health maintenance organization, an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the department of public health, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. However, "insurer" does not include an entity that sells disability income or long-term care insurance.

Sec. 8. NEW SECTION. 507B.4A DUTY TO RESPOND TO INQUIRIES AND PROMPT PAYMENT OF CLAIM.

1. A person shall promptly respond to inquiries from the commissioner.

a. A person's actions are deemed untimely under this subsection if the person fails to respond to an inquiry from the commissioner within thirty days of the receipt of the inquiry, unless good cause exists for delay.

b. Failure to respond to inquiries from the commissioner pursuant to this subsection with such frequency as to indicate a general business practice shall subject the person to penalty under this chapter.

2. a. An insurer providing accident and sickness insurance under chapter 509, 514, or 514A; a health maintenance organization; an organized delivery system authorized under 1993 Iowa Acts, chapter 158, and licensed by the department of public health; or another entity providing health insurance or health benefits subject to state insurance regulation shall either accept and pay or deny a clean claim.

b. For purposes of this subsection, "clean claim" means a properly completed paper or electronic billing instrument containing all reasonably necessary information, that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

c. The commissioner shall adopt rules establishing processes for timely adjudication and payment of claims by insurers for health care benefits. The rules shall be consistent with the time frames and other procedural standards for claims decisions by group health plans established by the United States department of labor pursuant to 29 C.F.R. pt. 2560 in effect at the time of passage of this Act.

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

e. This subsection shall not apply to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 9. Section 507B.6, subsection 1, Code 2001, is amended to read as follows:

1. Whenever the commissioner ~~shall have reason to believe~~ believes that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice whether or not defined in section 507B.4, 507B.4A, or 507B.5 and that a proceeding by the commissioner in respect thereto to such method of competition or unfair or deceptive act or practice would be to ~~the interest of~~ in the public interest, the commissioner shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon on such charges to be held at a time and place fixed in the notice, which shall not be less than ten days after the date of the service thereof of such notice.

Sec. 10. Section 507B.7, subsection 1, Code 2001, is amended to read as follows:

1. If, after such hearing, the commissioner ~~shall determine~~ determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of such findings, an order requiring such person to cease and desist from engaging in such method of competition, act or practice and if the act or practice is a violation of section 507B.4, 507B.4A, or 507B.5,

the commissioner may at the commissioner's discretion order any one or more of the following:

a. Payment of a civil penalty of not more than one thousand dollars for each act or violation, but not to exceed an aggregate of ten thousand dollars, unless the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or 507B.5, in which case the penalty shall be not more than five thousand dollars for each act or violation, but not to exceed an aggregate penalty of fifty thousand dollars in any one six-month period. ~~The commissioner shall, if~~ If the commissioner finds the ~~violations~~ that a violation of section 507B.4, 507B.4A, or 507B.5 ~~were~~ was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer.

b. Suspension or revocation of the license of a person as defined in section 507B.2, subsection 1, if the person knew or reasonably should have known the person was in violation of section 507B.4, 507B.4A, or section 507B.5.

c. Payment of interest at the rate of ten percent per annum if the commissioner finds that the insurer failed to pay interest as required under section 507B.4, subsection 10B.

Sec. 11. Section 507B.12, unnumbered paragraph 1, Code 2001, is amended to read as follows:

The commissioner may, after notice and hearing, promulgate reasonable rules, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by section 507B.4, 507B.4A, or 507B.5, but the rules shall not enlarge upon or extend the provisions of such sections. Such rules shall be subject to review in accordance with chapter 17A.

Sec. 12. Section 511.4, Code 2001, is amended to read as fo.lows:

511.4 ADVERTISEMENTS -- WHO DEEMED AGENT.

The provisions of sections ~~515.122~~ 515.123 to 515.126 shall apply to life insurance companies and associations.

Sec. 13. Section 513B.2, subsections 3 and 20, Code 2001, are amended to read as follows:

3. "Basic health benefit plan" means a plan which-is offered established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

20. "Standard health benefit plan" means a plan which-is offered established by the board of the small employer health reinsurance program pursuant to section ~~513B.14~~ 513B.13, subsection 8, paragraph "a".

Sec. 14. Section 513B.4, subsection 1, paragraphs d and e, Code 2001, are amended by striking the paragraphs.

Sec. 15. Section 513B.4, subsection 2, Code 2001, is amended by striking the subsection.

Sec. 16. Section 513B.10, subsection 1, paragraph a, Code 2001, is amended to read as follows:

a. A carrier or an organized delivery system that offers health insurance coverage in the small group market shall accept every small employer that applies for health insurance coverage and shall accept for enrollment under such coverage every eligible individual who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the health insurance coverage and shall not place any restriction which is inconsistent with eligibility rules established under this chapter. A-carrier or-organized-delivery-system-shall-offer-health-insurance coverage-which-constitutes-a-basic-health-benefit-plan-and which-constitutes-a-standard-health-benefit-plan.

Sec. 17. Section 513B.10, subsection 3, Code 2001, is amended by striking the subsection.

Sec. 18. Section 513B.13, subsection 3, paragraph c, Code 2001, is amended by striking the paragraph.

Sec. 19. Section 513B.13, subsection 3, paragraph d, Code 2001, is amended to read as follows:

d. Subsequent-members Members shall be appointed for terms of three years. A board member's term shall continue until the member's successor is appointed.

Sec. 20. Section 513B.13, subsections 4 and 5, Code 2001, are amended to read as follows:

4. The board,-within-one-hundred-eighty-days-after-the initial-appointments,-shall may submit a plan of operation to the commissioner. The commissioner, after notice and hearing, may approve the a plan of operation if the commissioner determines that the plan is suitable to assure the fair, reasonable, and equitable administration of the program, and provides for the sharing of program gains and losses on an equitable and proportionate basis in accordance with the provisions of this section. The A plan of operation is effective upon written approval of the commissioner. After the-initial-plan-of-operation-is-submitted-and-approved-by-the commissioner,-the

5. The board may submit to the commissioner any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the program. The amendments shall be effective upon the written approval of the commissioner.

5.--If-the-board-fails-to-submit-a-plan-of-operation-within one-hundred-eighty-days-after-the-board's-appointment,-the commissioner,-after-notice-and-hearing,-shall-establish-and adopt-a-temporary-plan-of-operation.--The-commissioner-shall amend-or-rescind-a-plan-adopted-pursuant-to-this-subsection-at the-time-a-plan-is-submitted-by-the-board-and-approved-by-the commissioner.

Sec. 21. Section 513B.13, subsection 8, paragraph a, Code 2001, is amended to read as follows:

a. With-respect-to-a-basic-health-benefit-plan-or-a standard-health-benefit-plan,-the-program-shall-reinsure-the

~~level-of-coverage-provided-and,-with-respect-to-other-plans,~~ the The program shall reinsure up to the level of coverage provided in either a basic health benefit plan or standard health benefit plan established by the board.

Sec. 22. Section 513B.13, subsection 13, Code 2001, is amended by striking the subsection.

Sec. 23. Section 514E.1, subsection 15, paragraph a, Code 2001, is amended to read as follows:

a. "Health insurance coverage" means health insurance coverage offered to individuals~~,-but-does-not-include-short-term-limited-duration-insurance~~.

Sec. 24. NEW SECTION. 514J.3A NOTICE.

When a claim is denied in whole or in part based on medical necessity, the carrier or organized delivery system shall provide a notice in writing to the enrollee of the internal appeal mechanism provided under the carrier or organized delivery system's plan or policy.

At the time of a coverage decision, the carrier or organized delivery system shall notify the enrollee in writing of the right to have the coverage decision reviewed under the external review process.

Sec. 25. Section 514J.4, subsection 1, Code 2001, is amended by striking the subsection.

Sec. 26. Section 514J.5, Code 2001, is amended to read as follows:

514J.5 CERTIFICATION OF REQUEST -- ELIGIBILITY.

1. The commissioner shall have two business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria are satisfied:

a. The enrollee was covered by the carrier or organized delivery system at the time the service or treatment was proposed or received.

b. The enrollee has been denied coverage based on a determination by the carrier or organized delivery system that

the proposed or received service or treatment does not meet the definition of medical necessity as defined in the ~~enrollee's-evidence-of-coverage~~ carrier's or organized delivery system's plan or policy.

c. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, has exhausted all internal appeal mechanisms provided under the carrier's or the organized delivery system's ~~contract~~ plan or policy.

d. The written request for external review was filed within sixty days of receipt of the coverage decision.

2. The commissioner shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, and the carrier or organized delivery system in writing of the ~~decision~~ certification.

3. The carrier or organized delivery system has three business days to contest ~~the-eligibility-of-the-request-for-external-review-with-the-commissioner~~ the commissioner's certification decision. If the commissioner finds that the request for external review is not eligible for full-review certification, the commissioner, within two business days, shall notify the enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, in writing of the reasons that the request for external review is not eligible for full-review certification.

4. If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the carrier or organized delivery system, the commissioner shall notify the carrier or organized delivery system in writing of the reasons for upholding the certification.

Sec. 27. Section 514J.7, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

514J.7 EXTERNAL REVIEW.

The external review process shall meet the following criteria:

1. The carrier or organized delivery system, within three business days of a receipt of an eligible request for an external review from the commissioner, or within three business days of receipt of the commissioner's denial of the carrier's or organized delivery system's contest of the certification of the request under section 514J.5, subsection 3, whichever is later, shall do all of the following:

a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the carrier or organized delivery system, or owned or controlled by a trade association of carriers or organized delivery systems of which the carrier or organized delivery system is a member.

b. Notify the enrollee, and the enrollee's treating health care provider, of the name, address, and telephone number of the independent review entity and of the enrollee's and treating health care provider's right to submit additional information.

c. Notify the selected independent review entity by facsimile that the carrier or organized delivery system has chosen it to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.

d. Provide to the commissioner by facsimile a copy of the notices sent to the enrollee and to the selected independent review entity.

2. The independent review entity, within three business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the enrollee of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A

copy of the notice shall be sent by facsimile to the commissioner. If the independent review entity does not have a person who is an expert in the treatment of the medical condition under review and certified by the commissioner to conduct an independent review, the independent review entity may either decline the review request or may request from the commissioner additional time to have such an expert certified. The independent review entity shall notify the commissioner by facsimile of its choice between these options within three business days of receipt of the notice from the carrier or organized delivery system. The commissioner shall provide a notice to the enrollee and carrier or organized delivery system of the independent review entity's decision and of the commissioner's decision as to how to proceed with the external review process within three business days of receipt of the independent review entity's decision.

3. The enrollee, or the enrollee's treating health care provider acting on behalf of the enrollee, may object to the independent review entity selected by the carrier or organized delivery system or to the person selected as the reviewer by the independent review entity by notifying the commissioner and carrier or organized delivery system within ten days of the mailing of the notice by the independent review entity. The commissioner shall have two business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the enrollee, the enrollee's treating health care provider, and the carrier or organized delivery system.

4. The carrier or organized delivery system, within fifteen days of the mailing of the notice by the independent review entity, or within three business days of a receipt of notice by the commissioner following an objection by the enrollee, whichever is later, shall do all of the following:

a. Provide to the independent review entity any information submitted to the carrier or organized delivery system by the enrollee or the enrollee's treating health care provider in support of the request for coverage of a service or treatment under the carrier's or organized delivery system's appeal procedures.

b. Provide to the independent review entity any other relevant documents used by the carrier or organized delivery system in determining whether the proposed service or treatment should have been provided.

c. Provide to the commissioner a confirmation that the information required in paragraphs "a" and "b" has been provided to the independent review entity, including the date the information was provided.

5. The enrollee, or the enrollee's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the carrier's or organized delivery system's evidence of coverage, and other newly discovered relevant information. The enrollee shall have ten business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the ten-day period.

6. The independent review entity shall notify the enrollee and the enrollee's treating health care provider of any additional medical information required to conduct the review within five business days of receipt of the documentation required under subsection 4. The enrollee or the enrollee's treating health care provider shall provide the requested information to the independent review entity within five days after receipt of the notification requesting additional medical information. The independent review entity may

reasonably decide whether to consider any information provided by the enrollee or the enrollee's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the carrier or organized delivery system of this request.

7. The independent review entity shall submit its external review decision as soon as possible, but not later than thirty days from the date the independent review entity received the information required under subsection 4 from the carrier or organized delivery system. The independent review entity, for good cause, may request an extension of time from the commissioner. The independent review entity's external review decision shall be mailed to the enrollee or the treating health care provider acting on behalf of the enrollee, the carrier or organized delivery system, and the commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

Sec. 28. NEW SECTION. 514J.15 PENALTIES.

A carrier who fails to comply with this chapter or with rules adopted pursuant to this chapter is subject to the penalties provided under chapter 507B.

Sec. 29. Section 515.35, subsection 4, paragraph n, subparagraph (1), Code 2001, is amended to read as follows:

(1) A company organized under this chapter may invest up to two five percent of its admitted assets in securities or property of any kind, without restrictions or limitations except those imposed on business corporations in general.

Sec. 30. Section 515.51, Code 2001, is amended to read as follows:

515.51 POLICIES -- EXECUTION -- REQUIREMENTS.

All policies or contracts of insurance except surety bonds made or entered into by the company may be made either with or without the seal of the company, but shall be subscribed by the president, or such other officer as may be designated by

the directors for that purpose, and be attested to by the secretary or the secretary's designee of the company. A group motor vehicle or group homeowners policy shall not be written or delivered within this state unless such policy is an individual policy or contract form.

Sec. 31. Section 515B.1, subsection 2, Code 2001, is amended to read as follows:

2. Mortgage guaranty, financial guaranty, residual value, or other forms of insurance offering protection against investment risks.

Sec. 32. Section 515B.5, subsection 1, paragraph b, Code 2001, is amended to read as follows:

b. Be obligated to pay covered claims subject to a limitation as established by the rights, duties, and obligations under the policy of the insolvent insurer. However, the association is not obligated to pay a claimant an amount in excess of the obligation under the policy of the insolvent insurer, regardless of whether such claim is based on contract or tort.

Sec. 33. Section 515B.16, Code 2001, is amended by striking the section and inserting in lieu thereof the following:

515B.16 ACTIONS AGAINST THE ASSOCIATION.

Any action against the association shall be brought against the association in the association's own name. The Polk county district court shall have exclusive jurisdiction and venue of such actions. Service of the original notice in actions against the association may be made on any officer of the association or upon the commissioner of insurance on behalf of the association. The commissioner shall promptly transmit any notice so served upon the commissioner to the association.

Sec. 34. NEW SECTION. 515F.4A REASONABLENESS OF BENEFITS IN RELATION TO PREMIUM CHARGED.

Benefits provided by credit personal property insurance shall be reasonable in relation to the premium charged. This requirement is satisfied if the premium rate charged develops or may reasonably be expected to develop a loss ratio of not less than fifty percent or such lower loss ratio as designated by the commissioner to afford a reasonable allowance for actual and expected loss experience including a reasonable catastrophe provision, general and administrative expenses, reasonable acquisition expenses, reasonable creditor compensation, investment income, premium taxes, licenses, fees, assessments, and reasonable insurer profit.

Sec. 35. Section 518.23, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of such notice mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded to the insured upon the surrender of the policy to the association at its home office.

Sec. 36. Section 518A.29, subsection 4, Code 2001, is amended to read as follows:

4. NOTICE. Service of notice under subsection 2 or 3 may be ~~made in person, or by mailing such notice by certified mail deposited in the post office and directed~~ delivered in person or mailed to the insured at the insured's post office address as given in or upon the policy, or to such other address as the insured shall have given to the association in writing. A post office department ~~receipt of certified or registered mail~~ certificate of mailing shall be deemed proof of receipt of

such ~~notice~~ mailing. If in either case the cash payments exceed the amount properly chargeable, the excess shall be refunded upon the surrender of the policy to the association at its home office.

Sec. 37. Section 515.122, Code 2001, is repealed.

Sec. 38. Sections 432.12, 513B.14, 513B.16, 513B.17A, 513B.18, and 513B.31 through 513B.43, Code 2001, are repealed.

Sec. 39. EFFECTIVE DATE. Sections 4, 7 through 11, 13 through 22, 34, and 38 of this Act take effect January 1, 2002.

MARY E. KRAMER
President of the Senate

BRENT SIEGRIST
Speaker of the House

I hereby certify that this bill originated in the Senate and is known as Senate File 500, Seventy-ninth General Assembly.

MICHAEL E. MARSHALL
Secretary of the Senate

Approved 4/24, 2001

THOMAS J. VILSACK
Governor