Senate File 2306 - Introduced

SENATE FILE ______
BY COMMITTEE ON COMMERCE

(SUCCESSOR TO SSB 3173)

Passed Senate, Date ____________ Passed House, Date ____________
Vote: Ayes ______ Nays _______ Vote: Ayes ______ Nays ________
Approved ____________________________

A BILL FOR

1 An Act relating to long=term care insurance, and providing for
2 penalties, an applicability date, repeals, and an
3 appropriation and providing an effective date.
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:
5 TLSB 5433SV 82
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1 1 Section 1. Section 505.8, Code Supplement 2007, is amended
1 2 by adding the following new subsection:
1 3 NEW SUBSECTION. 15. The commissioner shall utilize the
1 4 senior health insurance information program to assist in the
1 5 dissemination of objective and noncommercial educational
1 6 material and to raise awareness of prudent consumer choices in
1 7 considering the purchase of various insurance products
1 8 designed for the health care needs of older Iowans.
1 9 Sec. 2. NEW SECTION. 514G.101 TITLE AND PURPOSE.
1 10 This chapter may be known and cited as the "Long=term Care
1 11 Insurance Act". The purpose of this chapter is to promote the
1 12 public interest, to promote the availability of long=term care
1 13 insurance, to protect applicants for long=term care insurance
1 14 from unfair or deceptive sales or enrollment practices, to
1 15 establish standards for long=term care insurance, to
1 16 facilitate public understanding and comparison of long=term
1 17 care insurance policies, and to facilitate flexibility and
1 18 innovation in the development of long=term care insurance
1 19 coverage.
1 20 Sec. 3. NEW SECTION. 514G.102 SCOPE.
1 21 The requirements of this chapter apply to policies
1 22 delivered or issued for delivery in this state on or after
1 23 July 1, 2008. This chapter is not intended to supersede the
1 24 obligations of entities subject to this chapter to comply with
1 25 the substance of other applicable insurance laws not in
1 26 conflict with this chapter, except that laws and regulations
1 27 designed and intended to apply to Medicare supplement
1 28 insurance policies shall not be applied to long=term care
1 29 insurance.
1 30 Sec. 4. NEW SECTION. 514G.103 DEFINITIONS.
1 31 As used in this chapter, unless the context requires
1 32 otherwise:
1 33 1. "Activities of daily living" means at least bathing,
1 34 continence, dressing, eating, toileting, and transferring.
1 35 2. "Applicant" means either of the following:
2 1 a. In the case of an individual long=term care insurance
2 2 policy, the person who seeks to contract for benefits.
2 3 b. In the case of a group long=term care insurance policy,
2 4 the proposed certificate holder.
2 5 3. "Benefit trigger" means a contractual provision in a
2 6 policy of long=term care insurance that conditions the payment
2 7 of benefits on a determination of the insured's ability to
2 8 perform activities of daily living and on cognitive
2 9 impairment, or on other conditions of the insured as specified
2 10 in the policy. For purposes of a qualified long=term care
2 11 insurance contract, "benefit trigger" means a determination by
2 12 a licensed health care practitioner that an insured is a
2 13 chronically ill individual. For purposes of this definition,
2 14 "licensed health care practitioner" means the same as defined
2 15 in section 7702B(c)(4) of the Internal Revenue Code.
2 16 4. "Certificate" means any certificate issued under a
2 17 group long=term care insurance policy, which policy has been

2 18 delivered or issued for delivery in this state.
2 19 5. "Chronically ill individual" means the same as defined
2 20 in section 7702B(c)(2) of the Internal Revenue Code.
2 21 6. "Claim" means a request for payment of benefits under
2 22 an in=force long=term care insurance policy, regardless of
2 23 whether the benefit claimed is covered under the policy or any
2 24 terms or conditions of the policy have been met.
2 25 7. "Cognitive impairment" means a deficiency in a person's
2 26 short=term or long=term memory; orientation as to person,
2 27 place, and time; deductive or abstract reasoning; or judgment
2 28 as it relates to safety awareness.
2 29 8. "Commissioner" means the commissioner of insurance.
2 30 9. "Group long=term care insurance" means a long=term care
2 31 insurance policy that is delivered or issued for delivery in
2 32 this state to any of the following:
2 33 a. One or more employers or labor organizations, or to a
2 34 trust or to the trustee or trustees of a fund established,
2 35 created, or maintained by one or more employers or labor
3 1 organizations or a combination thereof, for the benefit of
3 2 employees or former employees or a combination thereof, or for
3 3 members or former members or a combination thereof, of the
3 4 employers or labor organizations.
3 5 b. Any professional, trade, or occupational association
3 6 for its members or former or retired members, or a combination
3 7 thereof, if the association meets both of the following
3 8 requirements:
3 9 (1) Is composed of individuals all of whom are or were
3 10 actively engaged in the same profession, trade, or occupation.
3 11 (2) Has been maintained in good faith for purposes other
3 12 than obtaining insurance.
3 13 c. An association or associations, or to a trust or to the
3 14 trustee or trustees of a fund established, created, or
3 15 maintained for the benefit of members of one or more
3 16 associations, which files evidence with the commissioner prior
3 17 to advertising, marketing, or offering a policy within this
3 18 state by the association or associations, or their insurer,
3 19 that the following organizational requirements have been met:
3 20 (1) At the outset, there are a minimum of one hundred
3 21 members of the association or associations.
3 22 (2) The association or associations have been organized
3 23 and maintained in good faith for purposes other than that of
3 24 obtaining insurance.
3 25 (3) The association or associations have been in active
3 26 existence for at least one year at the time of filing.
3 27 (4) The association or associations have a constitution
3 28 and bylaws that require all of the following:
3 29 (a) The association or associations have regular meetings,
3 30 not less than annually, to further the purposes of the
3 31 members.
3 32 (b) Except for credit unions, the association or
3 33 associations collect dues or solicit contributions from
3 34 members.
3 35 (c) The members have voting privileges and representation
4 1 on a governing board and committees.
4 2 Thirty days after the required evidentiary filings have
4 3 been made, the association or associations shall be deemed to
4 4 satisfy the organizational requirements, unless the
4 5 commissioner makes a finding that the association or
4 6 associations do not satisfy those requirements.
4 7 d. A group other than those described in paragraphs "a"
4 8 through "c", subject to a finding by the commissioner that all
4 9 of the following are true:
4 10 (1) The issuance of the group policy is not contrary to
4 11 the best interests of the public.
4 12 (2) The issuance of the group policy would result in
4 13 economies of acquisition or administration.
4 14 (3) The benefits are reasonable in relation to the
4 15 premiums charged.
4 16 10. "Independent review entity" means a review entity
4 17 certified by the commissioner pursuant to section 514G.110,
4 18 subsection 5.
4 19 11. "Insurer" means an entity qualified and licensed by
4 20 the insurance division to transact the business of insurance
4 21 in this state by a certificate issued pursuant to chapter 508,
4 22 512B, 514, or 514B.
4 23 12. "Licensed health care professional" means a qualified
4 24 professional in an appropriate field for determining an
4 25 insured's functional or cognitive impairment as it relates to
4 26 the insured's specific diagnosis. Licensed health care
4 27 professionals include but are not limited to physical
4 28 therapists, occupational therapists, neurologists, physical

4 29 medicine specialists, and rehabilitation medicine specialists.
4 30   13. "Long=term care insurance" means any insurance policy
4 31 or rider advertised, marketed, offered, or designed to provide
4 32 coverage for not less than twelve consecutive months for each
4 33 covered person on an expense=incurred, indemnity, prepaid, or
4 34 other basis, for one or more necessary or medically necessary
4 35 diagnostic, preventive, therapeutic, rehabilitative,
5 1 maintenance, or personal care services that are provided in a
5 2 setting other than an acute care unit of a hospital.
5 3 "Long=term care insurance" includes group and individual
5 4 annuities and life insurance policies or riders that directly
5 5 provide or supplement long=term care insurance. The term also
5 6 includes a policy or rider that provides for payment of
5 7 benefits based upon cognitive impairment or the loss of
5 8 functional capacity. The term also includes a qualified
5 9 long=term care insurance contract. Long=term care insurance
5 10 may be issued by an insurer. "Long=term care insurance" does
5 11 not include any insurance policy that is offered primarily to
5 12 provide basic Medicare supplement coverage, basic hospital
5 13 expense coverage, basic medical=surgical expense coverage,
5 14 hospital confinement indemnity coverage, major medical expense
5 15 coverage, disability income or related asset=protection
5 16 coverage, accident=only coverage, specified disease or
5 17 specified accident coverage, or limited benefit health
5 18 coverage. With regard to life insurance, "long=term care
5 19 insurance" does not include life insurance policies that
5 20 accelerate the death benefit specifically for one or more of
5 21 the qualifying events of terminal illness, medical conditions
5 22 requiring extraordinary medical intervention or permanent
5 23 institutional confinement, and that provide the option of a
5 24 lump=sum payment for those benefits, where neither the
5 25 benefits nor the eligibility for the benefits is conditioned
5 26 upon the receipt of long=term care. Notwithstanding any other
5 27 provision of this chapter, any product advertised, marketed,
5 28 or offered as long=term care insurance shall be subject to the
5 29 provisions of this chapter.
5 30   14. "Policy" means any policy, contract, subscriber
5 31 agreement, rider, or endorsement delivered or issued for
5 32 delivery in this state by an insurer; fraternal benefit
5 33 society; nonprofit health, hospital, or medical service
5 34 corporation; prepaid health plan; or health maintenance
5 35 organization or any similar organization.
6 1   15. "Preexisting condition" means a condition for which
6 2 medical advice or treatment was recommended by, or received
6 3 from, a provider of health care services within six months
6 4 preceding the effective date of coverage of an individual.
6 5   16. "Qualified long=term care insurance contract" or
6 6 "federally tax=qualified long=term care insurance contract"
6 7 means any of the following:
6 8   a. An individual or group insurance contract that meets
6 9 the requirements of section 7702B(b) of the Internal Revenue
6 10 Code, as follows:
6 11   (1) The only insurance protection provided under the
6 12 contract is coverage of qualified long=term care services. A
6 13 contract does not fail to satisfy the requirements of this
6 14 subparagraph because payments are made on a per diem or other
6 15 periodic basis without regard to the expenses incurred during
6 16 the period to which the payments relate.
6 17   (2) The contract does not pay or reimburse expenses
6 18 incurred for services or items to the extent that the expenses
6 19 are reimbursable under Title XVIII of the federal Social
6 20 Security Act, as amended, or would be reimbursable but for the
6 21 application of a deductible or coinsurance amount. The
6 22 requirements of this subparagraph do not apply to expenses
6 23 that are reimbursable under Title XVIII of the federal Social
6 24 Security Act only as a secondary payor. A contract does not
6 25 fail to satisfy the requirements of this subparagraph because
6 26 payments are made on a per diem or other periodic basis
6 27 without regard to the expenses incurred during the period to
6 28 which the payments relate.
6 29   (3) The contract is guaranteed renewable within the
6 30 meaning of section 7702B(b)(1)(C) of the Internal Revenue
6 31 Code.
6 32   (4) The contract does not provide for a cash surrender
6 33 value or for other money that can be paid, assigned or pledged
6 34 as collateral for a loan, or borrowed except as provided in
6 35 subparagraph (5).
7 1   (5) All refunds of premiums and all policyholder dividends
7 2 or similar accounts under the contract are to be applied as a
7 3 reduction in future premiums or to increase future benefits,
7 4 except that a refund in the event of the death of the insured

7 5 or a complete surrender or cancellation of the contract shall
7 6 not exceed the aggregate premiums paid under the contract.
7 7 (6) The contract meets the consumer protection provisions
7 8 set forth in section 7702B(g) of the Internal Revenue Code.
7 9 b. The portion of a life insurance contract that provides
7 10 long=term care insurance coverage by rider or as part of the
7 11 contract and that satisfies the requirements of section
7 12 7702B(b) and (e) of the Internal Revenue Code.
7 13 Sec. 5. NEW SECTION. 514G.104 EXTRATERRITORIAL
7 14 JURISDICTION == GROUP LONG=TERM CARE INSURANCE.
7 15 Group long=term care insurance coverage shall not be
7 16 offered to a resident of this state under a group policy
7 17 issued in another state unless either this state or another
7 18 state with statutory and regulatory requirements for long=term
7 19 care insurance that are substantially similar to those adopted
7 20 in this state has made a determination that the group to which
7 21 the policy is issued meets the requirements of section
7 22 514G.103, subsection 9.
7 23 Sec. 6. NEW SECTION. 514G.105 DISCLOSURE AND PERFORMANCE
7 24 STANDARDS FOR LONG=TERM CARE INSURANCE.
7 25 1. PROHIBITED POLICY PRACTICES. A long=term care
7 26 insurance policy shall not:
7 27 a. Be canceled, nonrenewed, or otherwise terminated on the
7 28 grounds of the age or deterioration of the mental or physical
7 29 health of the insured individual or certificate holder.
7 30 b. Contain a provision establishing a new waiting period
7 31 in the event that existing coverage is converted to or
7 32 replaced by a new or other policy form within the same
7 33 company, except with respect to an increase in benefits
7 34 voluntarily selected by the insured individual, the
7 35 certificate holder, or the group policyholder.
8 1 c. Provide coverage for skilled nursing care only, or
8 2 provide significantly more coverage for skilled care in a
8 3 facility than coverage for lower levels of care.
8 4 2. PREEXISTING CONDITIONS.
8 5 a. A long=term care insurance policy or certificate, other
8 6 than a policy or certificate issued to a group as described in
8 7 section 514G.103, subsection 9, shall not use a definition of
8 8 "preexisting condition" that is more restrictive than the
8 9 definition contained in section 514G.103, subsection 15.
8 10 b. A long=term care insurance policy or certificate, other
8 11 than a policy or certificate issued to a group as described in
8 12 section 514G.103, subsection 9, shall not exclude coverage for
8 13 a loss or confinement that is the result of a preexisting
8 14 condition unless the loss or confinement begins within six
8 15 months following the effective date of coverage of an insured
8 16 individual.
8 17 c. The commissioner may extend the limitation periods set
8 18 forth in paragraphs "a" and "b" as to specific age group
8 19 categories in specific policy forms upon finding that such an
8 20 extension is in the best interest of the public.
8 21 d. The requirements of paragraph "a" do not prohibit an
8 22 insurer from using an application form designed to elicit the
8 23 complete health history of an applicant, and on the basis of
8 24 the answers on that application, underwriting in accordance
8 25 with that insurer's established underwriting standards.
8 26 Unless otherwise provided in the policy or certificate, a
8 27 preexisting condition, regardless of whether it is disclosed
8 28 on the application, is not required to be covered until the
8 29 waiting period described in paragraph "b" expires. A
8 30 long=term care insurance policy or certificate shall not
8 31 exclude, or use waivers or riders of any kind to exclude,
8 32 limit, or reduce coverage or benefits for specifically named
8 33 or described preexisting diseases or physical conditions
8 34 beyond the waiting period described in paragraph "b".
8 35 3. PRIOR HOSPITALIZATION OR INSTITUTIONALIZATION.
9 1 a. A long=term care insurance policy shall not be
9 2 delivered or issued for delivery in this state if the policy
9 3 does any of the following:
9 4 (1) Conditions eligibility for any benefits on a prior
9 5 hospitalization requirement.
9 6 (2) Conditions eligibility for any benefits provided in an
9 7 institutional care setting on the receipt of a higher level of
9 8 institutional care.
9 9 (3) Conditions eligibility for any benefits other than
9 10 waiver of premium, post=confinement, post=acute care, or
9 11 recuperative benefits on a prior institutionalization
9 12 requirement.
9 13 b. A long=term care insurance policy that contains
9 14 post=confinement, post=acute care, or recuperative benefits
9 15 shall contain, in a clearly visible, separate paragraph or the

9 16 policy or certificate entitled "limitations or conditions on
9 17 eligibility for benefits", a description of such limitations
9 18 or conditions, including any required number of days of
9 19 confinement.
9 20 c. A long=term care insurance policy or rider that
9 21 conditions eligibility for noninstitutional benefits on the
9 22 prior receipt of institutional care shall not require a prior
9 23 institutional stay of more than thirty days.
9 24 d. A long=term care insurance policy or rider that
9 25 provides benefits only following institutionalization shall
9 26 not condition such benefits upon admission to a facility for
9 27 the same or related conditions within a period of less than
9 28 thirty days after discharge from the institution.
9 29 4. RIGHT TO RETURN == FREE LOOK == REFUND.
9 30 a. A long=term care insurance applicant shall have the
9 31 right to return the long=term care insurance policy or
9 32 certificate within thirty days of its delivery and to have the
9 33 premium refunded if, after examination of the policy or
9 34 certificate, the applicant is not satisfied for any reason.
9 35 b. A long=term care insurance policy or certificate
10 1 delivered or issued for delivery in this state shall have a
10 2 notice prominently displayed on the first page of the policy
10 3 or certificate, or attached thereto, which states in substance
10 4 that the applicant has the right to return the policy or
10 5 certificate within thirty days of its delivery and to have the
10 6 premium refunded if, after examination of the policy or
10 7 certificate, other than a certificate issued pursuant to a
10 8 policy issued to a group as described in section 514G.103,
10 9 subsection 9, paragraph "a", the applicant is not satisfied
10 10 for any reason.
10 11 c. Any premium refund shall be made to the applicant
10 12 within thirty days of the return.
10 13 5. DENIALS == REFUND. If an application is denied by an
10 14 insurer, any premium refund shall be made to the applicant
10 15 within thirty days of the denial.
10 16 6. OUTLINE OF COVERAGE.
10 17 a. A written outline of coverage shall be delivered to a
10 18 prospective applicant for long=term care insurance at the time
10 19 of the initial solicitation for coverage which prominently
10 20 directs the attention of the applicant to the document and its
10 21 purpose.
10 22 b. The commissioner shall prescribe, by rule, a standard
10 23 format, including style, arrangement, and overall appearance,
10 24 and content of the outline of coverage.
10 25 c. In the case of producer solicitations, a producer shall
10 26 deliver the outline of coverage to a prospective applicant
10 27 prior to the presentation of an application or enrollment
10 28 form.
10 29 d. In the case of direct response solicitations, the
10 30 outline of coverage shall be presented in conjunction with any
10 31 application or enrollment form.
10 32 e. In the case of a policy issued to a group as described
10 33 in section 514G.103, subsection 9, paragraph "a", an outline
10 34 of coverage is not required to be delivered to the applicant,
10 35 provided that the information described in subsection 7 of
11 1 this section, paragraphs "a" through "f", is contained in
11 2 other enrollment materials provided. Upon request, such other
11 3 enrollment materials shall be made available to the
11 4 commissioner.
11 5 7. CONTENTS OF OUTLINE OF COVERAGE. An outline of
11 6 coverage of long=term care insurance shall include all of the
11 7 following:
11 8 a. A description of the principal benefits and coverage
11 9 provided in the policy.
11 10 b. A statement of the principal exclusions, reductions,
11 11 and limitations contained in the policy.
11 12 c. A statement of the terms under which the policy or
11 13 certificate, or both, may be continued in force or
11 14 discontinued, including any reservation in the policy of a
11 15 right to change the premium. Continuation or conversion
11 16 provisions of group coverage shall be specifically described.
11 17 d. A statement that the outline of coverage is a summary
11 18 of coverage only, not a contract of insurance, and that the
11 19 policy or group master policy contains governing contractual
11 20 provisions.
11 21 e. A description of the terms under which the policy or
11 22 certificate may be returned and the premium refunded.
11 23 f. A brief description of the relationship of cost of care
11 24 and benefits.
11 25 g. A statement that discloses to the policyholder or
11 26 certificate holder whether the policy is intended to be a

11 27 federally tax=qualified long=term care insurance contract
11 28 under section 7702B(b) of the Internal Revenue Code.
11 29 8. CONTENTS OF GROUP CERTIFICATE. A certificate issued
11 30 pursuant to a group long=term care insurance policy which
11 31 policy is delivered or issued for delivery in this state shall
11 32 include all of the following:
11 33 a. A description of the principal benefits and coverage
11 34 provided in the policy.
11 35 b. A statement of the principal exclusions, reductions,
12 1 and limitations contained in the policy.
12 2 c. A statement that the group master policy determines
12 3 governing contractual provisions.
12 4 9. TIME FOR DELIVERY. If an application for a long=term
12 5 care insurance policy or certificate is approved, the issuer
12 6 shall deliver the policy or certificate of insurance to the
12 7 applicant no later than thirty days after the date of
12 8 approval.
12 9 10. INDIVIDUAL LIFE INSURANCE == POLICY SUMMARY.
12 10 a. A written policy summary shall accompany the delivery
12 11 of an individual life insurance policy that provides long=term
12 12 care benefits within the policy or by rider. In the case of
12 13 direct response solicitations, the insurer shall deliver a
12 14 policy summary upon the applicant's request or at the time of
12 15 policy delivery, whichever occurs first.
12 16 b. A policy summary shall include all of the following:
12 17 (1) An explanation of how the long=term care benefit
12 18 interacts with other components of the policy, including
12 19 deductions from death benefits.
12 20 (2) An illustration of the amount of benefits, the length
12 21 of benefits, and the guaranteed lifetime benefits if any, for
12 22 each covered person.
12 23 (3) Any exclusions, reductions, or limitations on
12 24 long=term care benefits.
12 25 (4) A statement that a long=term care inflation protection
12 26 option required by 191 IAC 39.10 is not available under this
12 27 policy.
12 28 (5) If applicable to the policy type, the summary shall
12 29 also include all of the following:
12 30 (a) A disclosure of the effect of exercising other rights
12 31 under the policy.
12 32 (b) A disclosure of guarantees related to long=term care
12 33 costs of insurance charges.
12 34 (c) Current and projected maximum lifetime benefits.
12 35 c. The requirements of a policy summary set forth in
13 1 paragraph "b" may be incorporated into the basic illustration
13 2 required to be delivered in accordance with 191 IAC 14, or
13 3 into the life insurance policy summary required to be
13 4 delivered in accordance with 191 IAC 15.4.
13 5 11. MONTHLY REPORT. If a long=term care benefit, funded
13 6 through a life insurance vehicle by the acceleration of the
13 7 death benefit, is in benefit payment status, a monthly report
13 8 shall be provided to the policyholder. The report shall
13 9 include all of the following:
13 10 a. Any long=term care benefits paid out during the month.
13 11 b. An explanation of any changes in the policy, including
13 12 but not limited to changes in death benefits or cash values
13 13 due to long=term care benefits being paid out.
13 14 c. The amount of long=term care benefits existing or
13 15 remaining.
13 16 12. CLAIM DENIAL. If a claim made under a long=term care
13 17 insurance policy is denied, the issuer, within sixty days of
13 18 the date of receipt of a written request by the policyholder,
13 19 certificate holder, or a representative thereof, shall provide
13 20 a written explanation of the reasons for the denial, and shall
13 21 make all information directly related to the denial available
13 22 to the requestor.
13 23 13. COMPLIANCE. Any policy or rider advertised, marketed,
13 24 or offered as long=term care insurance or nursing home
13 25 insurance shall comply with the provisions of this chapter.
13 26 Sec. 7. NEW SECTION. 514G.106 INCONTESTABILITY PERIOD.
13 27 1. An insurer may rescind a long=term care insurance
13 28 policy or certificate or deny an otherwise valid long=term
13 29 care insurance claim if the policy or certificate has been in
13 30 force for less than six months upon a showing of
13 31 misrepresentation that is material to the insurer's acceptance
13 32 for coverage.
13 33 2. An insurer may rescind a long=term care insurance
13 34 policy or certificate or deny an otherwise valid long=term
13 35 care insurance claim if the policy or certificate has been in
14 1 force for at least six months but less than two years, upon a
14 2 showing of misrepresentation that is both material to the

14 3 acceptance for coverage and pertains to the condition for
14 4 which benefits are sought.
14 5 3. An insurer shall not contest a long=term care insurance
14 6 policy or certificate that has been in force for two or more
14 7 years solely upon the grounds of misrepresentation. Such a
14 8 policy or certificate may be contested only upon a showing
14 9 that the insured knowingly and intentionally misrepresented
14 10 relevant facts relating to the insured's health.
14 11 4. A long=term care insurance policy or certificate may be
14 12 field=issued if the compensation paid to the field issuer is
14 13 not based on the number of policies or certificates issued.
14 14 For the purposes of this subsection, a "field=issued" policy
14 15 means a policy or certificate issued by a producer or
14 16 third=party administrator pursuant to the underwriting
14 17 authority granted to the producer or third=party administrator
14 18 by an insurer and using the insurer's underwriting guidelines.
14 19 5. An insurer that has paid benefits under a long=term
14 20 care insurance policy or certificate shall not recover such
14 21 benefit payments if the policy or certificate is rescinded.
14 22 6. The provisions of this section are applicable to life
14 23 insurance policies or certificates that accelerate benefits
14 24 for long=term care. However, if an insured dies, the
14 25 remaining death benefits of a life insurance policy that
14 26 accelerates benefits for long=term care are not governed by
14 27 this section but by the provisions of section 508.28. In all
14 28 other situations, this section shall apply to life insurance
14 29 policies that accelerate benefits for long=term care.
14 30 Sec. 8. NEW SECTION. 514G.107 NONFORFEITURE BENEFITS.
14 31 1. Except as otherwise provided in subsection 2, a
14 32 long=term care insurance policy or certificate shall not be
14 33 delivered or issued for delivery in this state unless the
14 34 policyholder or certificate holder has been offered the option
14 35 of purchasing a policy or certificate that includes a
15 1 nonforfeiture benefit. A nonforfeiture benefit may be offered
15 2 in the form of a rider that is attached to the policy or
15 3 certificate. If the policyholder or certificate holder
15 4 declines the nonforfeiture benefit, the insurer shall provide
15 5 a contingent benefit upon lapse that is available for a
15 6 specified period of time following a substantial increase in
15 7 premium rates.
15 8 2. When a group long=term care insurance policy or
15 9 certificate is delivered or issued for delivery in this state,
15 10 an offer of benefits shall be made to the group policyholder
15 11 that meets the requirements of subsection 1. However, if the
15 12 policy is delivered or issued for delivery to a group as
15 13 described in section 514G.103, subsection 9, paragraph "d",
15 14 that is not a continuing care retirement community or other
15 15 similar entity, the offer of benefits shall be made to each
15 16 proposed certificate holder.
15 17 3. The commissioner shall, by rule, specify the type or
15 18 types of nonforfeiture benefits to be offered as part of
15 19 long=term care insurance policies and certificates, the
15 20 standards for such nonforfeiture benefits, and the standards
15 21 for contingent benefit upon lapse including a specified period
15 22 of time during which a contingent benefit upon lapse will be
15 23 available and what constitutes a substantial premium rate
15 24 increase that will trigger a contingent benefit upon lapse as
15 25 provided in subsection 1.
15 26 Sec. 9. NEW SECTION. 514G.108 PROMPT PAYMENT OF CLAIMS
15 27 == REQUIREMENTS.
15 28 1. An insurer providing long=term care insurance under
15 29 this chapter and subject to state insurance regulation shall
15 30 either accept and pay or deny a clean claim. For the purposes
15 31 of this section, "clean claim" means a properly completed
15 32 paper or electronic request for payment that contains all
15 33 necessary information for the insurer to timely adjudicate and
15 34 pay claims for long=term care benefits under the policy, does
15 35 not involve coordination of benefits for third=party liability
16 1 or subrogation, and does not involve the existence of
16 2 particular circumstances requiring special treatment that
16 3 prevents a prompt payment from being made.
16 4 2. The commissioner shall adopt rules establishing
16 5 processes for timely adjudication and payment of claims for
16 6 long=term care benefits by insurers.
16 7 3. Payment of a clean claim shall include interest at the
16 8 rate of ten percent per annum when an insurer or other entity
16 9 that administers or processes claims on behalf of the insurer
16 10 fails to timely pay a clean claim.
16 11 Sec. 10. NEW SECTION. 514G.109 BENEFIT TRIGGER
16 12 DETERMINATIONS == NOTICE == APPEALS.
16 13 1. NOTICE. When a long=term care insurer determines that

16 14 the benefit trigger in an insured's long=term care insurance
16 15 policy has not been met, the insurer shall provide a clear,
16 16 written notice to the insured of all of the following:
16 17   a. The reason that the insurer determined that the
16 18 insured's benefit trigger has not been met.
16 19   b. The insurer's internal appeal process provided under
16 20 the insured's long=term care insurance policy.
16 21   c. The insured's right, after exhaustion of the insurer's
16 22 internal appeal process, to have the benefit trigger
16 23 determination reviewed under the independent review process
16 24 set forth in section 514G.110.
16 25   2. INTERNAL APPEAL.
16 26   a. An insured may request an internal appeal of a benefit
16 27 trigger determination by sending a written request to the
16 28 insurer, along with any additional supporting information,
16 29 within sixty days after the insured receives the notice
16 30 described in subsection 1. The internal appeal shall be
16 31 considered by an individual or group of individuals designated
16 32 by the insurer, provided that the individual or individuals
16 33 making the internal appeal decision shall not be the same
16 34 individual or individuals who made the initial benefit trigger
16 35 determination. All internal appeals shall be completed and
17 1 written notice of the internal appeal decision sent to the
17 2 insured within sixty days of the insurer's receipt of all
17 3 necessary information upon which a final determination can be
17 4 made.
17 5   b. If the determination that the benefit trigger was not
17 6 met is upheld upon internal appeal, the notice of the appeal
17 7 decision shall describe additional internal appeal rights that
17 8 are offered by the insurer, if any. Nothing in this paragraph
17 9 shall require an insurer to offer any internal appeal rights
17 10 other than those described in paragraph "a".
17 11   c. If the determination that the benefit trigger was not
17 12 met is upheld after the internal appeal process has been
17 13 exhausted and there is no new information not previously
17 14 provided to the insurer for consideration, the insurer shall
17 15 provide the insured with a written description of the
17 16 insured's right to request an independent review of the
17 17 benefit trigger determination.
17 18   3. RECEIPT OF NOTICE. Notices required by this section
17 19 shall be deemed received within five days after the date of
17 20 mailing.
17 21   Sec. 11. NEW SECTION. 514G.110 INDEPENDENT REVIEW OF
17 22 BENEFIT TRIGGER DETERMINATIONS.
17 23   1. REQUEST. An insured may file a written request for
17 24 independent review of a benefit trigger determination with the
17 25 commissioner after the internal appeal process has been
17 26 exhausted. The request shall be filed within sixty days after
17 27 the insured receives written notice of the insurer's internal
17 28 appeal decision.
17 29   2. FEE. A request for independent review shall be
17 30 accompanied by a twenty=five dollar filing fee. The
17 31 commissioner may waive the filing fee for good cause. The
17 32 filing fee shall be refunded if the insured prevails in the
17 33 independent review process.
17 34   3. ELIGIBILITY FOR REVIEW. The commissioner shall certify
17 35 that the request is eligible for independent review if all of
18 1 the following criteria are satisfied:
18 2   a. The insured was covered by a long=term care insurance
18 3 policy issued by the insurer at the time the benefit trigger
18 4 determination was made.
18 5   b. The sole reason for requesting an independent review is
18 6 to review the insurer's determination that the benefit trigger
18 7 was not met.
18 8   c. The insured has exhausted all internal appeal
18 9 procedures provided under the insured's long=term care
18 10 insurance policy.
18 11   d. The written request for independent review was filed by
18 12 the insured within sixty days from the date of receipt of the
18 13 insurer's internal appeal decision.
18 14   4. NOTICE OF ELIGIBILITY. The commissioner shall provide
18 15 written notice regarding eligibility of a request for
18 16 independent review to the insured and the insurer within two
18 17 business days from the date of receipt of the request.
18 18   a. If the commissioner decides that the request is not
18 19 eligible for independent review, the written notice shall
18 20 indicate the reasons for that decision.
18 21   b. If the commissioner certifies that the request is
18 22 eligible for independent review, the insurer may appeal that
18 23 certification by filing a written notice of appeal with the
18 24 commissioner within three business days from the date of

18 25 receipt of the notice of certification. If upon further
18 26 review, the commissioner upholds the certification, the
18 27 commissioner shall promptly notify the insured and the insurer
18 28 in writing of the reasons for that decision.
18 29 5. QUALIFICATIONS OF INDEPENDENT REVIEW ENTITIES. The
18 30 commissioner shall maintain a list of qualified independent
18 31 review entities that are certified by the commissioner.
18 32 Independent review entities shall be recertified by the
18 33 commissioner every two years in order to remain on the list.
18 34 In order to be certified, an independent review entity shall
18 35 meet all of the following criteria:
19 1 a. Have on staff, or contract with, a qualified, licensed
19 2 health care professional in an appropriate field for
19 3 determining an insured's functional or cognitive impairment
19 4 who can conduct an independent review.
19 5 (1) In order to be qualified, a licensed health care
19 6 professional who is a physician shall hold a current
19 7 certification by a recognized American medical specialty board
19 8 in a specialty appropriate for determining an insured's
19 9 functional or cognitive impairment.
19 10 (2) In order to be qualified, a licensed health care
19 11 professional who is not a physician shall hold a current
19 12 certification in the specialty in which that person is
19 13 licensed, by a recognized American specialty board in a
19 14 specialty appropriate for determining an insured's functional
19 15 or cognitive impairment.
19 16 b. Ensure that any licensed health care professional who
19 17 conducts an independent review has no history of disciplinary
19 18 actions or sanctions, including but not limited to the loss of
19 19 staff privileges or any participation restrictions taken or
19 20 pending by any hospital or state or federal government
19 21 regulatory agency.
19 22 c. Ensure that the independent review entity or any of its
19 23 employees, agents, or licensed health care professionals
19 24 utilized does not receive compensation of any type that is
19 25 dependent on the outcome of a review.
19 26 d. Ensure that the independent review entity or any of its
19 27 employees, agents, or licensed health care professionals
19 28 utilized are not in any manner related to, employed by, or
19 29 affiliated with the insured or with a person who previously
19 30 provided medical care to the insured.
19 31 e. Ensure that an independent review entity or any of its
19 32 employees, agents, or licensed health care professionals
19 33 utilized is not a subsidiary of, or owned or controlled by, an
19 34 insurer or by a trade association of insurers of which the
19 35 insurer is a member.
20 1 f. Have a quality assurance program on file with the
20 2 commissioner that ensures the timeliness and quality of
20 3 reviews performed, the qualifications and independence of the
20 4 licensed health care professionals who perform the reviews,
20 5 and the confidentiality of the review process.
20 6 g. Have on staff or contract with a licensed health care
20 7 practitioner, as defined in section 514G.103, subsection 3,
20 8 who is qualified to certify that an individual is chronically
20 9 ill for purposes of a qualified long=term care insurance
20 10 contract.
20 11 6. INDEPENDENT REVIEW PROCESS. The independent review
20 12 process shall be conducted as follows:
20 13 a. Within three business days of receiving a notice from
20 14 the commissioner of the certification of a request for
20 15 independent review or receipt of a denial of an insurer's
20 16 appeal from such a certification, the insurer shall do all of
20 17 the following:
20 18 (1) Select an independent review entity from the list
20 19 certified by the commissioner and notify the insured in
20 20 writing of the name, address, and telephone number of the
20 21 independent review entity selected. The independent review
20 22 entity selected shall utilize a licensed health care
20 23 professional with qualifications appropriate to the benefit
20 24 trigger determination that is under review.
20 25 (2) Notify the independent review entity that it has been
20 26 selected to conduct an independent review of a benefit trigger
20 27 determination and provide sufficient descriptive information
20 28 to enable the independent review entity to provide licensed
20 29 health care professionals who will be qualified to conduct the
20 30 review.
20 31 (3) Provide the commissioner with a copy of the notices
20 32 sent to the insured and to the independent review entity
20 33 selected.
20 34 b. Within three business days of receiving a notice from
20 35 an insurer that it has been selected to conduct an independent

21 1 review, the independent review entity shall do one of the
21 2 following:
21 3 (1) Accept its selection as the independent review entity,
21 4 designate a qualified licensed health care professional to
21 5 perform the independent review, and provide notice of that
21 6 designation to the insured and the insurer, including a brief
21 7 description of the health care professional's qualifications
21 8 and the reasons that person is qualified to determine whether
21 9 the insured's benefit trigger has been met. A copy of this
21 10 notice shall be sent to the commissioner via facsimile. The
21 11 independent review entity is not required to disclose the name
21 12 of the health care professional selected.
21 13 (2) Decline its selection as the independent review entity
21 14 or, if the independent review entity does not have a licensed
21 15 health care professional who is qualified to conduct the
21 16 independent review available, request additional time from the
21 17 commissioner to have a qualified licensed health care
21 18 professional certified, and provide notice to the insured, the
21 19 insurer, and the commissioner. The commissioner shall notify
21 20 the review entity, the insured, and the insurer of how to
21 21 proceed within three business days of receipt of such notice
21 22 from the independent review entity.
21 23 c. An insured may object to the independent review entity
21 24 selected by the insurer or to the licensed health care
21 25 professional designated by the independent review entity to
21 26 conduct the review by filing a notice of objection along with
21 27 reasons for the objection, with the commissioner within ten
21 28 days of receipt of a notice sent by the independent review
21 29 entity pursuant to paragraph "b". The commissioner shall
21 30 consider the insured's objection and shall notify the insured,
21 31 the insurer, and the independent review entity of its decision
21 32 to sustain or deny the objection within two business days of
21 33 receipt of the objection.
21 34 d. Within five business days of receiving a notice from
21 35 the independent review entity accepting its selection or
22 1 within five business days of receiving a denial of an
22 2 objection to the review entity selected, whichever is later,
22 3 the insured may submit any information or documentation in
22 4 support of the insured's claim to both the independent review
22 5 entity and the insurer.
22 6 e. Within fifteen days of receiving a notice from the
22 7 independent review entity accepting its selection or within
22 8 three business days of receipt of a denial of an objection to
22 9 the independent review entity selected, whichever is later, an
22 10 insurer shall do all of the following:
22 11 (1) Provide the independent review entity with any
22 12 information submitted to the insurer by the insured in support
22 13 of the insured's internal appeal of the insurer's benefit
22 14 trigger determination.
22 15 (2) Provide the independent review entity with any other
22 16 relevant documents used by the insurer in making its benefit
22 17 trigger determination.
22 18 (3) Provide the insured and the commissioner with
22 19 confirmation that the information required under subparagraphs
22 20 (1) and (2) has been provided to the independent review
22 21 entity, including the date the information was provided.
22 22 f. The independent review entity shall not commence its
22 23 review until fifteen days after the selection of the
22 24 independent review entity is final including the resolution of
22 25 any objection made pursuant to paragraph "c". During this
22 26 time period, the insurer may consider any information provided
22 27 by the insured pursuant to paragraph "d" and overturn or
22 28 affirm the insurer's benefit trigger determination based on
22 29 such information. If the insurer overturns its benefit
22 30 trigger determination, the independent review process shall
22 31 immediately cease.
22 32 g. In conducting a review, the independent review entity
22 33 shall consider only the information and documentation provided
22 34 to the independent review entity pursuant to paragraphs "d"
22 35 and "e".
23 1 h. The independent review entity shall submit its decision
23 2 as soon as possible, but not later than thirty days from the
23 3 date the independent review entity receives the information
23 4 required under paragraphs "d" and "e", whichever is received
23 5 later. The decision shall include a description of the basis
23 6 for the decision and the date of the benefit trigger
23 7 determination to which the decision relates. The independent
23 8 review entity, for good cause, may request an extension of
23 9 time from the commissioner to file its decision. A copy of
23 10 the decision shall be mailed to the insured, the insurer, and
23 11 the commissioner.

23 12   i. All medical records submitted for use by the
23 13 independent review entity shall be maintained as confidential
23 14 records as required by applicable state and federal laws. The
23 15 commissioner shall keep all information obtained during the
23 16 independent review process confidential pursuant to section
23 17 505.8, subsection 6, except that the commissioner may share
23 18 some information obtained as provided under section 505.8,
23 19 subsection 6, and as required by this chapter and rules
23 20 adopted pursuant to this chapter.
23 21   j. If an insured dies before completion of the independent
23 22 review, the review shall continue to completion if there is
23 23 potential liability of an insurer to the estate of the insured
23 24 or to a provider for rendering qualified long=term care
23 25 services to the insured.
23 26   7. COSTS. All reasonable fees and costs of the
23 27 independent review entity incurred in conducting an
23 28 independent review under this section shall be paid by the
23 29 insurer.
23 30   8. IMMUNITY. An independent review entity that conducts a
23 31 review under this section is not liable for damages arising
23 32 from determinations made during the review. Immunity does not
23 33 apply to any act or omission made by an independent review
23 34 entity in bad faith or that involves gross negligence.
23 35   9. EFFECT OF INDEPENDENT REVIEW DECISION.
24 1   a. The review decision by the independent review entity
24 2 conducting the review is binding on the insurer.
24 3   b. The independent review process set forth in this
24 4 section shall not be considered a contested case under chapter
24 5 17A.
24 6   c. An insured may appeal the review decision by the
24 7 independent review entity conducting the review by filing a
24 8 petition for judicial review in the district court in the
24 9 county in which the insured resides. The petition for
24 10 judicial review shall be filed within fifteen business days
24 11 after the issuance of the review decision. The petition shall
24 12 name the insured as the petitioner and the insurer as the
24 13 respondent. The petitioner shall not name the independent
24 14 review entity as a party. The commissioner shall not be named
24 15 as a respondent unless the insured alleges action or inaction
24 16 by the commissioner under the standards articulated under
24 17 section 17A.19, subsection 10. Allegations made against the
24 18 commissioner under section 17A.19, subsection 10, must be
24 19 stated with particularity. The commissioner may, upon motion,
24 20 intervene in a judicial review proceeding brought pursuant to
24 21 this paragraph. The findings of fact by the independent
24 22 review entity conducting the review are conclusive and binding
24 23 on appeal.
24 24   d. An insurer shall not be subject to any penalties,
24 25 sanctions, or damages for complying in good faith with a
24 26 review decision rendered by an independent review entity
24 27 pursuant to this section.
24 28   e. Nothing contained in this section or in section
24 29 514G.109 shall be construed to limit the right of an insurer
24 30 to assert any rights an insurer may have under a long=term
24 31 care insurance policy related to:
24 32   (1) An insured's misrepresentation.
24 33   (2) Changes in the insured's benefit eligibility.
24 34   (3) Terms, conditions, and exclusions contained in the
24 35 policy, other than failure to meet the benefit trigger.
25 1   f. The requirements of this section and section 514G.109
25 2 are not applicable to a group long=term care insurance policy
25 3 that is governed by the federal Employee Retirement Income
25 4 Security Act of 1974, as codified at 29 U.S.C. } 100 et seq.
25 5   g. The provisions of this section and section 514G.109 are
25 6 in lieu of and supersede any other third=party review
25 7 requirement contained in chapter 514J or in any other
25 8 provision of law.
25 9   h. The insured may bring an action in the district court
25 10 in the county in which the insured resides to enforce the
25 11 review decision of the independent review entity conducting
25 12 the review or the decision of the court on appeal.
25 13   10. RECEIPT OF NOTICE. Notice required by this section
25 14 shall be deemed received within five days after the date of
25 15 mailing.
25 16   Sec. 12. NEW SECTION. 514G.111 AUTHORITY TO PROMULGATE
25 17 RULES.
25 18   The commissioner may adopt rules pursuant to chapter 17A
25 19 related to long=term care insurance and to the administration
25 20 and enforcement of this chapter, including but not limited to
25 21 the following:
25 22   1. Promoting adequate premiums and protecting

25 23 policyholders in the event of substantial rate increases.
25 24 2. Establishing minimum standards for producer education,
25 25 compensation, and testing; marketing practices; reporting
25 26 practices; and penalties related to the sale of long=term care
25 27 insurance in this state.
25 28 3. Establishing loss ratio standards for long=term care
25 29 insurance policies with specific reference to such policies.
25 30 4. Providing standards for full and fair disclosure by
25 31 setting forth the manner and content of disclosures required
25 32 for the sale of long=term care insurance policies including
25 33 terms of renewability; initial and subsequent conditions of
25 34 eligibility; nonduplication of coverage provisions; coverage
25 35 of dependents; effect of preexisting conditions; termination,
26 1 continuation, or conversion of policies; probationary periods;
26 2 limitations, exceptions, and reductions; elimination periods;
26 3 requirements for replacement; recurrent conditions; and
26 4 definitions of terms.
26 5 5. Requiring certain remedial actions necessitated by
26 6 changes in the long=term care insurance market to provide fair
26 7 and reasonable protections for long=term care insurance
26 8 purchasers and beneficiaries.
26 9 6. Ensuring the prompt payment of clean claims.
26 10 7. Administering the independent review process of
26 11 insurers' benefit trigger determinations.
26 12 Sec. 13. NEW SECTION. 514G.112 SEVERABILITY.
26 13 If any provision of this chapter or the application of this
26 14 chapter to any person or circumstance is for any reason held
26 15 to be invalid, the remainder of the chapter and the
26 16 application of the provision to other persons or circumstances
26 17 shall not be affected.
26 18 Sec. 14. NEW SECTION. 514G.113 PENALTIES.
26 19 In addition to any other penalties provided by the laws of
26 20 this state, any insurer or any producer found to have violated
26 21 a provision of this chapter or any other requirement of this
26 22 state relating to the regulation of long=term care insurance
26 23 or the marketing of such insurance shall be subject to a fine
26 24 of up to three times the amount of any commission paid for
26 25 each policy involved in the violation, or up to ten thousand
26 26 dollars, whichever is greater.
26 27 Sec. 15. Section 514H.1, subsection 3, Code 2007, is
26 28 amended to read as follows:
26 29 3. "Long=term care insurance" means long=term care
26 30 insurance as defined in section ~~514G.4~~ 514G.103 and regulated
26 31 in section ~~514G.7~~ 514G.105.
26 32 Sec. 16. Sections 514G.1 through 514G.8 and section
26 33 514G.10, Code 2007, are repealed.
26 34 Sec. 17. SENIOR HEALTH INSURANCE INFORMATION PROGRAM ==
26 35 APPROPRIATION. There is appropriated from the general fund of
27 1 the state to the division of insurance of the department of
27 2 commerce for the fiscal year beginning July 1, 2008, and
27 3 ending June 30, 2009, the following amount, or so much thereof
27 4 as is necessary, for the use of the senior health insurance
27 5 information program:
27 6 .... $ 60,000
27 7 .... FTEs 1.00
27 8 Sec. 18. EFFECTIVE DATE. The provision of this
27 9 Act enacting section 514G.109, subsection 2, paragraph
27 10 "c", and the section of this Act enacting section
27 11 514G.110 take effect on January 1, 2009.
27 12 EXPLANATION
27 13 This bill repeals existing provisions regulating long=term
27 14 care insurance and creates new ones, provides for penalties,
27 15 repeals, and an appropriation. The new provisions apply to
27 16 policies delivered or issued for delivery in this state on or
27 17 after July 1, 2008.
27 18 DEFINITIONS == STANDARDS. The bill includes new and
27 19 additional definitions and expanded disclosure and performance
27 20 standards for long=term care insurance. These standards set
27 21 forth prohibited policy practices and permissible treatment of
27 22 preexisting conditions, prior hospitalizations, and
27 23 institutionalizations. The standards also allow applicants
27 24 for such insurance the right to return a policy and to receive
27 25 a refund. The standards require an outline of coverage and
27 26 specify contents of that outline and any group certificate
27 27 that is issued. Policies must be delivered within 30 days
27 28 after an application is approved. Individual life insurance
27 29 policies which provide for long=term care benefits within the
27 30 policy or by rider are required to provide a written policy
27 31 summary. If a long=term care benefit funded through life
27 32 insurance is in benefit payment status, the policyholder is
27 33 entitled to a monthly report. Within 60 days of denying a

27 34 claim under a long=term care insurance contract, an insurer
27 35 must provide a written explanation of the denial.
28 1 INCONTESTABILITY PERIOD. The bill sets forth conditions
28 2 under which an insurer is allowed to rescind a long=term care
28 3 insurance policy or certificate or deny a claim thereunder.
28 4 NONFORFEITURE BENEFITS. The bill requires insurers to
28 5 offer long=term care insurance policyholders and certificate
28 6 holders the option to purchase a nonforfeiture benefit.
28 7 PROMPT PAYMENT OF CLAIMS. The bill contains requirements
28 8 for prompt payment of claims when there are no circumstances
28 9 which prevent prompt payment from being made.
28 10 BENEFIT TRIGGER DETERMINATIONS. The bill requires insurers
28 11 to notify an insured making a claim under a long=term care
28 12 insurance policy when the insurer denies the payment of
28 13 benefits because the insured's benefit trigger has not been
28 14 met. The bill requires the insurer to provide an internal
28 15 review process to the insured to appeal the insurer's initial
28 16 benefit trigger determination. If the internal appeal
28 17 decision upholds the denial of benefits, the insurer must
28 18 notify the insured of additional internal appeal rights, if
28 19 any, and that the insured has the right to request an
28 20 independent review of the benefit trigger determination.
28 21 INDEPENDENT REVIEW. The bill sets forth the process for an
28 22 independent review of an insurer's benefit determination. The
28 23 commissioner is required to certify a list of qualified
28 24 independent review entities that meet the specified criteria
28 25 required to be a reviewer of an insurer's benefit trigger
28 26 determination.
28 27 RULES. The commissioner is authorized to adopt rules
28 28 pursuant to Code chapter 17A related to long=term care
28 29 insurance and to the administration and enforcement of Code
28 30 chapter 514G.
28 31 SEVERABILITY. If any of the provisions of the bill are
28 32 found to be invalid, the remainder are not affected.
28 33 PENALTIES. If an insurer or insurance producer violates
28 34 any requirements relating to long=term care insurance or the
28 35 marketing of such insurance, that person is subject to a fine
29 1 of up to three times the amount of any commission paid for
29 2 each policy involved in the violation, or up to $10,000,
29 3 whichever is greater. This penalty is in addition to any
29 4 other penalties provided for by state law.
29 5 REPEALS. Code sections 514G.1 through 514G.8 and section
29 6 514G.10, which currently regulate long=term care insurance,
29 7 are repealed on July 1, 2008.
29 8 SENIOR HEALTH INSURANCE INFORMATION PROGRAM ==
29 9 APPROPRIATION. There is an appropriation of $60,000 from the
29 10 state's general fund to fund one full=time position for the
29 11 senior health insurance information program in the division of
29 12 insurance. The purpose of this program is to assist in the
29 13 dissemination of objective and noncommercial educational
29 14 material and to raise public awareness of prudent consumer
29 15 choices in considering the purchase of various insurance
29 16 products designed for the health care needs of older Iowans.
29 17 EFFECTIVE DATE. The provisions of the Act referring to and
29 18 enacting the independent review process of benefit trigger
29 19 determinations take effect January 1, 2009.
29 20 LSB 5433SV 82
29 21 av/nh/8