IOWA COMPREHENSIVE
HEALTH INSURANCE ASSOCIATION

514E.1 Definitions.

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

1. *"Association"* means the Iowa comprehensive health insurance association established by section 514E.2.

2. *"Association policy"* means an individual or group policy issued by the association that provides the coverage specified in section 514E.4.

3. *"Carrier"* means an insurer providing accident and sickness insurance under chapter 509, 514 or 514A and includes a health maintenance organization established under chapter 514B if payments received by the health maintenance organization are considered premiums pursuant to section 514B.31 and are taxed under chapter 432. *"Carrier"* also includes a corporation which becomes a mutual insurer pursuant to section 514.23 and any other person as defined in section 4.1, subsection 20, who is or may become liable for the tax imposed by chapter 432.

4. *"Church plan"* means the same as defined in the federal Employee Retirement Income Security Act of 1974, 29 U.S.C. § 3(33).

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

6. *"Creditable coverage"* means health benefits or coverage provided to an individual under any of the following:

a. A group health plan.

b. Health insurance coverage.

c. Part A or Part B Medicare pursuant to Title XVIII of the federal Social Security Act.

d. Medicaid pursuant to Title XIX of the federal Social Security Act, other than coverage consisting solely of benefits under section 1928 of that Act.

e. 10 U.S.C. ch. 55.

f. A health or medical care program provided through the Indian health service or a tribal organization.

g. A state health benefits risk pool.

h. A health plan offered under 5 U.S.C. ch. 89.

i. A public health plan as defined under federal regulations.

j. A health benefit plan under section 5(e) of the federal Peace Corps Act, 22 U.S.C. § 2504(e).

k. An organized delivery system licensed by the director of public health.

l. The hawk-i program authorized by chapter 514I.

7. *"Director"* means the director of public health.

8. *"Eligible expenses"* means the usual, customary and reasonable charges for the health care services specified in section 514E.4.

9. *"Federally eligible individual"* means an individual who satisfies the following:

a. For whom, as of the date on which the individual seeks coverage under this chapter, the aggregate of the periods of creditable coverage is eighteen or more months with no more than a sixty-three day lapse of coverage, and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan.

b. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the federal Social Security Act, or a state plan under Title XIX of that Act, or any successor program, and does not have other health insurance coverage.

c. With respect to whom the most recent coverage within the coverage period described in paragraph *"a"* was not terminated based on a nonpayment of premiums or fraud.

d. If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, and elected such coverage.

e. Who, if the individual elected continuation coverage as provided in paragraph *"d"*, has exhausted the continuation coverage under the provision or program.

10. *"Governmental plan"* means as defined under section 3(32) of the federal Employee Retirement Income Security Act of 1974 and any federal governmental plan.

11. *a. "Group health plan"* means an employee welfare benefit plan as defined in section 3(1) of the federal Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

b. For purposes of this subsection, *"medical care"* means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting a structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in subparagraph (1).

(3) Insurance covering medical care referred to in subparagraph (1) or (2).

c. For purposes of this chapter, the following apply:

(1) A plan, fund, or program established or maintained by a partnership which, but for this subsection, would not be an employee welfare benefit plan, shall be treated as an employee welfare benefit plan which is a group health plan to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care for present or former partners in the partnership or to the dependents of such partners, as defined under the terms of the plan, fund, or program, either directly or through insurance, reimbursement, or otherwise.

(2) With respect to a group health plan, the term *"employer"* includes a partnership with respect to a partner.

(3) With respect to a group health plan, the term *"participant"* includes the following:

(a) With respect to a group health plan maintained by a partnership, an individual who is a partner in the partnership.

(b) With respect to a group health plan maintained by a self-employed individual under which one or more of the self-employed individual's employees are participants, the self-employed individual, if that individual is, or may become, eligible to receive benefits under the plan or the individual's dependents may be eligible to receive benefits under the plan.

12. *"Health care facility"* means a health care facility as defined in section 135C.1, a hospital as defined in section 135B.1, or a community mental health center established under chapter 230A.

13. *"Health care services"* means services, the coverage of which is authorized under chapter 509, chapter 514, chapter 514A, or chapter 514B as limited by sections 514E.4 and 514E.5, and includes services for the purposes of preventing, alleviating, curing, or healing human illness, injury or physical disability.

14. *"Health insurance"* means accident and sickness insurance authorized by chapter 509, 514 or 514A.

15. *a. "Health insurance coverage"* means health insurance coverage offered to individuals.

b. "Health insurance coverage" does not include any of the following:

(1) Coverage for accident-only, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Liability insurance, including general liability insurance and automobile liability insurance.

(4) Workers' compensation or similar insurance.

(5) Automobile medical-payment insurance.

(6) Credit-only insurance.

(7) Coverage for on-site medical clinic care.

(8) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance coverage or benefits.

c. "Health insurance coverage" does not include benefits provided under a separate policy as follows:

(1) Limited-scope dental or vision benefits.

(2) Benefits for long-term care, nursing home care, home health care, or community-based care.

(3) Any other similar limited benefits as provided by rule of the commissioner.

d. "Health insurance coverage" does not include benefits offered as independent noncoordinated benefits as follows:

(1) Coverage only for a specified disease or illness.

(2) A hospital indemnity or other fixed indemnity insurance.

e. "Health insurance coverage" does not include Medicare supplemental health insurance as defined under section 1882(g)(1) of the federal Social Security Act, coverage supplemental to the coverage provided under 10 U.S.C. ch. 55 and similar supplemental coverage provided to coverage under group health insurance coverage.

16. *"Insured"* means an individual who is provided qualified comprehensive health insurance under an association policy, which policy may include dependents and other covered persons.

17. *"Involuntary termination"* includes, but is not limited to, termination of coverage when a conversion policy is not available or where benefits under a state or federal law providing for continuation of coverage upon termination of employment will cease or have ceased.

18. *"Medicaid"* means the federal-state assistance program established under Title XIX of the federal Social Security Act.

19. *"Medicare"* means the federal government health insurance program established under Title XVIII of the Social Security Act.

20. *"Organized delivery system"* means an organized delivery system as licensed by the director of the department of public health.

21. *"Policy"* means a contract, policy, or plan of health insurance.

22. *"Policy year"* means a consecutive twelve-month period during which a policy provides or obligates the carrier to provide health insurance.

23. *"Preexisting condition exclusion"*, with respect to coverage, means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

86 Acts, ch 1156, § 1; 89 Acts, ch 304, §1003; 97 Acts, ch 103, § 42, 43; 98 Acts, ch 1100, § 70; 2000 Acts, ch 1058, §47; 2001 Acts, ch 69, §23; 2002 Acts, ch 1111, §16; 2003 Acts, ch 108, §131

Footnotes

Organized delivery systems authorized, see 93 Acts, ch
158, §3

514E.2 Iowa comprehensive health insurance association.

1. The Iowa comprehensive health insurance association is established as a nonprofit corporation. The association shall assure that health insurance, as limited by sections 514E.4 and 514E.5, is made available to each eligible Iowa resident and each federally eligible individual applying to the association for coverage. The association shall also be responsible for administering the Iowa individual health benefit reinsurance association pursuant to all of the terms and conditions contained in chapter 513C.

a. All carriers as defined in section 514E.1, subsection 3, and all organized delivery systems licensed by the director of public health providing health insurance or health care services in Iowa shall be members of the association.

b. The association shall operate under a plan of operation established and approved under subsection 3 and

shall exercise its powers through a board of directors established under this section.

2. The board of directors of the association shall consist of all of the following:

a. Two members who shall be representatives of the two largest domestic carriers of individual health insurance in the state as of the calendar year ending December 31, 2000, based on earned premium standards.

b. Three members who shall be representatives of the three largest carriers of health insurance in the state, based on earned premium standards, excluding Medicare supplement coverage premiums, that are not otherwise represented.

c. Two members selected by the members of the association, one of whom shall be a representative from a corporation operating pursuant to chapter 514 on July 1, 1989, or any successor in interest, and one of whom shall be a representative of an organized delivery system or an insurer providing coverage pursuant to chapter 509 or 514A.

d. Four public members selected by the governor.

e. The commissioner or the commissioner's designee from the division of insurance.

f. Two members of the general assembly, one of whom shall be appointed by the speaker of the house and one of whom shall be appointed by the president of the senate, after consultation with the majority leader and the minority leader of the senate, who shall be ex officio, nonvoting members.

The composition of the board of directors shall be in compliance with sections 69.16 and 69.16A. The governor's appointees shall be chosen from a broad cross-section of the residents of this state.

Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not be otherwise compensated by the association for their services.

3. The association shall submit to the commissioner a plan of operation for the association and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner prior to the date on which the coverage under this chapter must be made available. After notice and hearing, the commissioner shall approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association, and provides for the sharing of association losses, if any, on an equitable and proportionate basis among the member carriers. If the association fails to submit a suitable plan of operation within one hundred eighty days after the appointment of the board of directors, or if at any later time the association fails to submit suitable amendments to the plan, the commissioner shall adopt, pursuant to chapter 17A, rules necessary to implement this section. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. In addition to other requirements, the plan of operation shall provide for all of the following:

a. The handling and accounting of assets and moneys of the association.

b. The amount and method of reimbursing members of the board.

c. Regular times and places for meeting of the board of directors.

d. Records to be kept of all financial transactions, and the annual fiscal reporting to the commissioner.

e. Procedures for selecting the board of directors and submitting the selections to the commissioner for approval.

f. The periodic advertising of the general availability of health insurance coverage from the association.

g. Additional provisions necessary or proper for the execution of the powers and duties of the association.

4. The plan of operation may provide that the powers and duties of the association may be delegated to a person who will perform functions similar to those of the association. A delegation under this section takes effect only upon the approval of both the board of directors and the commissioner. The commissioner shall not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

5. The association has the general powers and authority enumerated by this subsection and executed in accordance with the plan of operation approved by the commissioner under subsection 3. The association has the general powers and authority granted under the laws of this state to carriers licensed to issue health insurance. In addition, the association may do any of the following:

a. Enter into contracts as necessary or proper to carry out this chapter.

b. Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

c. Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

d. Establish or utilize a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

e. Establish appropriate rates, scales of rates, rate classifications, and rating adjustments, which rates shall not be unreasonable in relation to the coverage provided and the reasonable operations expenses of the association.

f. Pool risks among members.

g. Issue association policies on an indemnity or provision of service basis providing the coverage required by this chapter.

h. Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

i. Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

j. Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other functions within the authority of the association.

k. Hire independent consultants as necessary.

l. Develop a method of advising applicants of the availability of other coverages outside the association, and shall promulgate a list of health conditions the existence of which would make an applicant eligible without demonstrating a rejection of coverage by one carrier.

m. Include in its policies a provision providing for subrogation rights by the association in a case in which the association pays expenses on behalf of an individual who is injured or suffers a disease under circumstances

creating a liability upon another person to pay damages to the extent of the expenses paid by the association but only to the extent the damages exceed the policy deductible and coinsurance amounts paid by the insured. The association may waive its subrogation rights if it determines that the exercise of the rights would be impractical, uneconomical, or would work a hardship on the insured.

6. Rates for coverages issued by the association shall not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing coverage. Separate scales of rates based on age may apply for individual risks. Rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification shall not be more than one hundred fifty percent of the average premium or payment rate for that classification charged by the five carriers with the largest health insurance premium or payment volume in the state during the preceding calendar year. In determining the average rate of the five largest carriers, the rates or payments charged by the carriers shall be actuarially adjusted to determine the rate or payment that would have been charged for benefits similar to those issued by the association.

7. Following the close of each calendar year, the association shall determine the net premiums and payments, the expenses of administration, and the incurred losses of the association for the year. The association shall certify the amount of any net loss for the preceding calendar year to the commissioner of insurance and director of revenue. Any loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums or payments for subscriber contracts received in Iowa during the second preceding calendar year, or with paid losses in the year, coinciding with or ending during the calendar year or on any other equitable basis as provided in the plan of operation. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for an initial or interim assessment against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the next calendar year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums.

8. The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations, made by an independent certified public accountant.

9. The association is subject to examination by the commissioner of insurance. Not later than April 30 of each year, the board of directors shall submit to the commissioner a financial report for the preceding calendar year in a form approved by the commissioner.

10. The association is subject to oversight by the legislative fiscal committee of the legislative council. Not later than April 30 of each year, the board of directors shall submit to the legislative fiscal committee a financial report for the preceding year in a form approved by the committee.

11. All policy forms issued by the association must be filed with and approved by the commissioner before their use.

12. The association is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

13. A member who, after July 1, 1986, has paid one or more assessments levied under this chapter may take a credit against the premium taxes, or similar taxes, upon revenues or income of the member that are imposed by the state on health insurance premiums pursuant to chapter 432 or payments subject to taxation under section 514B.31, up to the amount of twenty percent of those taxes due, for each of the five calendar years

following the year for which an assessment was paid, or until the aggregate of those assessments has been offset by credits against those taxes if this occurs first. If a member ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

86 Acts, ch 1156, § 2; 89 Acts, ch 304, § 10041006; 90 Acts, ch 1223, § 28; 97 Acts, ch 103, §4448; 2001 Acts, ch 125, §7; 2003 Acts, ch 145, §286

514E.3 Health insurance trust fund deposit of moneys. Repealed by 97 Acts, ch 103, § 56.

514E.4 Association policy coverage and benefit requirements eligible expenses.

The association policy shall pay only the usual, customary and reasonable charges for medically necessary eligible health care services which exceed the deductible and coinsurance amounts applicable under section 514E.6. Eligible expenses are the charges for the following health care services furnished by a health care provider in an emergency situation or furnished or prescribed by a health care provider:

1. Hospital services, including charges for the most common semiprivate room, for the most common private room if semiprivate rooms do not exist in the health care facility, or for the private room if medically necessary, but limited to a total of one hundred eighty days in a calendar year.

2. Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a health care provider, or at the direction of a health care provider, by a staff of registered nurses, licensed practical nurses, or other health care providers.

3. The first twenty professional visits for the diagnosis or treatment of one or more mental conditions, rendered during a calendar year by one or more health care providers, or at their direction, by their staff of registered nurses, licensed practical nurses, or other health care providers.

4. Drugs and contraceptive devices requiring a prescrip- tion.

5. Services of a nursing facility as defined in section 135C.1, for not more than one hundred eighty days in a calendar year.

6. Homemaker-home health services up to one hundred eighty days of service in a calendar year.

7. Use of radium or other radioactive material.

8. Oxygen.

9. Anesthetics.

10. Prostheses, other than dental.

11. Rental of durable medical equipment, other than eye glasses and hearing aids, which have no personal use in the absence of the condition for which prescribed.

12. Diagnostic X rays and laboratory tests.

13. Oral surgery for any of the following:

a. Excision of partially or completely erupted impacted teeth.

b. Excision of a tooth root without the extraction of the entire tooth.

c. The gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

14. Services of a physical therapist and services of a speech therapist.

15. Professional ambulance services to the nearest health care facility qualified to treat the illness, injury, or condition.

16. Processing of blood, including but not limited to, collecting, testing, fractionating, and distributing blood.

86 Acts, ch 1156, § 4; 90 Acts, ch 1039, § 18

514E.5 Expenses excluded.

Eligible expenses shall not include an expense for any of the following:

1. Services for which a charge is not made in the absence of insurance or for which there is no legal obligation on the part of a patient to pay.

2. Services and charges made for benefits provided under the laws of the United States, excluding Medicare and Medicaid, military service-connected disabilities, but including medical services provided for members of the armed forces and their dependents or for employees of the armed forces of the United States, and medical services financed on behalf of all citizens by the United States.

However, the association policy shall pay benefits as a primary payer in any case where benefit coverage provided under the laws of the United States or under the laws of this state is, by rule or statute, secondary to all other coverages.

3. Benefits which would duplicate the provision of services or payment of charges for any care for an injury, disease, or condition for which either of the following applies:

a. It arises out of and in the course of an employment subject to a workers' compensation or similar law.

b. Benefits for it are payable without regard to fault under a coverage required to be contained in any motor vehicle or other liability insurance policy or equivalent self- insurance. However, this does not authorize exclusion of charges that exceed the benefits payable under the applicable workers' compensation or no-fault coverage.

4. Care which is primarily for a custodial or domiciliary purpose.

5. Cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure.

6. Services the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services.

7. That part of any charge for services or articles rendered or prescribed by a health care provider which exceeds the prevailing charge in the locality where the service is provided, or a charge for services or articles not medically necessary.

8. Services rendered prior to the effective date of coverage under this plan for the person on whose behalf the expense is incurred.

9. Routine physical examinations including examinations to determine the need for eye glasses and hearing aids.

10. Illness or injury due to an act of war.

11. Service of a blood donor and any fee for failure to replace the first three pints of blood provided to an eligible person each calendar year.

12. Personal supplies or services provided by a health care facility or any other nonmedical or nonprescribed supply or service.

13. Experimental services or supplies. *"Experimental"* means a service or supply not recognized by the appropriate medical board as normal mode of treatment for the illness or injury involved.

14. Eye surgery if corrective lenses would alleviate the problem.

The coverage and benefit requirements of this section for association policies shall not be altered by any other state law without specific reference to this chapter indicating a legislative intent to add or delete from the coverage requirements of this chapter.

This chapter does not prohibit the association from issuing additional types of health insurance policies with different types of benefits which, in the opinion of the board of directors, may be of benefit to the citizens of the state.

86 Acts, ch 1156, § 5; 89 Acts, ch 321, § 36; 97 Acts, ch 103, §49

514E.6 Policies, deductible and coinsurance requirements limitations.

1. Except as provided in subsection 3, an association policy offered in accordance with this chapter shall include a deductible. Deductibles of five hundred dollars and one thousand dollars on a per person per calendar year basis shall be offered. The board may authorize deductibles in other amounts. The deductibles must be applied to the first five hundred dollars, one thousand dollars, or other authorized amount of eligible expenses incurred by the covered person.

2. Except as provided in subsection 3, a mandatory coinsurance requirement shall be imposed at the rate of twenty percent of eligible expenses in excess of the mandatory deductible.

3. The maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance shall not exceed in a policy year:

a. One thousand five hundred dollars for an individual five-hundred-dollar deductible policy.

b. Two thousand dollars for an individual one-thousand- dollar deductible policy.

c. Three thousand dollars for a family five-hundred-dollar deductible policy.

d. Four thousand dollars for a family one-thousand-dollar deductible policy.

e. An amount as determined by the association for any other association policy offered.

4. For a family policy, the maximum annual deductible under the policy shall be the deductible chosen for a maximum of two individuals under the policy.

5. Eligible expenses incurred by a covered person in the last three months of a calendar year, and applied toward a deductible, shall also be applied toward the deductible amount in the next calendar year.

6. The association, in addition to other policies, shall offer one which is comparable to the standard health benefit plan as defined in section 513B.2.

7. The association shall, in addition to other policies, offer Medicare supplement policies designed to supplement Medicare and provide coverage of at least fifty percent of the deductible and eighty percent of the covered expenses in section 514E.4. Medicare supplement plans are subject to the same limitations on premiums, deductibility, and annual out- of-pocket expenses as other association policies.

86 Acts, ch 1156, § 6; 97 Acts, ch 103, §50, 51

514E.7 Policies eligible persons dependent coverage preexisting conditions.

1. An individual who is and continues to be a resident is eligible for plan coverage if evidence is provided of any of the following:

a. A notice of rejection or refusal to issue substantially similar insurance for health reasons by one carrier or organized delivery system.

b. A refusal by a carrier or organized delivery system to issue insurance except at a rate exceeding the plan rate.

c. That the individual is a federally defined eligible individual.

A rejection or refusal by a carrier or organized delivery system offering only stoploss, excess of loss, or reinsurance coverage with respect to an applicant under paragraphs *"a"* and *"b"* is not sufficient evidence for purposes of this subsection.

2. An association policy shall provide that coverage of a dependent unmarried person terminates when the person becomes nineteen years of age or, if the person is enrolled full time in an accredited educational institution, terminates at twenty-five years of age. The policy shall also provide in substance that attainment of the limiting age does not operate to terminate coverage when the person is and continues to be both of the following:

a. Incapable of self-sustaining employment by reason of mental retardation or physical disability.

b. Primarily dependent for support and maintenance upon the person in whose name the contract is issued.

Proof of incapacity and dependency must be furnished to the carrier within one hundred twenty days of the person's attain- ment of the limiting age, and subsequently as may be required by the carrier, but not more frequently than annually after the two-year period following the person's attainment of the limiting age.

3. An association policy that provides coverage for a family member of the person in whose name the contract is issued shall also provide, as to the family member's coverage, that the health insurance benefits applicable for children include the coverage required under section 514C.1.

4. *a.* A preexisting condition exclusion shall not apply to a federally defined eligible individual.

b. Plan coverage shall not impose any preexisting condition exclusion as follows:

(1) In the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This subparagraph shall not apply to coverage before the date of such adoption or placement for adoption.

(2) In the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Relating to pregnancy as a preexisting condition.

c. Plan coverage shall exclude charges or expenses incurred during the first six months following the effective date of coverage for preexisting conditions. Such preexisting condition exclusions shall be waived to the extent that similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, provided both of the following apply:

(1) Application for association coverage is made no later than sixty-three days following such involuntary termination and, in such case, coverage under the plan is effective from the date on which such prior coverage was terminated.

(2) The applicant is not eligible for continuation or conversion rights that would provide coverage substantially similar to plan coverage.

d. This subsection does not prohibit preexisting conditions coverage in an association policy that is more favorable to the insured than that specified in this subsection.

If the association policy contains a waiting period for preexisting conditions, an insured may retain any existing coverage the insured has under an insurance plan that has coverage equivalent to the association policy for the duration of the waiting period only.

5. An individual is not eligible for coverage by the association if any of the following apply:

a. The individual is at the time of application eligible for health care benefits under chapter 249A.

b. The individual has terminated coverage by the association within the past twelve months, except that this paragraph does not apply to an applicant who is a federally eligible individual.

c. The individual is an inmate of a public institution, except that this paragraph does not apply to an applicant who is a federally defined eligible individual.

d. The individual premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent of the employee, of a government agency or health care provider.

e. The individual, on the effective date of the coverage applied for, has not been rejected for, already has, or will have coverage similar to an association policy as an insured or covered dependent. This paragraph does not apply to an applicant who is a federally eligible individual.

86 Acts, ch 1156, § 7; 90 Acts, ch 1163, §13; 96 Acts, ch 1129, § 113; 97 Acts, ch 103, § 52, 53; 98 Acts, ch 1100, § 71

514E.8 Policies renewal provisions election to continue coverage upon death of policyholder.

1. An association policy shall contain provisions under which the association is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the durational requirements of this subsection. However, when the individual in whose name the contract is issued becomes eligible for Medicare coverage, the person shall be eligible for the Medicare supplement plan offered by the association.

2. The association shall not change the rates for association policies except on a class basis with a clear disclosure in the policy of the association's right to do so.

3. An association policy shall provide that upon the death of the individual in whose name the policy is issued, every other individual then covered under the contract may elect, within a period specified in the policy, to continue coverage under the same or a different policy until such time as the person would have ceased to be entitled to coverage had the individual in whose name the policy was issued lived.

86 Acts, ch 1156, § 8

514E.9 Rules.

Pursuant to chapter 17A, the commissioner and the director of public health shall adopt rules to provide for disclosure by carriers and organized delivery systems of the availability of insurance coverage from the association, and to otherwise implement this chapter.

86 Acts, ch 1156, § 9; 97 Acts, ch 103, §54

514E.10 Collective action immunity.

Neither the participation by carriers or members in the association, the establishment of rates, forms, or procedures for coverage issued by the association, nor any joint or collective action required by this chapter shall be the basis of any legal civil action, or criminal liability against the association or members of it either jointly or separately.

86 Acts, ch 1156, § 10

514E.11 Notice of association policy.

Every carrier, including a health maintenance organization subject to chapter 514B and an organized delivery system, authorized to provide health care insurance or coverage for health care services in Iowa, shall provide a notice of the availability of coverage by the association to any person who receives a rejection of coverage for health insurance or health care services, or a notice to any person who is informed that a rate for health insurance or coverage for health care services will exceed the rate of an association policy, that person is eligible to apply for health insurance provided by the association. Application for the health insurance shall be on forms prescribed by the board and made available to the carriers and organized delivery systems.

86 Acts, ch 1156, § 11; 97 Acts, ch 103, §55