514G.103 Definitions.

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

1. *"Activities of daily living"* means at least bathing, continence, dressing, eating, toileting, and transferring.

2. *"Applicant"* means either of the following:

a. In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits.

b. In the case of a group long-term care insurance policy, the proposed certificate holder.

3. *"Benefit trigger"* means a contractual provision in a policy of long-term care insurance that conditions the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment, or on other conditions of the insured as specified in the policy. For purposes of a qualified long-term care insurance contract, *"benefit trigger"* means a determination by a licensed health care practitioner that an insured is a chronically ill individual. For purposes of this definition, *"licensed health care practitioner"* means the same as defined in section 7702B(c)(4) of the Internal Revenue Code.

4. *"Certificate"* means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

5. *"Chronically ill individual"* means the same as defined in section 7702B(c)(2) of the Internal Revenue Code.

6. *"Claim"* means a request for payment of benefits under an in-force long-term care insurance policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met.

7. *"Cognitive impairment"* means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

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

9. *"Group long-term care insurance"* means a long-term care insurance policy that is delivered or issued for delivery in this state to any of the following:

a. One or more employers or labor organizations, or to a trust or to the trustee or trustees of a fund established, created, or maintained by one or more employers or labor organizations or a combination thereof, for the benefit of employees or former employees or a combination thereof, or for members or former members or a combination thereof, of the employers or labor organizations.

b. Any professional, trade, or occupational association for its members or former or retired members, or a combination thereof, if the association meets both of the following requirements:

(1) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation.

(2) Has been maintained in good faith for purposes other than obtaining insurance.

c. (1) An association or associations, or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations, which files evidence with the commissioner prior to advertising, marketing, or offering a policy within this state by the association or associations, or their insurer, that the following organizational requirements have been met:

(a) At the outset, there is a minimum of one hundred members of the association or associations.

(b) The association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance.

(c) The association or associations have been in active existence for at least one year at the time of filing.

(d) The association or associations have a constitution and bylaws that require all of the following:

(i) The association or associations have regular meetings, not less than annually, to further the purposes of the members.

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members.

(iii) The members have voting privileges and representation on a governing board and committees.

(2) Thirty days after the required evidentiary filings have been made, the association or associations shall be deemed to satisfy the organizational requirements, unless the commissioner makes a finding that the association or associations do not satisfy those requirements.

d. A group other than those described in paragraphs "*a*" through "*c*", subject to a finding by the commissioner that all of the following are true:

(1) The issuance of the group policy is not contrary to the best interests of the public.

(2) The issuance of the group policy would result in economies of acquisition or administration.

(3) The benefits are reasonable in relation to the premiums charged.

10. *"Independent review entity"* means a review entity certified by the commissioner pursuant to section 514G.110, subsection 5.

11. *"Insurer"* means an entity qualified and licensed by the insurance division to transact the business of insurance in this state by a certificate issued pursuant to chapter 508, 512B, 514, or 514B.

12. *"Licensed health care professional"* means a qualified professional in an appropriate field for determining an insured's functional or cognitive impairment as it relates to the insured's specific diagnosis. Licensed health care professionals include but are not limited to physical therapists, occupational therapists, neurologists, physical medicine specialists, and rehabilitation medicine specialists.

13. *a. "Long-term care insurance"* means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than twelve consecutive months for each covered person on an expense-incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital. *"Long-term care insurance"* includes group and individual annuities and life insurance policies or riders that directly provide or supplement long-term care insurance. The term also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term also includes a qualified long-term care insurance contract. Long-term care insurance may be issued by an insurer.

b. "*Long-term care insurance*" does not include any insurance policy that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident-only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, *"long-term care insurance"* does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits, where neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

c. Notwithstanding any other provision of this chapter, any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this chapter.

14. "*Policy*" means any policy, contract, subscriber agreement, rider, or endorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital, or medical service corporation; prepaid health plan; or health maintenance organization or any similar organization.

15. "*Preexisting condition*" means a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services within six months preceding the effective date of coverage of an individual.

16. *"Qualified long-term care insurance contract"* or "*federally tax-qualified long-term care insurance contract"* means any of the following:

a. An individual or group insurance contract that meets the requirements of section 7702B(b) of the Internal Revenue Code, as follows:

(1) The only insurance protection provided under the contract is coverage of qualified long-term care services. A contract does not fail to satisfy the requirements of this subparagraph because payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(2) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the federal Social Security Act, as amended, or would be reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the federal Social Security Act only as a secondary payor. A contract does not fail to satisfy the requirements of this subparagraph because payments are made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(3) The contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code.

(4) The contract does not provide for a cash surrender value or for other money that can be paid, assigned or pledged as collateral for a loan, or borrowed except as provided in subparagraph (5).

(5) All refunds of premiums and all policyholder dividends or similar accounts under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund in the event of the death of the insured or a complete surrender or cancellation of the contract shall not exceed the aggregate premiums paid under the contract.

(6) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code.

b. The portion of a life insurance contract that provides long-term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the Internal Revenue Code.

2008 Acts, ch 1175, §4