513B.2 Definitions.

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

1. *"Actuarial certification"* means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of section 513B.4, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods utilized by the small employer carrier in establishing premium rates for applicable health insurance coverages.

2. *"Base premium rate"* means, for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under a rating system for that class of business, by the small employer carrier to small employers for health insurance plans with the same or similar coverage.

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

4. *"Carrier"* means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

5. *"Case characteristics"* means demographic or other relevant characteristics of a small employer, as determined by a small employer carrier, which are considered by the insurer in the determination of premium rates for the small employer. Claim experience, health status, and duration of coverage since issue are not case characteristics for the purpose of this subchapter.

6. *"Class of business"* means all or a distinct grouping of small employers as shown on the records of the small employer carrier.

a. A distinct grouping may only be established by the small employer carrier on the basis that the applicable health insurance coverages meet one or more of the following requirements:

(1) The coverages are marketed and sold through individuals and organizations which are not participating in the marketing or sales of other distinct groupings of small employers for the small employer carrier.

(2) The coverages have been acquired from another small employer carrier as a distinct grouping of plans.

(3) The coverages are provided by a policy of group health insurance coverage through a bona fide association as provided in section 509.1, subsection 8, which meets the requirements for a class of business under section 513B.4. A small employer carrier may condition coverages under such a policy of group health insurance coverage on any of the following requirements:

(a) Minimum levels of participation by employees of each member of a bona fide association that offers the coverage to its employees.

(b) Minimum levels of contribution by each member of a bona fide association that offers the coverage to its employees.

(c) A specified policy term, subject to annual premium rate adjustments as permitted by section 513B.4.

(4) The coverages are provided by a policy of group health insurance coverage through two or more bona fide associations as provided in section 509.1, subsection 8, which a small employer carrier has aggregated as a distinct grouping that meets the requirements for a class of business under section 513B.4. After a distinct grouping of bona fide associations is established as a class of business, the small employer carrier shall not remove a bona fide association from the class based on the claims experience of that association. A small employer carrier may condition coverages under such a policy of group health insurance coverage on any of the following requirements:

(a) Minimum levels of participation by employees of each member of a bona fide association in the class that offers the coverage to its employees.

(b) Minimum levels of contribution by each member of a bona fide association in the class that offers the coverage to its employees.

(c) A specified policy term, subject to annual premium rate adjustments as permitted by section 513B.4.

b. A small employer carrier may establish additional groupings under each of the subparagraphs in paragraph *"a"* on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs.

c. The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer insurance marketplace.

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

8. *"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 Tit. XVIII of the federal Social Security Act.

d. Medicaid pursuant to Tit. 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. A short-term limited duration policy.

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

9. *"Division"* means the division of insurance.

10. *"Eligible employee"* means an employee who works on a full-time basis and has a normal workweek of thirty or more hours. The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under health insurance coverage of a small employer, but does not include an employee who works on a part-time, temporary, or substitute basis.

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 subsection, a partnership which establishes and maintains a plan, fund, or program to provide medical care to present or former partners in the partnership or to their dependents directly or through insurance, reimbursement, or other method, which would not be an employee benefit welfare plan but for this paragraph, shall be treated as an employee benefit welfare plan which is a group health plan.

(1) For purposes of a group health plan, an employer includes the partnership in relation to any partner.

(2) For purposes of a group health plan, the term *"participant"* also includes both of the following:

(a) An individual who is a partner in relation to a partnership which maintains a group health plan.

(b) An individual who is a self-employed individual in connection with a group health plan maintained by the self-employed individual where one or more employees are participants, if the individual is or may become eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive a benefit.

12. *a. "Health insurance coverage"* means benefits consisting of health care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

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.

f. "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan.

13. *"Index rate"* means, for each class of business for small employers, the average of the applicable base premium rate and the corresponding highest premium rate.

14. *"Late enrollee"* means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided the initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if any of the following apply:

a. The individual meets all of the following:

(1) The individual was covered under creditable coverage at the time of the initial enrollment.

(2) The individual lost creditable coverage as a result of termination of the individual's employment or eligibility, the involuntary termination of the creditable coverage, death of the individual's spouse, or the individual's divorce.

(3) The individual requests enrollment within thirty days after termination of the creditable coverage.

b. The individual is employed by an employer that offers multiple health insurance coverages and the individual elects a different coverage during an open enrollment period.

c. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health insurance coverage and the request for enrollment is made within thirty days after issuance of the court order.

d. The individual changes status and becomes an eligible employee and requests enrollment within sixty-three days after the date of the change in status.

e. The individual was covered under a mandated continuation of group health plan or group health insurance coverage plan until the coverage under that plan was exhausted.

15. *"New business premium rate"* means, for each class of business as to a rating period, the lowest premium rate charged or offered by the small employer carrier to small employers for newly issued health insurance coverages with the same or similar coverage.

16. *"Preexisting conditions exclusion"* means, with respect to health insurance coverage, 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.

17. *"Rating period"* means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier.

18. *"Small employer"* means a person actively engaged in business who, on at least fifty percent of the employer's working days during the preceding year, employed at least one and not more than fifty full-time equivalent eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation are considered one employer.

19. *"Small employer carrier"* means any carrier which offers health benefit plans covering the employees of a small employer.

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

91 Acts, ch 244, §2; 92 Acts, ch 1167, §1; 93 Acts, ch 80, §2, 3; 94 Acts, ch 1176, §9; 95 Acts, ch 185, §9; 97 Acts, ch 103, §2 – 11; 98 Acts, ch 1057, §8; 2000 Acts, ch 1023, §20; 2001 Acts, ch 69, §13, 39; 2007 Acts, ch 57, §3 – 5, 8; 2007 Acts, ch 215, §255; 2009 Acts, ch 118, §20; 2011 Acts, ch 70, §26, 49; 2017 Acts, ch 148, §37

Referred to in §135H.3, 509.1, 509.3, 509A.13B, 514A.3B, 514B.9A, 514C.14, 514C.15, 514C.16, 514C.17, 514C.22, 514C.27, 514C.31, 514F.5, 729.6