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 as set forth in the benefit plans adopted by the association's board of directors and approved by the commissioner.

3. *"Carrier"* means an insurer providing accident and sickness insurance under chapter 509, 514, 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 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. The hawk-i program authorized by chapter 514I.

7. *"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 Tit. XVIII of the federal Social Security Act, or a state plan under Tit. 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.

f. Who has been confirmed eligible under the federal Trade Adjustment Act of 2002, Pub. L. No. 107-210, as a recipient under that Act, by the department of workforce development and the federal internal revenue service.

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

9. *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.

10. *"Health care services"* means services, the coverage of which is authorized under chapter 509, chapter 514, chapter 514A, or chapter 514B as limited by benefit plans established by the association's board of directors, with the approval of the commissioner and includes services for the purposes of preventing, alleviating, curing, or healing human illness, injury or physical disability.

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

12. *a.* *"Health insurance coverage"* means health insurance coverage offered to individuals, including group conversion coverage.

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.

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

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

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

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

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

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

19. *"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; 2004 Acts, ch 1110, §40 – 43; 2004 Acts, ch 1158, §6 – 9; 2008 Acts, ch 1123, §25, 26; 2008 Acts, ch 1188, §17; 2009 Acts, ch 118, §2, 5; 2017 Acts, ch 148, §83, 84

Referred to in §514E.2