513C.3 Definitions.

As used in this chapter, 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 an individual carrier is in compliance with the provisions of section 513C.5 which is based upon the actuary's or individual's examination, including a review of the appropriate records and the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable individual health benefit plans.

2. *"Affiliate"* or *"affiliated"* means any entity or person who directly or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

3. *"Basic or standard health benefit plan"* means the core group of health benefits developed pursuant to section 513C.8.

4. *"Block of business"* means all the individuals insured under the same individual health benefit plan.

5. *"Carrier"* means any entity that provides individual health benefit plans in this state. For purposes of this chapter, carrier includes an insurance company, a group hospital or medical service corporation, a fraternal benefit society, a health maintenance organization, and any other entity providing an individual plan of health insurance or health benefits subject to state insurance regulation.

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

7. *"Eligible individual"* means an individual who is a resident of this state and who either has qualifying existing coverage or has had qualifying existing coverage within the immediately preceding thirty days, or an individual who has had a qualifying event occur within the immediately preceding thirty days.

8. *"Established service area"* means a geographic area, as approved by the commissioner and based upon the carrier's certificate of authority to transact business in this state, within which the carrier is authorized to provide coverage.

9. *"Filed rate"* means, for a rating period related to each block of business, the rate charged to all individuals with similar rating characteristics for individual health benefit plans.

10. *"Individual health benefit plan"* means any hospital or medical expense incurred policy or certificate, hospital or medical service plan, or health maintenance organization subscriber contract sold to an individual, or any discretionary group trust or association policy, whether issued within or outside of the state, providing hospital or medical expense incurred coverage to individuals residing within this state. Individual health benefit plan does not include a self-insured group health plan, a self-insured multiple employer group health plan, a group conversion plan, an insured group health plan, accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

11. *"Premium"* means all moneys paid by an individual and eligible dependents as a condition of receiving coverage from a carrier or an organized delivery system, including any fees or other contributions associated with an individual health benefit plan.

12. *"Qualifying event"* means any of the following:

a. Loss of eligibility for medical assistance provided pursuant to chapter 249A or Medicare coverage provided pursuant to Tit. XVIII of the federal Social Security Act.

b. Loss or change of dependent status under qualifying previous coverage.

c. The attainment by an individual of the age of majority.

d. Loss of eligibility for the Hawki program authorized in chapter 514I.

13. *a. "Qualifying existing coverage"* or *"qualifying previous coverage"* means benefits or coverage provided under any of the following:

(1) Any group health insurance that provides benefits similar to or exceeding benefits provided under the standard health benefit plan, provided that such policy has been in effect for a period of at least one year.

(2) An individual health insurance benefit plan, including coverage provided under a health maintenance organization contract, a hospital or medical service plan contract, or a fraternal benefit society contract, that provides benefits similar to or exceeding the benefits provided under the standard health benefit plan, provided that such policy has been in effect for a period of at least one year.

b. For purposes of this subsection, an association policy under chapter 514E is not considered *"qualifying existing coverage"* or *"qualifying previous coverage"*.

14. *"Rating characteristics"* means demographic characteristics of individuals which are considered by the carrier in the determination of premium rates for the individuals and which are approved by the commissioner.

15. *"Rating period"* means the period for which premium rates established by a carrier are in effect.

16. *"Restricted network provision"* means a provision of an individual health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier to provide health care services to covered individuals.

95 Acts, ch 5, §5; 2002 Acts, ch 1111, §14; 2003 Acts, ch 108, §131; 2004 Acts, ch 1110, §35; 2004 Acts, ch 1158, §1; 2012 Acts, ch 1023, §79, 157; 2017 Acts, ch 148, §46 - 51; 2023 Acts, ch 19, §1190

Referred to in §514A.3B
Subsection 12, paragraph d amended