

**514C.8 Coordination of health care benefits with state medical assistance.**

1. An insurer, health maintenance organization, or hospital and medical service plan providing health care coverage to individuals in this state shall not consider the availability of or eligibility for medical assistance under Tit. XIX of the federal Social Security Act and [chapter 249A](#), when determining eligibility of the individual for coverage or calculating payments to the individual under the health care coverage plan.

2. The state acquires the rights of an individual to payment from an insurer, health maintenance organization, or hospital or medical service plan to the extent payment for covered expenses is made pursuant to [chapter 249A](#) for health care items or services provided to the individual. Upon presentation of proof that payment was made pursuant to [chapter 249A](#) for covered expenses, the insurer, health maintenance organization, or hospital or medical service plan shall make payment to the state medical assistance program to the extent of the coverage provided in the policy or contract.

3. An insurer shall not impose requirements on the state with respect to the assignment of rights pursuant to [this section](#) that are different from the requirements applicable to an agent or assignee of a covered individual.

4. For purposes of [this section](#), “insurer” means an entity which offers a health benefit plan, including a group health plan under the federal Employee Retirement Income Security Act of 1974.

[95 Acts, ch 185, §13; 2010 Acts, ch 1061, §180](#)