ARC 8112B

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 514I.5, the Department of Human Services proposes to amend Chapter 86, "Healthy and Well Kids in Iowa (HAWK-I) Program," Iowa Administrative Code.

The proposed amendments:

- Clarify that there are separate health and dental plans participating in the HAWK-I program; and
- Implement a new program to provide dental coverage to children who would be eligible for HAWK-I benefits except that they have health insurance.

Currently, children must be uninsured to obtain dental coverage through the HAWK-I program. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows states the option to offer a dental-only program. The General Assembly has appropriated funding to implement a dental-only program with approval of the HAWK-I Board. The HAWK-I Board has directed the Department to offer dental-only coverage to children who would qualify for the HAWK-I program except that they have health insurance.

Under these amendments, children who have health insurance but who do not have dental coverage can qualify for supplemental dental-only coverage to receive necessary preventive and restorative dental services. Some families will be charged a premium to participate in the program, based on their income. The amendments require coverage of diagnostic and preventive services, routine and restorative services, endodontic services, periodontal services, cast restorations, and prosthetics. Orthodontia is not a covered service. Payments will be made on a capitation basis.

These amendments do not contain a waiver provision because an extension of eligibility and coverage benefits the children affected. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

Any interested person may make written comments on the proposed amendments on or before September 29, 2009. Comments should be directed to Mary Ellen Imlau, Bureau of Policy Analysis and Appeals, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by E-mail to policyanalysis@dhs.state.ia.us.

These amendments are intended to implement Iowa Code sections 514I.4 through 514I.7 as amended by 2009 Iowa Acts, Senate File 389, sections 26 and 31 through 34.

The following amendments are proposed.

ITEM 1. Amend **441—Chapter 86**, preamble, as follows:

PREAMBLE

These rules define and structure the department of human services healthy and well kids in Iowa (HAWK-I) program. The purpose of this program is to provide transitional health and dental care coverage to uninsured children who are ineligible for Title XIX (Medicaid) assistance. The program is implemented and administered in compliance with Title XXI of the federal Social Security Act. The rules establish requirements for the third-party administrator responsible for the program administration and for the participating health and dental plans that will be delivering services to the enrollees.

ITEM 2. Amend rule **441—86.1(514I)**, definitions of "Benchmark benefit package," "Capitation rate," "Contract," "Covered services," "Emergency services," "HAWK-I program" and "Provider," as follows:

"Benchmark benefit package for health care coverage" shall mean any of the following:

1. to 3. No change.

"Capitation rate" shall mean the fee the department pays monthly to a participating health or dental plan for each enrollee for the provision of covered medical or dental services whether or not the enrollee received services during the month for which the fee is intended.

"Contract" shall mean the contract between the department and the person or entity selected as the third-party administrator or the contract between the department and the participating health or dental plan for the provision of medical or dental services to HAWK-I enrollees for whom the participating health or dental plans assume risk.

"Covered services" shall mean all or a part of those medical and ~~health~~ dental services set forth in rule 441—86.14(514I).

"Emergency services" shall mean, with respect to an individual enrolled with a plan, covered inpatient and outpatient services which are furnished by a provider qualified to furnish these services and which are needed to evaluate and stabilize an emergency medical or dental condition.

"HAWK-I program" or *"program"* shall mean the healthy and well kids in Iowa program implemented in this chapter to provide health and dental care coverage to eligible children.

"Health insurance coverage" shall mean health insurance coverage as defined in ~~42 U.S.C. Section 300gg(c)~~ 45 CFR Section 144.103, as amended to October 1, 2008.

"Provider" shall mean an individual, firm, corporation, association, or institution that is providing or has been approved to provide medical or dental care or services to an enrollee pursuant to the HAWK-I program.

ITEM 3. Adopt the following **new** definitions of "Dentist," "Emergency dental condition" and "Participating dental plan" in rule **441—86.1(514I)**:

"Dentist" shall mean a person who is licensed to practice dentistry in Iowa as provided in Iowa Code chapter 153.

"Emergency dental condition" shall mean an oral condition that occurs suddenly and creates an urgent need for professional consultation or treatment. Emergency conditions may include hemorrhage, infection, pain, broken teeth, knocked-out teeth, or other trauma.

"Participating dental plan" shall mean any entity licensed by the division of insurance of the department of commerce to provide dental insurance in Iowa that has contracted with the department to provide dental insurance coverage to eligible children under this chapter.

ITEM 4. Amend subrule 86.2(11) as follows:

86.2(11) *Preexisting ~~medical~~ conditions.* The child shall not be denied eligibility based on the presence of a preexisting medical or dental condition.

ITEM 5. Amend rule 441—86.6(514I) as follows:

441—86.6(514I) Selection of a plan. At the time of initial application, if there is more than one participating health or dental plan available in the child's county of residence, the applicant shall select the health or dental plan in which the applicant wishes to enroll as part of the eligibility process. The enrollee may change plans only at the time of the annual review unless the provisions of subrule 86.7(1) or paragraph 86.6(2)*"a"* apply. The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.

86.6(1) *Coverage in another county's health plan.* If a child traditionally travels to another county to receive medical care, the applicant may choose to participate in the health plan available in the county in which the child receives medical care.

86.6(2) *Period of enrollment.* Once enrolled in a health or dental plan, the child shall remain enrolled in the selected health or dental plan for a period of 12 months unless:

a. There is a substantial change in the provider panel of the health or dental plan originally chosen, as determined by the board. A substantial change means, but is not limited to, loss of a contracted hospital or provider group. When there is another participating health or dental plan available in the child's county of residence, the child may disenroll from the current health or dental plan and enroll in the other health or dental plan.

b. The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled unless the provisions of subrule 86.7(1) apply.

c. No change.

86.6(3) *Failure to select a health or dental plan.* When more than one health or dental plan is available, if the applicant fails to select a health or dental plan within ten working days of the written request to make a selection, the third-party administrator shall select the health or dental plan and notify the family of the enrollment. The third-party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating health and dental plans.

a. If the third-party administrator has assigned a child a health or dental plan, the family has 30 days to request enrollment into another participating health or dental plan. All changes shall be made prospectively and shall be effective on the first day of the month following the month of the request.

b. If the family has not requested a change of enrollment into another available health or dental plan within 30 days, the provisions of 86.6(2) shall apply.

86.6(4) *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

86.6(5) *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose. The child shall remain enrolled in the current health or dental plan if the family does not notify the third-party administrator of a new health or dental plan choice by the end of the current 12-month enrollment period.

ITEM 6. Amend rule 441—86.7(514I) as follows:

441—86.7(514I) ~~Disenrollment~~ Cancellation. The ~~child~~ child's eligibility for the HAWK-I program shall be ~~disenrolled from the selected plan prior to~~ canceled before the end of the 12-month enrollment period for any of the following:

~~**86.7(1)** *Child moves from the service area.* The child may be disenrolled from the plan when the child moves to an area of the state in which the plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.~~

86.7(2) *Age.* The child shall be ~~disenrolled from the plan and~~ canceled from the HAWK-I program as of the first day of the month following the month in which the child attained the age of 19.

86.7(3) *Nonpayment of premiums.* The child shall be ~~disenrolled from the plan and~~ canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3) and 86.8(5).

86.7(4) *Iowa residence abandoned.* The child shall be ~~disenrolled from the plan and~~ canceled from the program as of the first day of the month following the month in which the child relocated to another state. ~~A child~~ Eligibility shall not be ~~disenrolled~~ canceled when the child is temporarily absent from the state in accordance with the provisions of subrule 86.2(6).

86.7(5) *Eligible for Medicaid.* The child shall be ~~disenrolled from the plan and~~ canceled from the program as of the first day of the month following the month in which the third-party administrator is notified of Medicaid eligibility. If there are months during which the child is covered by both the Medicaid and HAWK-I programs, the HAWK-I program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(6) *Enrolled in other health insurance coverage.* The child shall be ~~disenrolled~~ canceled from the ~~plan~~ program as of the first day of the month following the month in which the third-party administrator is notified that the child has other health or dental insurance coverage. If the child has obtained only health insurance coverage, dental coverage may continue under the supplemental dental

program in accordance with the provisions of rule 441—86.20(514I). If there are months during which the child is covered by both another insurance plan and the HAWK-I program, the other insurance plan shall be the primary payor and HAWK-I shall be the payor of last resort.

86.7(7) *Admission to a nonmedical public institution.* The child shall be ~~disenrolled from the plan and~~ canceled from the program as of the first day of the month following the month in which the child enters a nonmedical public institution unless the temporary absence provisions of paragraph 86.2(3)*"d"* apply.

86.7(8) *Admission to an institution for mental disease.* The child shall be ~~disenrolled from the plan and~~ canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(9) *Employment with the state of Iowa.* The child shall be ~~disenrolled from the plan and~~ canceled from the HAWK-I program as of the first day of the month in which the child's parent became eligible to participate in a health or dental plan available to state of Iowa employees.

ITEM 7. Amend subrule 86.8(2), introductory paragraph, as follows:

86.8(2) *Premium amount.* ~~Premiums~~ Except as specified for supplemental dental-only coverage in subrule 86.20(4), premiums under the HAWK-I program shall be assessed as follows:

ITEM 8. Amend subparagraph **86.8(3)"b"(2)** as follows:

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the third-party administrator shall notify the ~~plan~~ health and dental plans of the enrollment.

ITEM 9. Amend paragraph **86.8(3)"c"** as follows:

c. Subsequent payments. All subsequent premiums are due by the tenth day of each month for the next month's coverage and must be postmarked no later than the last day of the month before the month of coverage. Failure to pay the premium by the last day of the month before the month of coverage shall result in ~~disenrollment~~ cancellation from the ~~plan~~ program. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

ITEM 10. Amend subrule 86.8(6) as follows:

86.8(6) *Failure to pay premium.* Failure to pay the premium in accordance with subrules 86.8(3) and 86.8(5) shall result in ~~disenrollment from the plan and~~ cancellation from the program unless the reinstatement provisions of subrule 86.8(4) apply. Once a child is ~~disenrolled and~~ canceled from the program due to nonpayment of premiums, the family must reapply for coverage.

ITEM 11. Rescind and reserve subrule **86.9(3)**.

ITEM 12. Amend paragraph **86.13(2)"c"** as follows:

c. Participating health and dental plan information.

ITEM 13. Amend paragraph **86.13(6)"f"** as follows:

f. Notifying the health and dental plans when the number of enrollees who speak the same non-English language equals or exceeds 10 percent of the number of enrollees in the health or dental plan.

ITEM 14. Amend subrules 86.13(8) to 86.13(10) as follows:

86.13(8) *Selection of health or dental plan.* The third-party administrator shall provide participating health and dental plan information to families of eligible children by telephone or mail and, if necessary, offer unbiased assistance in the selection of a health or dental plan in accordance with the provisions of rule 441—86.6(514I).

86.13(9) *Enrollment.* The third-party administrator shall notify participating health and dental plans of enrollments.

86.13(10) *Disenrollments.* The third-party administrator shall disenroll an enrollee when the enrollee's eligibility for the HAWK-I program is canceled in accordance with the provisions of rule 441—86.7(514I). The third-party administrator shall notify the participating health ~~plan~~ health and dental plans when an enrollee is disenrolled.

ITEM 15. Amend subrule 86.14(1) as follows:

86.14(1) *Required medical services.* The participating health plan shall cover at a minimum the following medically necessary services:

a. to *k.* No change.

~~*l.* Dental services (including restorative and preventative services).~~

m. and *n.* No change.

ITEM 16. Adopt the following **new** subrule 86.14(3):

86.14(3) *Required dental services.* Participating dental plans shall cover at a minimum the following necessary dental services:

a. Diagnostic and preventive services.

b. Routine and restorative services.

c. Endodontic services.

d. Periodontal services.

e. Cast restorations.

f. Prosthetics.

ITEM 17. Amend rule 441—86.15(514I) as follows:

441—86.15(514I) Participating health and dental plans.

86.15(1) *Licensure.* The participating health or dental plan must:

a. ~~be~~ Be licensed by the division of insurance of the department of commerce to provide health or dental care coverage in Iowa; or

b. ~~be~~ Be an organized delivery system licensed by the director of public health to provide health or dental care coverage.

86.15(2) *Services.* The participating health or dental plan shall provide ~~health care~~ coverage for the services specified in rule 441—86.14(514I) to all children determined eligible by the third-party administrator.

a. The participating health or dental plan shall make services it provides to HAWK-I enrollees at least as accessible to the enrollees (in terms of timeliness, duration and scope) as those services are accessible to other commercial enrollees in the area served by the health or dental plan.

b. No change.

c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county within the region in which the health or dental plan has contracted to provide services in which it is licensed and in which a provider network has been established. Regions are specified in rule 441—86.1(514I).

86.15(3) *Premium tax.* Premiums paid to participating health and dental plans by the third-party administrator are exempt from premium tax.

86.15(4) *Provider network.* The participating health or dental plan shall establish a network of providers. Providers contracting with the participating health or dental plan shall comply with HAWK-I requirements, which shall include collecting copayments, if applicable.

86.15(5) ~~*Medical*~~ *Identification cards.* ~~Medical identification~~ Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.15(6) *Marketing.*

a. Participating health and dental plans may not distribute directly or through an agent or independent contractor any marketing materials.

b. No change.

c. At a minimum, participating health and dental plans must provide the following material in writing or electronically:

(1) No change.

(2) All health and dental plan literature and brochures shall be available in English and any other language when enrollment in the health or dental plan by enrollees who speak the same non-English

language equals or exceeds 10 percent of all enrollees in the health or dental plan and shall be made available to the third-party administrator for distribution.

d. All health and dental plan literature and brochures shall be approved by the department.

e. The participating health and dental plans shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing.

f. The participating health or dental plan may make marketing presentations at the discretion of the department.

86.15(7) *Appeal process.* The participating health or dental plan shall have a written procedure by which enrollees may appeal issues concerning the health or dental care services provided through providers contracted with the health or dental plan and which:

a. to *d.* No change.

e. Ensures that the decision be made by a physician, dentist, or clinical peer not previously involved in the case.

f. to *h.* No change.

i. Ensures that the participating health or dental plan's written appeal procedures be provided to each newly covered enrollee.

j. Requires that the participating health or dental plan make quarterly reports to the department summarizing appeals and resolutions.

86.15(8) *Appeals to the department.* Rescinded IAB 1/13/99, effective 1/1/99.

86.15(9) *Records and reports.* The participating health ~~plan~~ and dental plans shall maintain records and reports as follows:

a. The health or dental plan shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition, the health or dental plan or subcontractor of the health or dental plan, as appropriate, must maintain a medical or dental records system that:

(1) Identifies each medical or dental record by HAWK-I enrollee identification number.

(2) Maintains a complete medical or dental record for each enrollee.

(3) Provides a specific medical or dental record on demand.

(4) No change.

(5) Maintains the confidentiality of medical or dental records information and releases the information only in accordance with established policy below:

1. All medical and dental records of the enrollee shall be confidential and shall not be released without the written consent of the enrollee or responsible party.

2. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, other practitioners, or facilities that are providing services to enrollees under a subcontract with the health or dental plan. This provision also applies to specialty providers who are retained by the health or dental plan to provide services which are infrequently used, which provide a support system service to the operation of the health or dental plan, or which are of an unusual nature. This provision is also intended to waive the need for written consent for department staff and the third-party administrator assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the health or dental plan itself, and other subcontractors which require information as described under numbered paragraph "5" below.

3. Written consent is not required for the transmission of medical or dental records information to physicians, dentists, or facilities providing emergency care pursuant to paragraph 86.15(2)*"b."*

4. Written consent is required for the transmission of the medical or dental records information of a former enrollee to any physician or dentist not connected with the health or dental plan.

5. The extent of medical or dental records information to be released in each instance shall be based upon a test of medical or dental necessity and a "need to know" on the part of the practitioner or a facility requesting the information.

6. Medical and dental records maintained by subcontractors shall meet the requirements of this rule.

EXCEPTION: Written consent is required for the transmission of medical records relating to substance abuse, HIV, or mental health treatment in accordance with state and federal laws.

b. Each health or dental plan shall provide at a minimum reports and plan information to the third-party administrator as follows:

(1) A list of providers of ~~medical~~ services under the plan.

~~(2) Rescinded IAB 10/17/01, effective 12/1/01.~~

~~(3) Rescinded IAB 10/17/01, effective 12/1/01.~~

~~(4) Rescinded IAB 10/17/01, effective 12/1/01.~~

~~(5)~~ (2) Encounter data on a monthly basis as required by the department.

~~(6) Rescinded IAB 10/17/01, effective 12/1/01.~~

~~(7)~~ (3) Other information as directed by the department.

c. Each health or dental plan shall at a minimum provide reports and health or dental plan information to the department as follows:

(1) to (5) No change.

86.15(10) *Systems.* The participating health or dental plan shall maintain data files that are compatible with the department's and third-party administrator's systems.

86.15(11) *Payment to the participating health or dental plan.*

a. In consideration for all services rendered by a health or dental plan, the health or dental plan shall receive a payment each month for each enrollee. This capitation rate represents the total obligation of the department with respect to the costs of medical or dental care and services provided to the enrollees.

b. No change.

c. The capitation rate does not include any amounts for the recoupment of losses suffered by the health or dental plan for risks assumed under the current or any previous contract. The health or dental plan accepts the rate as payment in full for the contracted services. Any savings realized by the health or dental plan due to lower utilization from a less frequent incidence of health or dental problems among the enrolled population shall be wholly retained by the health or dental plan.

d. If an enrollee has third-party coverage or a responsible party other than the HAWK-I program available for purposes of payment for medical or dental expenses, it is the right and responsibility of the health or dental plan to investigate these third-party resources and attempt to obtain payment. The health or dental plan shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

86.15(12) *Quality assurance.* The health or dental plan shall have in effect an internal quality assurance system.

ITEM 18. Amend rule 441—86.19(514I) as follows:

441—86.19(514I) Recovery.

86.19(1) *Definitions.*

"Administrative error" means an action attributed to the department or to the HAWK-I third-party administrator that results in incorrect payment of benefits, including premiums paid to a health or dental plan, due to one or more of the following circumstances:

1. to 9. No change.

"Client error" means an intentional or negligent action attributed to the enrollee that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because the enrollee or the enrollee's representative:

1. and 2. No change.

86.19(2) *Amount subject to recovery from the enrollee or representative.* The department may recover from the enrollee or the enrollee's representative the amount of premiums incorrectly paid to a health or dental plan on behalf of the enrollee due to client error, minus any premium payments made by the enrollee, in accordance with 441—Chapter 11.

a. Premiums incorrectly paid to a health or dental plan on behalf of an enrollee due to an administrative error are not subject to recovery from the enrollee.

b. Payments made by a health or dental plan to a provider of medical or dental services are not subject to recovery from the enrollee regardless of the cause of the error.

86.19(3) to **86.19(5)** No change.

ITEM 19. Adopt the following **new** rule 441—86.20(514I):

441—86.20(514I) Supplemental dental-only coverage.

86.20(1) *Definition.*

"Supplemental dental-only coverage" means dental care coverage provided to a child who meets the eligibility requirements for the HAWK-I program except that the child is covered by health insurance through an individual or group health plan.

86.20(2) *Eligibility.* Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.1(514I) through 441—86.12(514I), 441—86.18(514I), and 441—86.19(514I).

86.20(3) *Insured status.* The child may be enrolled in an individual or group health plan. However, a child who is currently enrolled in an individual or group dental plan is not eligible to participate in the supplemental dental-only coverage.

86.20(4) *Premiums.* Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families who meet the provisions of paragraph 86.8(2)*"a."*

b. If the family's gross countable income is equal to or exceeds 150 percent of the federal poverty level but does not exceed 200 percent of the federal poverty level for a family of the same size, the premium is $5 per child per month with a $10 monthly maximum per family.

c. If the family's gross countable income is equal to or exceeds 200 percent of the federal poverty level but does not exceed 250 percent of the federal poverty level for a family of the same size, the premium is $10 per child per month with a $15 monthly maximum per family.

d. If the family's gross countable income is equal to or exceeds 250 percent of the federal poverty level but does not exceed 300 percent of the federal poverty level for a family of the same size, the premium is $15 per child per month with a $20 monthly maximum per family.

e. If the family includes uninsured children who are eligible for both medical and dental coverage under HAWK-I and insured children who are eligible only for dental coverage, the premium shall be assessed as follows:

(1) The total premium shall be no more than the amount that the family would pay if all the children were eligible for both medical and dental coverage.

(2) If the family has one child eligible for both medical and dental coverage and one child eligible for dental coverage only, the premium shall be the total of the health and dental premium for one child and the dental premium for one child.

(3) If the family has two or more children eligible for both medical and dental coverage, no additional premium shall be assessed for dental-only coverage for the children who do not qualify for medical coverage under HAWK-I because they are covered by health insurance.

ITEM 20. Amend **441—Chapter 86**, implementation sentence, as follows:

These rules are intended to implement Iowa Code chapter 514I as amended by 2009 Iowa Acts, Senate File 389.