Regulatory Analysis

Notice of Intended Action to be published: 441—Chapter 74
"Iowa Health and Wellness Plan"

Iowa Code section(s) or chapter(s) authorizing rulemaking: 249A and 249N
State or federal law(s) implemented by the rulemaking: Iowa Code chapters 249A and 249N

Public Hearing

A public hearing at which persons may present their views orally or in writing will be held as follows:

December 2, 2025 10 a.m.	Microsoft Teams Meeting ID: 271 715 163 940 1 Passcode: vY6Zj9Sz

Public Comment

Any interested person may submit written or oral comments concerning this Regulatory Analysis, which must be received by the Department of Health and Human Services no later than 4:30 p.m. on the date of the public hearing. Comments should be directed to:

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Purpose and Summary

This proposed chapter defines and structures the Iowa Health and Wellness Plan, a medical assistance program for individuals with countable income that does not exceed 133 percent of the federal poverty level. This proposed chapter underwent a Red Tape Review pursuant to Executive Order 10. As a result, the Department removed duplicative, redundant, and outdated language and information. In addition, the Department is changing the due date for financial participation payments from the last day of the month to the fifteenth day of the month.

Analysis of Impact

1. **Persons affected by the proposed rulemaking:**

- **Classes of persons that will bear the costs of the proposed rulemaking:**

There are no costs associated with this proposed rulemaking.

- **Classes of persons that will benefit from the proposed rulemaking:**

Individuals who are covered by or eligible for the Iowa Health and Wellness Plan will benefit from the guidance in this proposed rulemaking.

2. **Impact of the proposed rulemaking, economic or otherwise, including the nature and amount of all the different kinds of costs that would be incurred:**

- **Quantitative description of impact:**

Almost 186,000 people were enrolled in the Iowa Health and Wellness Plan as of June 2025.

- **Qualitative description of impact:**

This proposed chapter defines and structures the Iowa Health and Wellness Plan, a medical assistance program for individuals with countable income that does not exceed 133 percent of the federal poverty level.

3. **Costs to the State:**

- **Implementation and enforcement costs borne by the agency or any other agency:**

The Department incurs personnel and other administrative costs to implement this proposed chapter.

- **Anticipated effect on State revenues:**

This proposed rulemaking has no effect on State revenues. The underlying program has a fiscal impact to the State. Information on historical expenditure will be submitted to the Legislative Services Agency with the Notice of Intended Action.

4. **Comparison of the costs and benefits of the proposed rulemaking to the costs and benefits of inaction:**

Rulemaking is required by Iowa Code chapter 249N.

5. **Determination whether less costly methods or less intrusive methods exist for achieving the purpose of the proposed rulemaking:**

Not applicable.

6. **Alternative methods considered by the agency:**

- **Description of any alternative methods that were seriously considered by the agency:**

Not applicable.

- **Reasons why alternative methods were rejected in favor of the proposed rulemaking:**

Not applicable.

Small Business Impact

If the rulemaking will have a substantial impact on small business, include a discussion of whether it would be feasible and practicable to do any of the following to reduce the impact of the rulemaking on small business:

- Establish less stringent compliance or reporting requirements in the rulemaking for small business.
- Establish less stringent schedules or deadlines in the rulemaking for compliance or reporting requirements for small business.
- Consolidate or simplify the rulemaking's compliance or reporting requirements for small business.
- Establish performance standards to replace design or operational standards in the rulemaking for small business.
- Exempt small business from any or all requirements of the rulemaking.

If legal and feasible, how does the rulemaking use a method discussed above to reduce the substantial impact on small business?

This proposed rulemaking has no impact on small business.

Text of Proposed Rulemaking

ITEM 1. Rescind 441—Chapter 74 and adopt the following **new** chapter in lieu thereof:

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

441—74.1(249A,249N) Definitions. The following definitions apply to this chapter in addition to the definitions in 441—Chapter 75.

"Caretaker" means the same as defined in rule 441—75.1(249A).

"Countable income" means "modified adjusted gross income" (MAGI) or "household income," as applicable, determined pursuant to 42 U.S.C. §1396a(e)(14) as amended to July 1, 2026.

"Enrollment period" means the period of time for which Iowa health and wellness plan eligibility is established.

"Essential health benefits" means the essential health benefits defined at 42 U.S.C. §18022 as amended to July 1, 2026.

"Iowa dental wellness plan" means the managed care dental benefit program set forth in 441—Chapter 73.

"Iowa health and wellness plan" or *"IHAWP"* means the medical assistance program set forth in this chapter for individuals with countable income that does not exceed 133 percent of the federal poverty level (FPL).

"Iowa wellness plan" means the benefits and services provided to IHAWP members.

"Managed care organization" or *"MCO"* means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of "health maintenance organization" as defined in Iowa Code section 514B.1.

"Medical assistance" or *"Medicaid"* means payment of all parts of the cost of the care and services made in accordance with Title XIX of the Federal Social Security Act as amended to July 1, 2026.

"Medically frail individual" means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR 440.315 as amended to July 1, 2026.

"Minimum essential coverage" means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code as amended to July 1, 2026.

"Prepaid ambulatory health plan" or *"PAHP"* has the meaning set forth in 42 CFR 438.2 as amended to July 1, 2026.

"Qualified employer-sponsored coverage" is defined pursuant to 42 U.S.C. §1396e1(b) as amended to July 1, 2026.

441—74.2(249A,249N) Eligibility factors. Except as more specifically provided in this chapter, IHAWP eligibility will be determined according to the requirements of 441—Chapter 75.

74.2(1) *Persons covered.* Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under IHAWP will be available to persons 19 through 64 years of age who:

a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;

b. Have countable income at or below 133 percent of the FPL for their household size;

c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act as amended to July 1, 2026; and

d. Are not pregnant at the time of application or reenrollment.

74.2(2) *Parents or caretakers of dependent children.* All children under the age of 21 living with a parent or caretaker who will be claimed as a dependent by the parent or caretaker for state or federal income tax purposes must be enrolled in Medicaid, in the Children's Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent's or caretaker's eligibility for IHAWP benefits.

74.2(3) *Citizenship.* To be eligible for IHAWP benefits, a person must meet the citizenship requirements in 441—Chapter 75.

441—74.3(249A,249N) Application. Medicaid application policies and procedures described in 441—Chapter 76 apply to applications for IHAWP.

441—74.4(249A,249N) Financial eligibility.

74.4(1) *Countable income.* Individuals are financially eligible for IHAWP if their countable income is no more than 133 percent of the FPL as of the date of a decision on initial or ongoing eligibility.

74.4(2) *Household size.* For financial eligibility purposes, household size will be determined according to the MAGI methodology.

441—74.5(249A,249N) Enrollment period.

74.5(1) *Effective dates of eligibility.* IHAWP eligibility will be effective on the first day of the month of application or the first day of the month all eligibility requirements are met, whichever is later.

74.5(2) *Reinstatement.* Enrollment for IHAWP may be reinstated without a new application in accordance with 441—Chapter 76.

74.5(3) *Presumptive eligibility.* The enrollment period is based on a presumptive eligibility determination by a qualified entity in accordance with 441—Chapter 76.

74.5(4) *Retroactive enrollment.* Medical assistance will be available to a pregnant woman or an infant (under one year of age), or a resident of a nursing facility licensed under Iowa Code chapter 135C, for all or any of the three months preceding the month in which an application is filed when eligibility requirements are met in accordance with 441—Chapter 76.

441—74.6(249A,249N) Reporting changes.

74.6(1) *Reporting requirements.* In addition to the reporting requirements in 441—Chapter 76, as a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

a. The member enters a nonmedical institution, including but not limited to a penal institution.

b. The member abandons Iowa residency.

c. The member turns 65.

d. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.

e. A child under the age of 21 living with the member loses minimum essential coverage if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.

f. The member is pregnant.

74.6(2) *Untimely report.* When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible will be considered an overpayment and be subject to recovery from the member in accordance with 441—Chapters 75 and 11. Program expenditures may include but are not limited to premiums and capitation payments.

74.6(3) *Effective date of change.* After enrollment, changes reported during the month that affect the member's eligibility will be effective the first day of the next calendar month unless:

a. Timely notice of adverse action is required as specified in rule 441—16.2(17A); or

b. The enrollment period has expired and the member is not eligible for a new enrollment period.

441—74.7(249A,249N) Reenrollment. A new eligibility determination is required to establish an enrollment period. The reenrollment process will follow the requirements in 441—Chapter 76.

441—74.8(249A,249N) Terminating enrollment. IHAWP enrollment ends when any of the following occurs:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.

2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.

3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled to or enrolled in Medicare Part A or Part B or both.
8. A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or caretaker and will claim the child as a dependent for state or federal income tax purposes.
9. The member's countable income exceeds 133 percent of the FPL.
10. IHAWP is discontinued according to the requirements in rule 441—74.14(249A,249N).
11. The member does not pay monthly contributions as required by subrule 74.11(2).

441—74.9(249A,249N) Recovery. The department will recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with 441—Chapter 75.

74.9(1) The department will recover Medicaid funds expended on behalf of a member from the member's estate in accordance with 441—Chapter 75.

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the department or the MCO, and an adjustment will be made to a previously submitted claim.

441—74.10(249A,249N) Right to appeal.

74.10(1) Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed to the extent permitted by 441—Chapter 7.

74.10(2) Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,249N).

441—74.11(249A) Financial participation.

74.11(1) *Copayment.* Payment for nonemergency use of a hospital emergency department shall be subject to an $8 copayment by the member, which will be subtracted from the IHAWP payment otherwise due to the provider.

74.11(2) *Monthly contributions.* Members enrolled in the IHAWP with household income at or above 50 percent of the FPL are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to 441—Chapter 75, as a percentage of the FPL for the household. Monthly contribution amounts are as follows:

(1) For a member with household income between 50 and 100 percent of the FPL, $5;

(2) For a member with household income above 100 percent of the FPL, $10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

(1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.

(2) The member is determined by the department to be a medically frail individual pursuant to subrule 74.12(2).

(3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.

(4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as amended to July 1, 2026, as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning Iowa Medicaid member services, by checking the hardship box on the billing statement (for the month of the billing statement), or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted. Members must complete the process in every month for which they wish to claim financial hardship. There is no limit to the number of hardship exemptions for which a member may apply.

d. Billing and payment. An Iowa Medicaid billing statement form will be used for billing and collection of the monthly contribution.

(1) Method of payment. Members shall submit contribution payments to the address specified by the department. Members can also submit contributions through the department's website.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution is due on the fifteenth day of the month in which the statement is received.

2. If the fifteenth day of the month falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department will apply monthly contribution payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department will hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An IHAWP member with household income between 50 and 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) An IHAWP member with household income above 100 percent of the FPL who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) will have the member's eligibility terminated. In addition, the member shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with 441—Chapter 75. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions may reenroll for Medicaid benefits pursuant to 441—Chapter 76.

3. Unpaid premiums will not be considered a collectible debt by the state if, at the member's next annual renewal date, the member does not apply for renewed eligibility, and the member has no claims for services delivered after the month of the last premium payment.

f. Refund of monthly contributions.

(1) Monthly contributions paid may be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2)*"c"* or when a member's IHAWP coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in IHAWP; or

2. The member dies.

(2) The amount of any refund will be offset by any outstanding monthly contributions owed.

(3) The refund will be paid within two calendar months from the date of termination from the program.

74.11(3) *Aggregate annual limits on copayments and monthly contributions.* The total aggregate annual amount of copayments and monthly contributions for an individual will not exceed 5 percent of the household's countable annual income determined pursuant to 441—Chapter 75.

74.11(4) *Healthy behaviors.* An IHAWP member who completes a wellness examination and health risk assessment during any enrollment year will have monthly contributions waived in the subsequent enrollment year.

a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department. Oral examinations must be performed by a dental provider consistent with standard oral health guidelines for preventive dental examinations and as outlined in 441—Chapter 73.

b. A health risk assessment is an assessment offered by a managed care plan through which the member is receiving IHAWP benefits.

441—74.12(249A) Benefits and service delivery. Covered benefits and the service delivery method will be determined by the member's health status.

74.12(1) *Iowa wellness plan services.* Members shall be enrolled in IHAWP unless the member is determined by the department to be a medically frail individual.

a. Covered Iowa wellness plan services are essential health benefits; all other benefits required pursuant to 42 U.S.C. §1396u-7(b)(1)(B) as amended to July 1, 2026, including prescription drugs; and dental services consistent with 441—Chapter 78.

b. Members enrolled in IHAWP shall be subject to enrollment in managed care, other than program for all-inclusive care for the elderly (PACE) programs, pursuant to 441—Chapter 73.

c. Dental services will be provided under the Iowa dental wellness plan as set forth in 441—Chapter 73 through a contract with one or more dental prepaid ambulatory health plans. The dental prepaid ambulatory health plan shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(2) *Medically frail individuals.* An IHAWP member who has been determined by the department to be a medically frail individual will be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

a. A provider with a current national provider identifier number, an employee of the department, a designee of the department of corrections, an MCO, a behavioral health administrative service organization established pursuant to Iowa Code chapter 225A, or a disability access point established pursuant to Iowa Code chapter 231 may refer a member for a medically frail individual determination by submitting a completed form prescribed by the department.

b. Upon receipt of the appropriate forms, the department will determine whether the member qualifies as a medically frail individual in accordance with 42 CFR 440.315 as amended to July 1, 2026.

74.12(3) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective, employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

441—74.13(249A,249N) Claims and reimbursement methodologies. Payment for services provided under the Iowa wellness plan services will be provided in accordance with 441—Chapter 79 or as provided in a contract between the department or the member's MCO and the provider.

441—74.14(249A,249N) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for IHAWP is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. §1396d(y) as amended to July 1, 2026, is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital services will be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

These rules are intended to implement Iowa Code chapters 249A and 249N.