CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWKI) PROGRAM

Chapter rescission date pursuant to Iowa Code section 17A.7: 10/1/30

441—86.1(514I) Definitions.

"Administrative error" means an action of the department 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. Misfiled or lost form or document.
2. Error in typing or copying.
3. Computer input error.
4. Mathematical error.
5. Failure to determine eligibility correctly when all essential information was available to the department.
6. Failure to request essential verification necessary to make an accurate eligibility determination.
7. Failure to make timely revision in eligibility following a change in policy requiring application of the policy change as of a specific date.
8. Failure to issue timely notice to cancel benefits that results in benefits continuing in error.

"Applicant" means anyone in the household, including all adults and children under the age of 19 who are counted in the hawki family size according to the modified adjusted gross income methodology and who are listed on the application or renewal form.

"Capitation rate" means the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

"Client error" means any action or inaction of the enrollee or the enrollee's representative that results in incorrect payment of benefits, including premiums paid to a health or dental plan, because at least one of the following occurred:

1. The enrollee or the enrollee's representative failed to disclose information or gave a false or misleading statement, oral or written, regarding income or another eligibility factor; or
2. The enrollee or the enrollee's representative failed to timely report a change as defined in rule 441—86.10(514I).

"Contract" means the contract between the department and the participating health or dental plan for the provision of medical or dental services to hawki enrollees for whom the participating health or dental plans assume risk.

"Cost sharing" means the payment of a premium or copayment as provided for by Title XXI of the federal Social Security Act, as amended to August 1, 2024, and Iowa Code section 514I.10.

"Countable income" means earned and unearned income of the family according to the modified adjusted gross income methodology.

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

"Dentist" means a person who is licensed to practice dentistry.

"Eligible child" means an individual who meets the criteria for participation in the hawki program as set forth in rule 441—86.2(514I).

"Emergency dental condition" means 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.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1. Placing the health of the person or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy,

2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

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

"Enrollee" means a child who has been determined eligible for the program and who has been enrolled with a participating health plan.

"Enrollment broker" means the entity the department uses to enroll eligible children with a managed care organization. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law.

"Family" means anyone in the household, including all adults and children under the age of 19 who are counted in the hawki family size according to the modified adjusted gross income methodology.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the United States Department of Health and Human Services.

"Good cause" means the family has demonstrated that one or more of the following conditions exist:

1. There was a serious illness or death of the enrollee or a member of the enrollee's family.
2. There was a family emergency or household disaster, such as a fire, flood, or tornado.
3. There was a reason beyond the enrollee's control.
4. There was a failure to receive the department's request for a reason not attributable to the enrollee. Lack of a forwarding address is attributable to the enrollee.

"Hawki program" or *"program"* means 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" means health insurance coverage as defined in 45 CFR Section 144.103 as amended to August 1, 2024.

"Health Insurance Marketplace" or *"Exchange"* means the entity authorized under 42 U.S.C. Section 18031(d)(4)(F) (as amended to August 1, 2024) to evaluate and determine eligibility of applicants for Medicaid, the Children's Health Insurance Program (CHIP), and other health programs.

"Initial application" means the first program application or a subsequent application that is not a renewal.

"Institution for mental diseases" means the same as defined in 42 CFR Section 435.1010 as amended to August 1, 2024.

"Medical Assistance Advisory Council" or *"MAAC"* means the advisory body authorized by Iowa Code section 249A.4B.

"Modified adjusted gross income" means the methodology prescribed in 42 U.S.C. Section 1396a(e)(14) and 42 CFR 435.603 as amended to August 1, 2024.

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

"Participating health plan" or *"PHP"* means any entity licensed by the division of insurance of the department of insurance and financial services to provide health insurance in Iowa or an organized delivery system licensed by the director that has contracted with the department to provide health insurance coverage to eligible children under this chapter.

"Passive enrollment process" means the process by which the department assigns a child to a participating health or dental plan and which seeks to preserve existing provider-enrollee relationships, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available health or dental plans.

"Physician" means the same as defined in Iowa Code section 135.1(4).

"Provider" means 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 hawki program.

"Public institution" means the same as defined in 42 CFR Section 435.1010 as amended to August 1, 2024.

"Renewal" means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

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

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.2(514I) Eligibility factors. The decision with respect to eligibility will be based primarily on electronic data matches and information furnished by the applicant, the enrollee, or a person acting on behalf of the applicant or enrollee. A child must meet the following eligibility factors to participate in the hawki program:

86.2(1) *Age.* The child shall be under 19 years of age. Eligibility for the program ends the first day of the month following the month of the child's nineteenth birthday.

86.2(2) *Income.*

a. Countable income. In determining initial and ongoing eligibility for the hawki program, countable income shall not exceed 302 percent of the federal poverty level for a family of the same size. Countable income shall be determined using the modified adjusted gross income methodology.

b. Verification of income. Income shall be verified through electronic data matches when possible or otherwise verified using the best information available.

(1) Pay stubs, tip records, tax records and employers' statements are acceptable forms of verification of earned income.

(2) If self-employment income cannot be verified through electronic means, business records or income tax returns from the previous year can be used if they are representative of anticipated earnings. If business records or tax returns from the previous year are not representative of anticipated earnings, an average of the business records or tax returns from the previous two or three years may be used if that average is representative of anticipated earnings.

c. Changes in income. Once initial eligibility is established, changes in income during the 12-month enrollment period shall not affect the child's eligibility to participate in the hawki program. However, if income has decreased, the family may request a review of their income to establish whether they are required to continue paying a premium in accordance with rule 441—86.8(514I).

86.2(3) *Family size.* For purposes of establishing initial and ongoing eligibility under the hawki program, the family size shall be determined according to the modified adjusted gross income methodology.

86.2(4) *Uninsured status.* The child must be uninsured as outlined in 42 CFR 457 as amended to August 1, 2024.

86.2(5) *Ineligibility for Medicaid.* The child shall not be receiving Medicaid or eligible to receive Medicaid except when the child would be required to meet a spenddown under the medically needy program in accordance with the provisions of 441—subrule 75.1(35).

86.2(6) *Iowa residency.* Residency in Iowa is a condition of eligibility for the hawki program. Residency shall be established in accordance with rule 441—75.10(249A).

86.2(7) *Citizenship and immigration status.* To be eligible for the hawki program, the child shall be a citizen or lawfully admitted immigrant. The criteria established under 441—subrule 75.11(2) shall be followed when determining whether a lawfully admitted immigrant child is eligible to participate in the hawki program.

a. The citizenship or immigration status of the parents or other responsible person shall not be considered when determining the eligibility of the child to participate in the program.

b. As a condition of eligibility for hawki:

(1) All applicants shall attest to their citizenship status by signing the application form, which contains a citizenship declaration.

(2) When a child under the age of 19 is not living independently, the child's parent or other responsible person with whom the child lives shall be responsible for attesting to the child's citizenship or immigration status and for providing any required proof of the status.

c. Except as provided in 441—paragraph 75.11(2)*"f,"* applicants or enrollees for whom an attestation of United States citizenship has been made pursuant to paragraph 86.2(7)*"b"* shall present satisfactory documentation of citizenship or nationality as defined in 441—paragraphs 75.11(2)*"d,""e,""g,""h,"* and *"i."*

d. An applicant or enrollee shall have a reasonable opportunity period to obtain and provide proof of citizenship and nationality in accordance with 441—paragraph 75.11(2)*"c."*

e. Failure to provide acceptable documentary evidence for a child shall not affect the eligibility of other children in the family for whom acceptable documentary evidence has been provided.

86.2(8) *Dependents of state of Iowa employees.* The child shall not be eligible for the hawki program if the child is eligible for health insurance coverage as a dependent of a state of Iowa employee unless the state contributes only a nominal amount toward the cost of dependent coverage. "Nominal amount" means $10 or less per month.

86.2(9) *Inmates of public institutions.* The child shall not be an inmate of a public institution as defined at 42 CFR Section 435.1010 as amended to August 1, 2024.

86.2(10) *Inmates of institutions for mental disease.* At the time of application or annual review of eligibility, the child shall not be an inmate of an institution for mental disease as defined at 42 CFR Section 435.1010 as amended to August 1, 2024.

86.2(11) *Furnishing a social security number.* As a condition of eligibility and in accordance with rule 441—75.7(249A), a social security number or proof of application for the number if the number has not been issued or is not known must be furnished for a child for whom coverage under hawki is being requested or received.

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441—86.3(514I) Application process.

86.3(1) *Who may apply.* Each person wishing to do so shall have the opportunity to apply for the hawki program in accordance with rule 441—76.1(249A).

86.3(2) *Place of filing.* An application for the hawki program may be filed with the department through an Internet website, by telephone, through other electronic means, or through an exchange, disproportionate share hospital, federally qualified health center, or other facility in which outstationing activities are provided.

86.3(3) *Right to withdraw application.* After an application has been filed, the applicant may withdraw the application at any time prior to the eligibility determination. Requests for voluntary withdrawal of the application will be documented, and the applicant will be sent a notice of decision confirming the request.

86.3(4) *Application not required.*

a. An application will not be required when a child becomes ineligible for Medicaid.

b. A new application will not be required when an eligible child is added to an existing hawki eligible group.

c. A new application will not be required when a child moves between supplemental dental-only coverage as specified in rule 441—86.20(514I) and full medical and dental coverage.

86.3(5) *Information and verification procedure.* The eligibility decision will be based primarily on information furnished by the applicant, enrollee, or person acting on behalf of the applicant or enrollee and verified through electronic data matches whenever possible.

a. The applicant, enrollee, or person acting on behalf of the applicant or enrollee will be notified in writing of additional information or verification that is required to establish eligibility. The notice may be provided personally, by U.S. mail, by email, or by facsimile.

b. Failure to supply the information or verification or refusal to authorize the department to secure the information will be a basis for rejection of the application or cancellation of coverage. If the requested information or authorization is received within 14 calendar days of the notice of decision on an application or within 14 calendar days of the effective date of cancellation for enrollees, the information or authorization will be acted upon as though it had been provided timely. If the fourteenth calendar day falls on a weekend or state holiday, the applicant or enrollee shall have until the next business day to provide the information.

c. The applicant, enrollee, or person acting on behalf of the applicant or enrollee will have 10 working days to supply the information or verification requested. The due date may be extended for a reasonable period when the applicant, enrollee, or person acting on behalf of the applicant or enrollee is making every effort but is unable to secure the required information or verification from a third party.

86.3(6) *Time limit for decision.* Decisions regarding the applicant's eligibility to participate in the hawki program will be made within 45 working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department. Day one of the 45-day period starts the first working day following the date of receipt of a completed application and all necessary information and verification.

86.3(7) *Applicant cooperation.* An applicant must cooperate with the department in the application process, which may include providing verification or signing documents. Failure to cooperate with the application process shall serve as basis for a denial of the application.

86.3(8) *Waiting lists.* When the department has established that all the funds appropriated for this program are obligated, all subsequent applications for hawki coverage will be denied unless Medicaid eligibility exists.

a. The department will mail a notice of decision to the applicant that states:

(1) The applicant meets the eligibility requirements but that no funds are available and that the applicant will be placed on a waiting list, or

(2) The applicant does not meet eligibility requirements, in which case the applicant will not be put on a waiting list.

b. Prior to an applicant's being denied or placed on the waiting list, it must be established that the child is not eligible for Medicaid.

c. Applicants will be placed on the waiting list on the basis of the date an identifiable application form specified in rule 441—76.1(249A) is received.

(1) In the event that more than one application is received on the same day, applicants will be placed on the waiting list on the basis of the day of the month of the oldest child's birthday, the lowest number being first on the list.

(2) Any subsequent ties will be determined by the month of birth of the oldest child, January being month one and the lowest number.

d. If funds become available, applicants will be selected from the waiting list based on the order in which their names appear on the list and will be notified of their selection.

e. After being notified of the availability of funding, the applicant shall have 15 working days to confirm the applicant's continued interest in applying for the program and to provide any information necessary to establish eligibility. If the applicant does not confirm continued interest in applying for the program and does not provide any additional information necessary to establish eligibility within 15 working days, the applicant's name will be deleted from the waiting list and the next applicant on the waiting list will be contacted.

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441—86.4(514I) Coordination with Medicaid.

86.4(1) *Hawki applicant eligible for Medicaid.* At the time of initial application, if it is determined the child is eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in the Medicaid program.

86.4(2) *Hawki enrollee eligible for Medicaid.* At the time of the annual review, if the child is determined eligible for Medicaid in accordance with the provisions of rule 441—75.1(249A), with the exception of meeting a spenddown under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in Medicaid effective the first day following the expiration of the 12-month hawki enrollment period.

86.4(3) *Medicaid member becomes ineligible.* If a child becomes ineligible for Medicaid under the provisions of rule 441—75.1(249A), with the exception of meeting a spend down under the medically needy program at 441—subrule 75.1(35), the child will be enrolled in the hawki program if otherwise eligible.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.5(514I) Effective date of coverage.

86.5(1) *Initial application.* Coverage for a child who is determined eligible for the hawki program on the basis of an initial application for either hawki or Medicaid will be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4)*"a,"* coverage shall be effective the first day of the month following the month in which health insurance coverage is lost.

86.5(2) *Referrals from Medicaid.*

a. Cancellation of Medicaid. Coverage for children who are determined eligible for the hawki program due to cancellation of Medicaid benefits will be effective the first day of the month after Medicaid eligibility is lost in order to ensure that there is no break in coverage.

b. If the child lost Medicaid eligibility solely because of the loss of income disregards from the implementation of the modified adjusted gross income methodology, the child may be covered under the hawki program for up to 12 months following the loss of Medicaid eligibility, regardless of the presence of other health insurance coverage.

86.5(3) *Annual renewals.* Coverage for children who are determined eligible for the hawki program on the basis of an annual renewal will be effective the first day of the month following the month in which the previous enrollment period ended.

86.5(4) *Children added to an existing hawki enrollment period.* Coverage for children who are determined eligible for the hawki program on the basis of a request from the family to add the child to an existing enrollment period will be effective the first day of the month following the month in which the request was made.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.6(514I) Selection of a plan. Upon the child's eligibility effective date, the child will be assigned to a health or dental plan using the department's passive enrollment process. The enrollee may change plans only at the time of the annual review unless the provisions of paragraph 86.6(1)*"a"* or subrule 86.6(2) apply.

86.6(1) *Period of enrollment.* Once enrolled in a health or dental plan, the child will remain enrolled in the health or dental plan for a period of 12 months.

a. Exceptions. A child may be enrolled in a plan for less than 12 months if:

(1) 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 will be enrolled in the health or dental plan from which the child was originally disenrolled.

(2) The child is added to an existing enrollment. When a family requests to add an eligible child, the child will be enrolled for the months remaining in the current enrollment period.

(3) A request to change plans is accepted in accordance with paragraph 86.6(1)*"b."*

b. Request to change plan. An enrollee may ask to change the health or dental plan either verbally or in writing to the enrollment broker:

(1) Within 90 days following the date of the enrollee's initial enrollment with the health or dental plan for any reason.

(2) At any time for cause. "Cause" as defined in 42 CFR 438.56(d)(2) as amended to August 1, 2024, includes but is not limited to:

1. The enrollee moves out of the plan's service area.
2. Because of moral or religious objections, the plan does not cover the services the enrollee seeks.
3. The enrollee needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time, not all related services are available within the network, and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

4. Other reasons including but not limited to poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

All approved changes shall be made prospectively and shall be effective no later than the first day of the second month beginning after the date on which the change request is received.

86.6(2) *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 will be enrolled in a participating health or dental plan in the new location. The period of enrollment will be the number of months remaining in the original certification period.

86.6(3) *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 to the enrollment broker. The child will remain enrolled in the current health or dental plan if the family does not notify the enrollment broker of a new health or dental plan choice by the end of the current 12-month enrollment period.

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441—86.7(514I) Cancellation. The child's eligibility for the hawki program shall be canceled before the end of the 12-month enrollment period for any of the following:

86.7(1) *Age.* The child shall be canceled from the hawki program as of the first day of the month following the month in which the child attained the age of 19.

86.7(2) *Iowa residence abandoned.* The child shall be canceled from the program as of the first day of the month following the month in which the child relocated to another state. Eligibility shall not be canceled when the child is temporarily absent from the state in accordance with the provisions of 441—subrule 75.10(2).

86.7(3) *Eligible for Medicaid.* The child shall be canceled from the program as of the first day of the month following the month in which Medicaid eligibility is obtained. If there are months during which the child is covered by both the Medicaid and hawki programs, the hawki program shall be the primary payor and Medicaid shall be the payor of last resort.

86.7(4) *Enrolled in other health insurance coverage.* The child shall be canceled from the program as of the first day of the month following the month in which the department is notified that the child has other health insurance coverage. If there are months during which the child is covered by both another insurance plan and the hawki program, the other insurance plan shall be the primary payor and hawki shall be the payor of last resort.

86.7(5) *Admission to a public institution.* The child shall be canceled from the program if the child is in a public institution at the time of the annual review.

86.7(6) *Admission to an institution for mental disease.* The child shall be canceled from the program if the child is a patient in an institution for mental disease at the time of annual review.

86.7(7) *Employment with the state of Iowa.* The child shall be canceled from the hawki 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.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.8(514I) Premiums and copayments.

86.8(1) *Income considered.* The income considered in determining the premium amount will be the family's countable income using the modified adjusted gross income methodology.

86.8(2) *Premium amount.* Except as specified for supplemental dental-only coverage in subrule 86.20(3), premiums under the hawki program will be assessed as follows:

a. No premium is charged if:

(1) The eligible child is an American Indian or Alaska Native; or

(2) The family's countable income is less than 181 percent of the federal poverty level for a family of the same size.

b. If the family's countable income is equal to or exceeds 181 percent of the federal poverty level for a family of the same size but does not exceed 242 percent of the federal poverty level for a family of that size, the premium is $10 per child per month with a $20 monthly maximum per family.

c. If the family's countable income is equal to or exceeds 243 percent of the federal poverty level for a family of the same size, the premium is $20 per child per month with a $40 monthly maximum per family.

86.8(3) *Due date.*

a. Payment upon initial application. Upon approval of an initial application, the first month for which a premium is due is the third month following the month of decision. The due date of the first premium shall be the fifth day of the second month following the month of decision.

b. Payment upon renewal.

(1) Upon approval of a renewal, the first month for which a premium is due is the first month of the enrollment period. The premium for the first month of the enrollment period shall be due by the fifth day of the month before the month of coverage or the tenth business day following the date of decision, whichever is later.

(2) When the premium is received, the department will notify the health and dental plans of the enrollment.

c. Subsequent payments. All subsequent premiums are due by the fifth day of each month for the next month's coverage. Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. Holiday or weekend. When the premium due date falls on a holiday or weekend, the premium shall be due on the first business day following the due date.

86.8(4) *Grace period.* A grace period will be allowed on any monthly premium not received as prescribed in paragraph 86.8(3)*"c."* The grace period will be the month immediately following the last month for which the premium has been paid.

a. Failure to submit a premium by the last calendar day of the grace period will result in disenrollment.

b. If the premium for the grace period and the premium for the following month's coverage are subsequently received within 45 calendar days following the last calendar day of the grace period, coverage will be reinstated, effective the first day of the calendar month following the grace period, without the need to reapply for coverage.

86.8(5) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the department.

86.8(6) *Copayment.* There will be a $25 copayment for each emergency room visit if the child's medical condition does not meet the definition of emergency medical condition. A copayment will not be imposed when family income is less than 181 percent of the federal poverty level for a family of the same size or when the child is an eligible American Indian or Alaska Native.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.9(514I) Annual reviews of eligibility. All eligibility factors will be reviewed at least every 12 months to establish ongoing eligibility for the program. "Month one" will be the first month in which coverage is provided.

86.9(1) *Review form.* The department will send the family a prepopulated review form on which the answers, except for income, have been completed based on the information on file. The family shall review the completed information for accuracy and fill in the income section of the form. If family income cannot be verified through electronic data matches, the family shall be required to provide verification of current income. The family shall sign and date the form attesting to its accuracy as part of the review process.

86.9(2) *Failure to provide information.* The child shall not be enrolled for the next 12-month period if the family fails to provide information and verification of income or otherwise fails to cooperate in the annual review process. If the completed review form and any information necessary to establish continued eligibility are received within 14 calendar days of the end of an enrollment period, the review form and information will be acted upon as though they had been received timely. If the fourteenth calendar day falls

on a weekend or state holiday, the enrollee shall have until the next business day to provide the review form and any information necessary to establish continued eligibility.
[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.10(514I) Reporting changes. Changes that may affect eligibility shall be reported timely to the department. "Timely" shall mean no later than ten working days after the change occurred. The ten working-day period begins the first working day following the date of the change. The parent, guardian, or other adult responsible for the child shall report the change unless the child is emancipated, married, or otherwise in an independent living situation, in which case the child shall be responsible for reporting the change.

86.10(1) *Iowa residence is abandoned.* The abandonment of Iowa residence shall be reported following the move from the state.

86.10(2) *Other insurance coverage.* Enrollment of the child in other health insurance coverage shall be reported.

86.10(3) *Decrease in income.* If the family reports a decrease in income, the department will ascertain whether the change affects the premium obligation of the family. If the change is such that the family is no longer required to pay a premium in accordance with the provisions of rule 441—86.8(514I), premiums will no longer be charged beginning with the month following the month of the report of the change.

86.10(4) *Information reported by a third party.* Information reported by a third party will not be acted upon until the information is verified in accordance with subrule 86.3(7).

86.10(5) *Cooperation.* The provisions of subrule 86.3(7) shall apply when a request for information or verification is made due to a change. In addition, failure of the enrollee or of the person acting on behalf of the enrollee to provide requested information or verification that may affect eligibility for the program shall result in cancellation and recoupment of all payments made by the department on behalf of the enrollee during the period in question.

86.10(6) *Effective date of change in eligibility.*

a. When a change in circumstances has a positive effect on eligibility, the change in eligibility shall be effective no earlier than the month following the month in which the change in circumstances was reported, regardless of when the change was reported.

b. When a change in circumstances has an adverse effect on eligibility, the change in eligibility shall be effective no earlier than the month following the issuance of a timely notification, in accordance with the provisions of rule 441—86.11(514I). When the change in circumstances was not reported timely, as defined in this rule, benefits shall be recouped beginning with the month following the month in which the change occurred.

c. When an anticipated change in circumstances is reported before the change occurs, no action will be taken until the change actually occurs and is verified in accordance with the provisions of subrule 86.3(7).
[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.11(514I) Notice requirements. The applicant will be provided an adequate written notice of the decision regarding the applicant's eligibility for the hawki program. The enrollee will be notified in writing of any decision that adversely affects the enrollee's eligibility or the amount of benefits. The notice will be timely and adequate as provided in rule 441—16.2(17A).
[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.12(514I) Appeals and fair hearings. If the applicant or enrollee disputes a decision to reduce, cancel or deny participation in the hawki program, the applicant or enrollee may appeal the decision in accordance with 441—Chapter 7.
[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.13(514I) Covered services. The benefits provided under the hawki program shall meet a benchmark, benchmark equivalent, or benefit plan that complies with Title XXI of the federal Social Security Act as amended to August 1, 2024.

86.13(1) *Required medical services.* The participating health plan shall cover at a minimum the following medically necessary services:

a. Inpatient hospital services (including medical, surgical, intensive care unit, mental health, and substance abuse services).

b. Physician services (including surgical and medical, and including office visits, newborn care, well-baby and well-child care, immunizations, urgent care, specialist care, allergy testing and treatment, mental health visits, and substance abuse visits).

c. Outpatient hospital services (including emergency room, surgery, lab, and x-ray services and other services).

d. Ambulance services.

e. Physical therapy.

f. Nursing care services (including skilled nursing facility services).

g. Speech therapy.

h. Durable medical equipment.

i. Home health care.

j. Hospice services.

k. Prescription drugs.

l. Hearing services.

m. Vision services (including corrective lenses).

n. Translation and interpreter services as specified pursuant to 42 U.S.C. Section 1397ee(a)(1) as amended to August 1, 2024.

o. Chiropractic services.

p. Occupational therapy.

86.13(2) *Abortion.* Payment for abortion shall only be made under the following circumstances:

a. The physician certifies that the pregnant enrollee suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the enrollee in danger of death unless an abortion is performed.

b. The pregnancy was the result of an act of rape or incest.

86.13(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.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.14(514I) Participating health and dental plans.

86.14(1) *Licensure.* The participating health or dental plan must:

a. Be licensed by the division of insurance of the department of insurance and financial services to provide health or dental care coverage in Iowa; or

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

86.14(2) *Services.* The participating health or dental plan shall provide coverage for the services specified in rule 441—86.13(514I) to all children determined eligible.

a. The participating health or dental plan shall make services it provides to hawki 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. Participating health plans shall ensure that emergency services (inpatient and outpatient) are available for treatment of an emergency medical condition 24 hours a day, seven days a week, either through the health plan's own providers or through arrangements with other providers.

c. If a participating health or dental plan does not provide statewide coverage, the health or dental plan shall participate in every county in which it is licensed and in which a provider network has been established.

86.14(3) *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 hawki requirements, which shall include collecting copayments, if applicable.

86.14(4) *Identification cards.* Identification cards shall be issued by the participating health or dental plan to the enrollees for use in securing covered services.

86.14(5) *Marketing.*

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

b. All marketing materials require prior approval from the department.

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

(1) A current member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to the hawki enrollees. At a minimum the handbook shall include covered services, network providers, exclusions, emergency services procedures, 24-hour toll-free number for certification of services, daytime number to call for assistance, appeal procedures, enrollee rights and responsibilities, and definitions of terms.

(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.

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.

86.14(6) *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. Is approved by the department prior to use.

b. Acknowledges receipt of the appeal to the enrollee.

c. Establishes time frames that ensure that appeals be resolved within 45 days, except for appeals that involve emergency medical conditions, which shall be resolved within time frames appropriate to the situations.

d. Ensures the participation of persons with authority to take corrective action.

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

f. Ensures the confidentiality of the enrollee.

g. Ensures issuance of a written decision to the enrollee for each appeal, which shall contain an adequate explanation of the action taken and the reason for the decision.

h. Maintains a log of the appeals that is made available to the department at the department's request.

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.

86.14(7) *Records and reports.* The participating health 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 hawki 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) Meets state and federal reporting requirements applicable to the hawki program.

(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 that are infrequently used, which provide a support system service to the operation of the health or dental plan, or that are of an unusual nature. This provision is also intended to waive the need for written consent for department staff 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 that 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 86.14(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 except that 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 department as follows:

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

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

(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) Information regarding the plan's appeal process.

(2) A plan for a health improvement program.

(3) Periodic financial, utilization and statistical reports as required by the department.

(4) Time-specific reports that define activity for child health care, appeals and other designated activities that may, at the department's discretion, vary among plans, depending on the services covered or other differences.

(5) Other information as directed by the department.

86.14(8) *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. The capitation rate shall be actuarially determined by the department July of 2000 and each fiscal year thereafter using statistics and data assumptions and relevant experience derived from similar populations.

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 hawki 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.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.15(514I) Use of donations to the hawki program. If an individual or other entity makes a monetary donation to the hawki program, the department will deposit the donation into the hawki trust fund. The department will track all donations separately and will not commingle the donations with other moneys in the trust fund. The department shall report the receipt of all donations to MAAC.

86.15(1) If the donor specifically identifies the purpose of the donation, regardless of the amount, the donation shall be used as specified by the donor as long as the identified purpose is permissible under state and federal law.

86.15(2) If the donation is less than $5,000 and the donor does not specifically identify how it is to be used, the department will use the moneys in the following order:

a. For the direct benefit of enrollees (e.g., premium payments).

b. For outreach activities.

c. For other purposes as determined by MAAC.

86.15(3) If the donation is more than $5,000 and the donor does not specify how the funds are to be used, MAAC will determine how the funds are to be used.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.16(514I) Recovery.

86.16(1) *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.

86.16(2) *Notification.* The enrollee will be promptly notified when it is determined that funds were incorrectly paid due to a client error. Notification shall include:

a. The name of the person for whom funds were incorrectly paid;

b. The period during which the funds were incorrectly paid;

c. The amount subject to recovery; and

d. The reason for the incorrect payment.

86.16(3) *Recovery.*

a. Recovery shall be made:

(1) From the enrollee when the enrollee completed the application and had responsibility for reporting changes, or

(2) From the enrollee's representative (i.e., the parent, guardian, or other responsible person acting on behalf of an enrollee who is under the age of 19) when the representative completed the application and had responsibility for reporting changes.

b. The enrollee or representative shall repay to the department the funds incorrectly expended on behalf of the enrollee.

c. Recovery may come from income, income tax refunds, lottery winnings, or other resources of the enrollee or representative.

86.16(4) *Appeals.* The enrollee shall have the right to appeal a decision to recover benefits under the provisions of 441—Chapter 7.

[**ARC 9468C**, IAB 8/6/25, effective 10/1/25]

441—86.17(514I) Supplemental dental-only coverage.

86.17(1) *Eligibility.* Unless otherwise specified, eligibility for supplemental dental-only coverage shall be determined in accordance with the provisions of rules 441—86.2(514I) through 441—86.12(514I) and 441—86.17(514I).

86.17(2) *Premiums.* Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families whose countable income is less than or equal to 167 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology or to an eligible child who is an American Indian or Alaska Native.

b. If the family's countable income is equal to or exceeds 168 percent of the federal poverty level but does not exceed 203 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 countable income exceeds 203 percent of the federal poverty level but does not exceed 254 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 countable income exceeds 254 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 hawki and insured children who are eligible only for dental coverage, the premium will be assessed as follows:

(1) The total premium will 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 will 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 hawki because they are covered by health insurance.

f. The provisions of subrules 86.8(3) through 86.8(6) apply to premiums specified in this subrule.

86.17(3) *Waiting lists.* Before the provisions of subrule 86.3(10) are implemented, all children enrolled in supplemental dental-only coverage shall be disenrolled from the program.

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