

WHAT DO THE KENTUCKY HEALTH MEDICAID CHANGES MEAN FOR KENTUCKIANS?

Kentucky HEALTH is Governor Bevin's signature Medicaid program that stands for "Helping to Engage and Achieve Long Term Health." Also called an "1115 Medicaid Waiver," this program is an alternative to traditional Medicaid, meaning that the federal government has "waived" certain Medicaid rules, allowing Kentucky to make changes to the way Medicaid is administered in the Commonwealth.

As a result of Kentucky HEALTH, almost 100,000 low-income Kentuckians will no longer be enrolled in Medicaid by 2022. Many more are expected to churn on and off coverage based on new requirements and penalties.

WHO WILL BE AFFECTED?

Medicaid covers low-income Kentuckians making at or below 138% of the Federal Poverty Level (FPL), about \$16,750 a year for an individual and \$34,600 for a family of four. In total, nearly 1.4 million Kentuckians are covered by Medicaid. Of these, about 1.2 million Medicaid members – covered by Aetna, Anthem, Humana CareSource, Passport, and WellCare – will be subject to some or all of the new rules of Kentucky HEALTH. That's more than 1 in 4 Kentuckians.

Medicaid members participating in Kentucky HEALTH include:

- Children
- Pregnant women
- Parents and caretakers below 55% FPL (also known as PACA)
- Parents and caretakers at or above 55% FPL (also known as Medicaid expansion)
- Former foster care youth up to age 26 (those who have "aged-out" of foster care)
- All other non-disabled adults without dependents (also known as Medicaid expansion)

The following individuals will not be subject to Kentucky HEALTH and will continue to receive traditional Medicaid:

- Over age 65
- Covered by Medicare
- Receiving SSI (Social Security Income)
- Living in a long-term care facility
- In the Medicaid buy-in program for working disabled adults
- Currently in foster care or receiving subsidized adoption
- Participating in the Breast and Cervical Cancer Treatment Program
- Enrolled in 1915c Waivers, including:
 - ◇ Home and Community Based Waiver
 - ◇ Michelle P. Waiver
 - ◇ Acquired Brain Injury (ABI) and ABI Long-term Care Waiver
 - ◇ Model Waiver II
 - ◇ Supports for Community Living

New Requirements and Benefit Changes



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ANNUAL RE-ENROLLMENT: Every year, you or your family will need to submit updated information or verify that your information is still correct. This must happen within 90-days of your annual re-determination date to stay enrolled in coverage.

REPORTING CHANGES IN ELIGIBILITY: You must report changes in income, household size, work status, and any other changes that would impact your eligibility for Medicaid. should not be required to report normal fluctuations, including:

- Changes in work hours that will not exceed 30-days
- A fifth or periodic paycheck
- Holidays, vacation days, or sick leave less than 30-days

EMPLOYER COVERAGE: If you work for an employer for at least one year and your employer offers health insurance, you must enroll in that plan. You will also be encouraged to enroll your children in the same plan. Medicaid would pay your out-of-pocket costs and provide "wrap-around" benefits if your employer plan does not provide every benefit offered by Medicaid. However, if your employer's plan offers fewer in-network providers or does not cover the same prescription drugs, these may not be covered by the state.

MULTIPLE ACCOUNTS: You can be enrolled in coverage as an individual or as part of a larger household. Adults will have two accounts: 1) a benefind account for enrollment, My Rewards, Deductible, and Community Engagement; and 2) an account with the managed care plan to pay premiums. Households will have three or more accounts: 1) the head of household will have a benefind account for enrollment; 2) each adult household member will have a separate benefind account for My Rewards, Deductible, and Community Engagement; and 3) each household will have at least one managed care plan account. If individuals living in the household are covered by different plans, they will have separate accounts.

"MY REWARDS" ACCOUNT: You can earn virtual reward "dollars" for preventive screenings, health classes, volunteering, job training and other activities. Reward dollars can be used to "buy" services like dental, vision, over-the-counter medicine, or a gym membership. In some cases, money can also be removed from your account as a penalty for using the emergency room when it is not an emergency or for missing too many medical appointments.

DEDUCTIBLE ACCOUNT: The Deductible Account is meant to function like a health savings account. The state will put \$1,000 virtual dollars into your account at the beginning of the coverage year. During the year, the money in the account pays for the first \$1,000 of non-preventive medical expenses. **After the account is empty, all medical services will continue to be covered by your managed care plan.**

RETROACTIVE COVERAGE: Medicaid usually covers medical expenses for 90-days before you are fully enrolled, assuming that you were already eligible for coverage during that time. This is helpful if you experience enrollment delays, get accidentally dis-enrolled, or have a gap in coverage. Under the new plan, coverage will only begin after you make the first premium payment and are fully enrolled. For example, if you make your first premium payment on the 5th of the month, coverage will start on the 1st day of that same month. Medicaid will not pay for medical services received before you are fully enrolled, even if enrollment is delayed for a reason beyond your control.

PREMIUMS: You will be charged monthly premiums based on your household income. Over time, the state may increase premiums up to 4% of your total income. For example, if you are an individual making about \$16,700/year (equivalent to earning about \$8/hr at 40 hrs/wk) your premium payment will start at \$15/month but could increase to \$55/month over time.

NON-EMERGENCY MEDICAL TRANSPORTATION: You will no longer have access to transportation services to get to and from a medical appointment.

CO-PAYS: If your household income is at or below 100% FPL (\$12,140 for an individual and \$25,100 for a family of 4) and you miss two premium payments, you will be charged a co-pay for each visit. Co-pays range from \$3 - \$50 per visit and could quickly add up to a lot more than your premium payment.

"PATH" REQUIREMENT TO WORK, VOLUNTEER, STUDY, OR TRAIN: You will need to complete 80 hours of approved activities each month. If you work at least 30 hours/week, are a full-time student, or a primary caregiver (1 per household), you should meet the work requirement. If you are enrolled in SNAP (food stamps) or TANF (cash assistance), you will only need to meet the work requirement once for all benefits.

DENTAL & VISION BENEFITS: You will no longer have access to dental or vision benefits. You will only be able to access dental and vision services by earning virtual dollars through your My Rewards Account.

Penalties and Lock Outs

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CHANGE IN ELIGIBILITY LOCK OUT: If you do not report a change in income or family size that makes you or your household ineligible for Medicaid within 30 days, you will be locked out of coverage for 6 months. The state may consider this to be Medicaid fraud, a very serious charge that is punishable by law.

MY REWARDS FINES: Your My Rewards Account could be charged \$20 - \$75 for inappropriate or non-emergency use of the Emergency Department (ED), unless you call the managed care plan's nurse hotline first. There could be a similar penalty for missing too many appointments without canceling ahead of time or without good cause.

MY REWARDS SUSPENSION: If you miss two premium payments, you will not be able to use your My Rewards Account to access vision, dental, over-the-counter medications, or gym membership.

LATE ENROLLMENT LOCK OUT: If you do not re-enroll during the 90-day window, you will be locked out of coverage for six months.

"PATH" LOCK OUT: If you do not complete at least 80-hours of "community engagement" activities each month, you could be locked out of coverage for up to six months.

CO-PAYS & ENROLLMENT DELAY: If your household income is at or below 100% FPL (12,140 for an individual and \$25,100 for a family of four) and you cannot pay your first premium, your coverage will be delayed up to 60 days. Once you are enrolled, if you miss two premium payments, you will be charged co-pays every time you seek care or need to fill a prescription. Co-pays range from \$3-\$50 and could quickly add up to a lot more than the missed premium payment.

PENDING ENROLLMENT: If your household income is above 100% FPL (12,140 for an individual and \$25,100 for a family of four), your coverage won't start until you pay your premium.

PREMIUM PAYMENT LOCK OUT: If your household income is above 100% FPL (12,140 for an individual and \$25,100 for a family of four) and you miss two or more premium payments, you will be locked-out of coverage for up to 6 months. You can reenroll sooner, by paying past due premiums and taking a re-entry course in health literacy or financial literacy

PREMIUM PAYMENT SCHEDULE BASED ON INCOME AND FAMILY SIZE:

Federal Poverty Level	Household Income (2018)				Household Monthly Premium (up to 4% annual income)	
	Individuals		Family of Four		Minimum	Maximum
	Annual	Monthly	Annual	Monthly		
<25%	\$3,035	\$253	\$6,275	\$523	\$1	\$10
25 - 50%	\$6,070	\$506	\$12,550	\$1,046	\$4	\$20
51 - 100%	\$12,140	\$1,012	\$25,100	\$2,092	\$8	\$40
101 - 138%	\$16,753	\$1,396	\$34,638	\$2,887	\$15	\$55

THIRD-PARTY PREMIUM PAYMENTS: If you cannot afford to pay your monthly premium, you may be able to get help from a local hospital, clinic, church, or other community organization. Assistance options will vary from county-to-county, so you should ask your health care provider or Application Assister for more information.

Exemptions from Certain Requirements and Penalties

"MEDICALLY FRAIL" EXEMPTION: Medicaid members may be considered "medically frail" for many different reasons, including:

- Disabling mental health diagnosis
- Chronic substance use disorder
- Serious and complex medical condition
- Significant impairment in ability to perform activities of daily living
- Diagnosed with HIV/AIDS
- Eligible for Social Security Disability Insurance (SSDI)
- Chronic homelessness
- First 12 months of refugee status

AUTOMATIC "MEDICALLY FRAIL" EXEMPTIONS: You may be granted automatic "medically frail" status for having HIV/AIDS, SSDI, or being identified as "medically frail" by your insurer based on existing diagnoses. You could also be considered "medically frail" for six-months if you self-attest to being chronically homeless or needing assistance with activities of daily living.

APPLYING FOR A "MEDICALLY FRAIL" EXEMPTION: If you are not granted an automatic exemption, you can self-attest to being "medically frail". This will initiate an assessment process that could take up to 60 days. The managed care plan will review your medical records and may ask your provider to complete additional paperwork. During this process, you will be subject to all applicable requirements, penalties, and reduced benefits.

APPLYING FOR A "GOOD CAUSE" EXEMPTION: You can apply for a "good cause" exemption to avoid a penalty if you are unable to comply with program requirements due to domestic violence, eviction, homelessness, or other reasons. The exception can apply to the current month or past months, but it is not ongoing.

DEFINITIONS

Chronic Homelessness: Kentucky HEALTH will use the federal definition to determine whether someone experiencing homelessness is eligible for an exemption of certain requirements. This is defined as: someone who sleeps in a place that is not meant for humans to live (for example, on the street) OR lives in a homeless emergency shelter; AND 1) Is homeless for a year or more; OR 2) has been homeless at least four times in the last three years.

CO-PAY: An amount of money people pay for each health service, office visit, or prescription medication. The amount differs depending on the services received.

DEDUCTIBLE: The amount people pay for covered health care services before their insurance plan starts to pay. With a \$1,000 annual deductible, for example, the person pays the first \$1,000 of covered services each year, and the insurance company pays for any expenses beyond \$1,000.

EXEMPTION: Waiving some or all requirements and penalties for certain individuals or populations.

FEDERAL POVERTY LEVEL (FPL): A measure of income used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage. This is based on your adjusted gross income, untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

LOCK-OUT: A penalty that results in an individual losing Medicaid coverage for a certain amount of time, even if they are eligible based on income.

MEDICAID EXPANSION: An expansion of coverage to low-income individuals and families created by the Affordable Care Act. In 2014, Kentucky expanded Medicaid to cover adults without dependent children making 0% - 138% FPL, as well as, adults with dependent children making 55% - 138% FPL.

PATH: An acronym for the state's requirement to work, volunteer, study, or train. PATH stands for "Partnering to Advance Training and Health" and is sometimes referred to as "community engagement".

PREMIUM: A fixed amount of money people have to pay each month to cover part of the cost of their health insurance.

PRIMARY CAREGIVER: The primary caregiver is an adult member of a household who provides full-time care for another dependent member of the household. In general, only one adult member in the household can claim to be the primary caregiver.