What do the Kentucky HEALTH Medicaid changes mean for Kentuckians?

- ADULTS WITHOUT DEPENDENTS
- VERY LOW INCOME PARENTS AND CARETAKERS
- EXPANSION PARENTS AND CARETAKERS
- MEDICALLY FRAIL
- FORMER FOSTER YOUTH UP TO AGE 26
- PREGNANT WOMEN
- CHILDREN

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 by the end of your annual re-determination month 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 within 30 days. You 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 will 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.

My Rewards Fines: Your My Rewards Account could be charged $20 - $75 for inappropriate or non-emergency use of the Emergency Department, 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. Your account can also be charged for failure to pay premiums, comply with PATH requirements, or voluntarily withdrawing from the program without good cause.

DEDUCTIBLE ACCOUNT: The Deductible Account is meant to be 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 healthcare services will continue to be covered by your managed care plan.

My Rewards Suspension: If you miss two premium payments or fail to comply with PATH requirements, you will not be able to use your My Rewards Account to access vision, dental, over-the-counter medications, or gym membership.

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 (earning about $8 an hour at 40 hours per week) your premium payment will start at $15 per month but could increase to $55 per month over time. Premiums will be optional for some.

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.

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 each time you seek care. Co-pays range from $3 - $50 per visit and could quickly add up to a lot more than your premium payment.

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Adults without dependents | Expansion parents/caretakers | Low income parents/caretakers

"PATH" Requirement to Work, Volunteer, Study, or Train: You will need to complete 80 hours of approved activities each month. If you already 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.

Late Re-enrollment Lock Out: If you do not re-enroll during the 90 day window following your re-determination month, you will be locked out of coverage for six months.

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. The length of time and opportunities to re-enroll may be different for each member of your household.

"PATH" Lock Out: If you do not complete at least 80 hours of "community engagement" activities each month, you could be suspended for the rest of your recertification period.

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.

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

Non-Emergency Medical Transportation: You will no longer have access to Medicaid transportation services to get to and from a medical appointment.

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.

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 suspended for the rest of your recertification period. To end suspension sooner, you must pay past due premiums, pay the next month's premium and take 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			
	Annual	Monthly	Annual	Monthly	Current Rate	Maximum
<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.

Kentucky Voices for Health

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