

KI HIP P

Kentucky Integrated Health Insurance Premium Payment Program

KI-HIPP Overview
October 2019

Objectives



1

Describe the KI-HIPP Program goals and benefits



2

Identify individuals and families who are potentially eligible for KI-HIPP



3

Review the processes for individuals to enroll and maintain enrollment in KI-HIPP

Program Overview

KI-HIPP Overview

What is KI-HIPP?

KI-HIPP is a voluntary Medicaid program offered to Medicaid members to help pay for the employee cost of an Employer-Sponsored Insurance (ESI) plan.

KI-HIPP helps Medicaid members take more control of their health care choices/decisions

KI-HIPP is designed to give Kentuckians the tools to afford quality, comprehensive coverage in the commercial marketplace while also allowing the Commonwealth to remain fiscally responsible.

KI-HIPP enrollment does **not result** in a loss of Medicaid benefits!

Benefits of the *new* KI-HIPP Program



May widen healthcare network by providing access to the full traditional Medicaid network



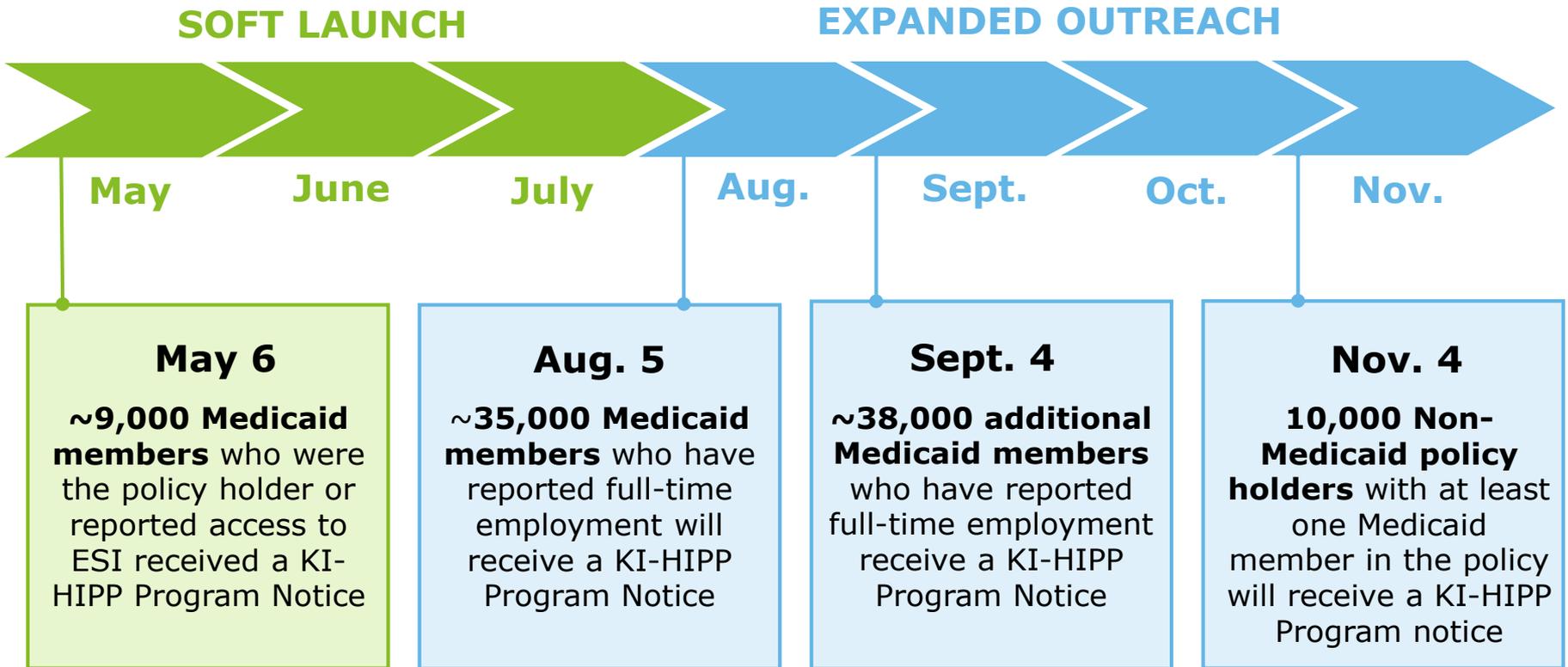
May help make employer health insurance affordable by reimbursing Medicaid member/policy holder for their premium



May allow an entire family to be on the same health insurance plan and access the same doctors

KI-HIPP Outreach Timeline

KI-HIPP outreach is being targeted to specific groups of eligible individuals between May and November 2019:



KI-HIPP Eligibility

Eligibility for the KI-HIPP program is based on the following criteria:



Medicaid Member
on the Policy



Enrollment or Access
to an ESI plan



Potentially
KI-HIPP
Eligible

Before a potentially eligible Kentuckian can enroll in KI-HIPP, the KI-HIPP team must review the ESI plan for **Plan Compatibility** based on the following criteria:

1

Cost-Effective

The premium, deductible, and co-pays of the ESI plan must cost the state less than it costs to cover a Medicaid member through Medicaid alone.

2

Comprehensive

An employer's insurance plan must cover at least one benefit from each of the 10 essential health benefits (EHB) categories to be considered comprehensive.

Qualifying Health Insurance Plans

The types of insurance plan that may be used for KI-HIPP include:



**Employer-Sponsored
Insurance (ESI)**



- **United Mine Workers**
- **Retiree Health Plan**
- **COBRA**



Please Note: ESI is the most common KI-HIPP qualifying health insurance plan.

Program Processes

KI-HIPP Eligible Member Enrollment Process

To enroll in KI-HIPP, an individual needs to follow the steps below:

Step 1



Apply for KI-HIPP

Step 2



Submit Accessible Plan Documents

Step 3



Enroll in Employer-Sponsored Insurance

Step 4



Payments & Ongoing Verification

Individuals may complete a KI-HIPP application, Health Coverage Form, via:

- benefind
- In-Person
- Phone
- Email

Submit the following documents to check plan compatibility:

- Premium Rate Sheet
- Summary of Benefits and Coverage (SBC)

After review, the policy holder will receive a "Notice of Health Insurance Review," the applicant must:

- Enroll in the eligible ESI plan (if not already enrolled)
- Send a copy of the insurance card

To stay enrolled, a member must:

1. Pay the health insurance premium
2. Submit proof of payment (paystub) to the KI-HIPP team each pay period

KI-HIPP Plan Compatibility Documents

Individuals who are interested in applying for KI-HIPP need copies of the following documents for health insurance plan(s) that they would like reviewed for plan compatibility.



Summary of Benefits and Coverage (SBC)

The **SBC** form shows comparisons of costs and coverage for health plans. The KI-HIPP team uses SBCs to evaluate **comprehensiveness**.

Insurance Company 1: Plan Option 1		Coverage Period: 01/01/2013 – 12/31/2013
Summary of Benefits and Coverage: What this Plan Covers & What it Costs		Coverage for: Individual + Spouse Plan Type: PPO
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].		
Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person / \$1,000 family Doesn't apply to preventive care	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes. \$300 for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers \$2,500 person / \$5,000 family For non-participating providers \$4,000 person / \$8,000 family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.[insert].com or call 1-800-[insert] for a list of participating providers.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.
Questions: Call 1-800-[insert] or visit us at www.[insert].com . If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.		
		OMB Control Number 1545-2229, 1210-0147, and 0938-1146
		1 of 8



Premium Rate Sheet

The **Premium Rate Sheet** details the premium rates of insurance plans. The KI-HIPP team uses the Premium Rate Sheet to evaluate **cost-effectiveness**.

Health Insurance Rates Effective January 1, 2017						
Insurance	Coverage	Bi-Weekly		Monthly		Total Premium
		Your Cost	SETA Cost	Your Cost	SETA Cost	
Kaiser HMO	Single - Employee Only	112.85	247.50	225.70	495.00	720.70
	Family - Employee w/dependent	531.52	390.00	1,063.04	780.00	1,843.04
Western Health Advantage HMO	Single - Employee Only	107.30	247.50	214.60	495.00	709.60
	Family - Employee w/dependent	518.30	390.00	1,036.60	780.00	1,816.60
Sutter Health Plus HMO	Single - Employee Only	99.06	247.50	198.12	495.00	693.12
	Family - Employee w/dependent	496.39	390.00	992.78	780.00	1,772.78
Kaiser High Deductible	Single - Employee Only	34.08	247.50	68.16	495.00	563.16
	Family - Employee w/dependent	330.10	390.00	660.20	780.00	1,440.20
Western Health High Deductible	Single - Employee Only	22.40	247.50	44.80	495.00	539.80
	Family - Employee w/dependent	300.90	390.00	601.80	780.00	1,381.80

Plan Compatibility Review Notice

Once the KI-HIPP Team receives correct documentation and runs the Plan Compatibility Review, the individual receives a notice with the Plan Compatibility Review results.

This notice shows if any of the plans are **comprehensive** and **cost-effective** and therefore, **eligible for KI-HIPP**.

Summary of Benefits and Coverage (SBC)

Premium Rate Sheet

HIP-XXXXXXXXXX 07/2019	COMMONWEALTH OF KENTUCKY Cabinet for Health and Family Services <Department for Community Based Services>	Date: 07/10/2019 Case Number: XXXXXXXX
John M Smith 123 Capitals Rd Lexington, KY 40515		
Kentucky Integrated Health Insurance Premium Payment (KI-HIPP)		
<u>Notice of Health Insurance Plan Review</u>		
Congratulations! You are now eligible to enroll in the KI-HIPP Program. Please see below for next steps to enroll in the KI-HIPP program.		
Based on the information you have submitted, the Commonwealth has completed the review of your health insurance plan(s). Please see the details below:		
Source of Coverage: ESI		Health Plan Name: Insurance Plan
Health Plan Policy #: XXXXXXXX		Coverage Year: 2019
Level of Coverage		Eligible for KI-HIPP?>
Employee Only		Yes
Employee plus dependent		Yes
Employee plus spouse		Yes

Please submit the document(s) below to complete your KI-HIPP enrollment:
• A Copy of your health insurance card or proof from your insurance company.

We will review your documentation. Once the verification process is complete, you will get another notice with your KI-HIPP coverage details.

You may submit the information on benefind.ky.gov, or send the information to:

KI-HIPP Address 275 East Main St., 6C-A Frankfort, KY 40621
Fax: 502-564-3232
Email: KIHIPPP.Program@ky.gov

If you have any questions, call us at 855-459-6328



Please Note: By federal regulation, determination of eligibility for a Medicaid HIPP program is a qualifying life event. The determination of eligibility triggers a special enrollment period through which the eligible individual has 60 days to enroll in a qualifying ESI plan.¹

¹ Section 701(f)(3) of the Employee Retirement Income Security Act (29 U.S. Code § 1181),

KI-HIPP Example Scenarios

Below outlines a realistic KI-HIPP member scenarios, including key information from the ESI plan compatibility review.

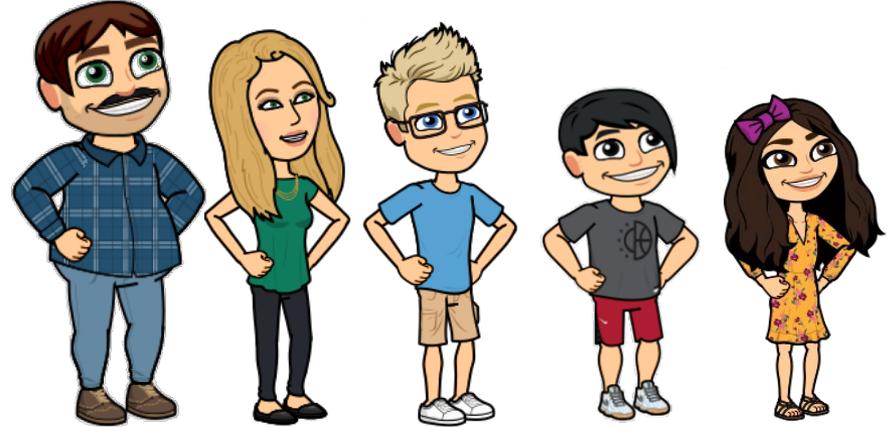
Scenario 1: Individual



Household Composition	1 Adult
Level of Coverage	Employee Only
Comprehensive?	Yes
Premium/Frequency	\$93.59/Bi-weekly
Deductible*	\$2,500
Copay	\$0

 **KI-HIPP Approved!**
Reimbursement amount: \$93.59/Bi-weekly

Scenario 2: Family



Household Composition	2 Adult, 3 children
Level of Coverage	Family
Comprehensive?	Yes
Premium/Frequency	\$142.28/Bi-weekly
Deductible*	\$6,000
Copay*	\$25

 **KI-HIPP Approved!**
Reimbursement amount: \$142.28/Bi-weekly

*The Medicaid eligible individual/family are not responsible for paying the ESI copay and deductible amount if they choose to see Medicaid providers.

KI-HIPP Members' Provider Visits

The following shows what a KI-HIPP member needs to bring to a provider visit in order for the providers to bill correctly.

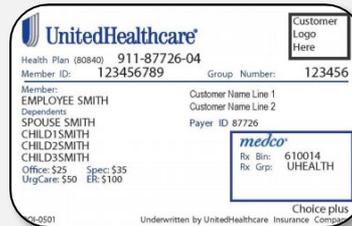
KI-HIPP members must give providers **BOTH** their **Insurance Card** and **Medicaid Card** to support correct billing for any medical services received (e.g. doctor's visits, etc.).



**KI-HIPP
Members**

1

Insurance Card



2

Medicaid Card



Please Note: There are no changes in the provider billing process. Providers use the same process they have used for individuals who have Medicaid and additional insurance or third party liability. Providers will be able to see any insurance information on the Medicaid member via KY Health Net.

Medical Costs Covered by KI-HIPP

The KI-HIPP program helps cover most of a member's medical costs. The providers that members choose to visit may impact the cost of services.

Costs Covered by KI-HIPP



Medicaid Provider

A provider who offers Medicaid services to eligible members

Costs Not Covered by KI-HIPP



Non-Medicaid Provider

A provider who does not offer Medicaid services to eligible members



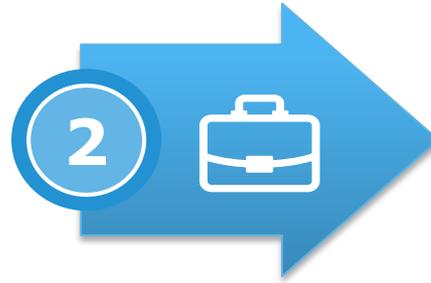
The KI-HIPP program does **NOT** cover or reimburse Medicaid KI-HIPP members for out-of-pocket costs incurred if they go to a provider that is a Non-Medicaid Provider. The Medicaid member is still responsible for the applicable Medicaid co-pay

Ongoing Member Responsibilities

Once enrolled in **KI-HIPP**, the policy holder must take **ALL** of the actions below in order to remain enrolled and receive a check to help cover the cost of the premiums:



Continue to have a Medicaid member on the ESI plan.



Remain employed and actively enrolled in the ESI plan.



Pay health insurance premium payment.



Submit proof of premium payment each time a payment is made.



Please Note: Members receive a **Notice of Renewal** 90 days before their ESI coverage ends as a reminder to report any potential changes to their plan.

Document Submission

KI-HIPP members are responsible for submitting documents to the KI-HIPP team to review.

How to submit KI-HIPP specific documents to the KI-HIPP team:



Upload:
benefind.ky.gov



Mail:
275 E. Main St., 6C-A
Frankfort, KY 40621



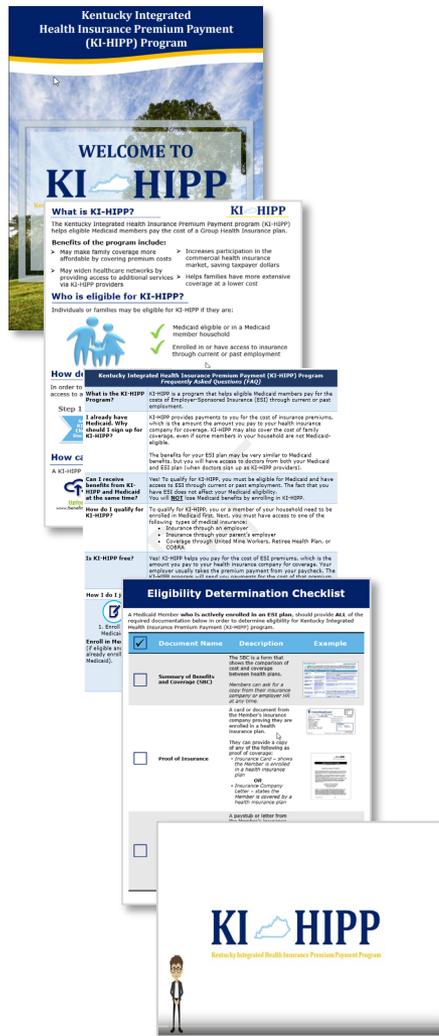
Email:
kihipp.program@ky.gov

Additional Questions?

Members can call **855-459-6328** for support!

KI-HIPP Resources on <http://bit.ly/kihipp>

The table below lists informational handouts and resources available on the KI-HIPP website.



Member Handbook

A detailed guide to the KI-HIPP program for individuals who are enrolled.

KI-HIPP 101

A one-pager that provides an overview of the KI-HIPP program and how interested individuals can apply.

Member FAQs

Frequently asked questions designed to address questions related to KI-HIPP and direct members to helpful resources.

Document Enrollment Checklist

A checklist that outlines the documents an eligible member should submit to check if their insurance plan is compatible for KI-HIPP.

Member videos

A series of brief videos that provide an overview of KI-HIPP eligibility, enrollment, and ongoing member responsibilities.

Questions?

THANK YOU!