

# kynect, Kentucky's Health Benefit Exchange

## kynect Training Manual for Agents and kynectors

October 2015



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# 1. Agents and kynectors Roles and Responsibilities

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Agents and kynectors play an important role in facilitating individuals' and small businesses' enrollment in health insurance plans including insurance affordability and public assistance programs.

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***By the end of this section, you will be able to:***

- 1.1 Understand how kynect facilitates the implementation of the Affordable Care Act.
- 1.2 Recall the three areas in which kynectors offer services and the level of involvement each role can have with an individual.
- 1.3 Understand the role of Agents and kynectors including how they interact with kynect, and how they fit into the overall structure of health insurance in the Commonwealth of Kentucky
- 1.4 Recall the purpose of the Entity Administrator participation agreement and the two primary rules of HIPAA that apply to the kynector program.

## 1.1 Functions of Agents and kynectors

The Commonwealth of Kentucky has implemented an integrated, web-based Health Benefit Exchange solution that fulfills the certification requirements set out by the Center for Medicare and Medicaid Services (CMS) and the Federal Government in response to the Patient Protection and Affordable Care Act (ACA).

In Kentucky, the health insurance exchange is known as kynect. kynect makes comprehensive Health Insurance Plans (HIPs) available to qualified individuals, and small businesses and their employees. kynect offers insurance affordability programs, including Medicaid, Kentucky Children's Health Insurance Program and tax credits for private insurance plans to help support residents that may be eligible for help paying for health insurance. kynect presents these plans in a "shop and compare" format that allows individuals to make informed decisions. The "shop and compare" format displays health insurance options based on price, benefits, quality, and other features in simple language that is easy for individuals to understand.

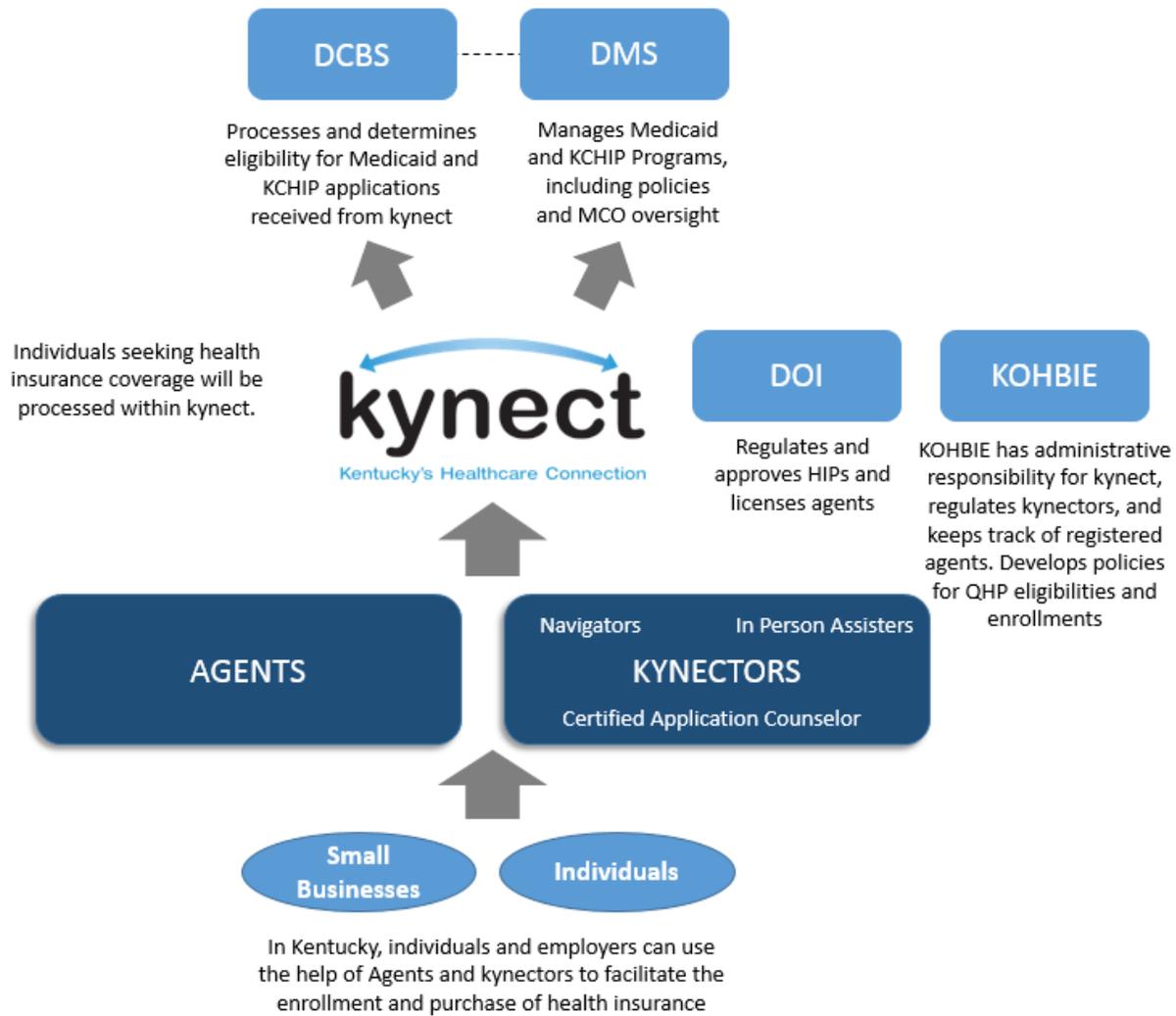
## 1.2 Stakeholders

One of the key roles of Agents and kynectors is facilitating the enrollment process for individuals and employers. In most instances, Agents and kynectors are the initial point of contact when individuals or employers begin identifying and purchasing health insurance plans. This requires that Agents and kynectors interact with a number of Commonwealth and local organizations. The figure below depicts the multi-step process of applying for and purchasing health care.

This is a high-level description of the roles each organization in the figure below plays in the application process:

- **Agents** offer advice and work to match the health insurance needs of individuals or small businesses seeking coverage with the products and options available. They sell insurance contracts or policies in return for a commission paid by the issuer for which they are appointed. Licensed insurance agents can recommend specific options and enroll individuals in health insurance plans.
- **kynectors** help individuals and small businesses understand their insurance needs, consider different coverage options available, and assist in the online enrollment process. Their role is to facilitate the application process, they may not recommend specific plans for individuals (for details of this distinction between Agents and kynectors, see the following section of this manual).
- **The Department of Insurance (DOI)** regulates and approves health insurance plans, and licenses Agents.
- **Kentucky Office of the Health Benefit and Information Exchange (KOHBE)** is the Commonwealth's office that maintains kynect and oversees kynectors and registered Agents.
- **The Department for Community Based Services (DCBS)** processes and determines eligibility for Medicaid and KCHIP applications received from kynect.
- **The Department of Medicaid and Medicare Services (DMS)** manages the policy for Medicaid and KCHIP.

**Please Note:** Detailed descriptions of the organizations above will be provided throughout this manual.



**Figure 1: kynect Stakeholders Involved in the Application Process**

The Department for Community Based Services (DCBS), part of the Cabinet for Health and Family Services (CHFS), provides services and programs to enhance the self-sufficiency of families, improve safety and permanency for children and vulnerable adults, and engage families and community partners in a collaborative decision-making process. DCBS helps Kentucky individuals by processing applications for Medicaid and the Kentucky Children’s Health Program (KCHIP) that are received through kynect and other means.

The Department for Medicaid Services (DMS) within the CHFS is the state agency responsible for the policies of how Medicaid and KCHIP are administered in Kentucky. DMS manages claims and services for members.

The Department of Insurance (DOI) licenses and registers Agents. DOI issues certificates of authorities for HIPs which are authorized by KOHBIE to participate in kynect. DOI regulates the

Commonwealth's insurance market, licenses Insurance Agents and other insurance professionals, monitors the financial condition of companies, educates consumers to make wise choices, and ensures that Kentuckians are treated fairly in kynect.

### 1.3 kynectors

kynectors help individuals and small businesses compare different coverage options available through kynect and facilitate enrollment.

Overall, kynectors offer services in the following three areas:

- **Outreach** – Attend community events to raise awareness about kynect, the services available via kynect, and how kynectors can help with enrollment through kynect.
- **Education** – Provide information to individuals and small businesses regarding health insurance, insurance affordability programs, HIP selection and other services available through kynect.
- **Enrollment Facilitation** – Assist individuals, families, and small businesses with enrollment in HIPs, public programs, and insurance affordability programs. This also includes supporting small business owners with online enrollment.

Refer to the Open Enrollment section 2.2.2 for details on when Agents and kynectors can expect to be busier during the calendar year.

#### 1.3.1 *Federal Expectations and Regulatory Compliance for Navigator programs*

The kynector program is a part of the Affordable Care Act (ACA) Navigator Program, In-Person Assistor Program, and Certified Application Counselor Program. Specific rules and regulations for these programs are found in regulations 45 CFR 155.210 and 45 CFR 155.205 and 45 CFR 155.215. Under the law, kynectors must:

- Facilitate selection of a HIP, maintain expertise in eligibility, provide referrals to those individuals whom they cannot help, and provide services in a fair and impartial manner.
- Conduct outreach and education activities to help inform individuals of kynect, the ACA, and answer any questions they may have.
- Not have conflicts of Interest – To maintain impartiality and provide objective guidance to individuals, kynectors may not be health insurance issuers, stop loss issuers, subsidiaries of such issuers, lobby on behalf of issuers, or receive any compensation from issuers.
- Not make eligibility determinations and will not select HIPs for individuals

#### 1.3.2 *Federal Conflicts of Interest Requirements*

A kynector must meet the conflict of interest standards as outlined in Appendix A. All kynector individuals and entities have to attest to this information before they can begin acting in their role. kynectors must disclose their role when providing services to the individual. An outline of what must be disclosed is set forth in Appendix B.

## 1.4 Insurance Agents

Insurance Agents are licensed and regulated by the Department of Insurance (DOI). Insurance Agents must be registered by KOHBIE to participate on kynect and are paid commissions by the insurance company with which they are appointed.

**Please Note:** within kynect, Insurance Agents are referred to as “Agents” and will be for the remainder of this document

### 1.4.1 Summary of Responsibilities for Agents:

- Represent a health insurance company to provide services for individuals or small businesses in the **solicitation, negotiation, or procurement of insurance policies**.
- **Select and enroll individuals** in Health Insurance Plans through kynect (unlike kynectors, who cannot enroll individuals in HIPs).
- **Offer advice** and work to match the health insurance needs of individuals or small businesses seeking coverage with the products and options available.
- Help individuals apply for payment assistance (APTC).

#### ***How do Agents and kynectors interact?***

Depending upon the needs of the individual, Agents and kynectors may work together to provide an individual-friendly shopping experience. In some instances, a kynector might refer an individual to an Insurance Agent. Likewise, an Insurance Agent may refer an individual to a kynector. For more information refer to section 1.4.3

## 1.5 Regulatory Compliance for Insurance Agents and kynectors

The following sections give an overview of required regulatory compliance for all Agents and kynectors.

### 1.5.1 Insurance Agent Participation Agreements

Insurance Agents must enter into a Participation Agreement with KOHBIE in order to participate. Please refer to Appendix D for the Insurance Agent Participation Agreements.

### 1.5.2 Privacy and Security When Handling Personal Information

It is of the utmost importance and a legal requirement to always be aware of the privacy and security of handling individuals’ personal information. While performing Agent and kynector duties, there is a high likelihood of being exposed to sensitive client information, or Personally Identifiable Information (PII). This personal information may include, but is not limited to:

1. Full name (if not common)
2. Date of birth

3. Birthplace
4. Social Security Number
5. Driver's license
- 6.
7. Mother's middle and maiden names
8. Citizenship, legal status, gender, race/ethnicity
9. Financial information, medical information, disability information
10. Law enforcement information, employment information, educational information
11. Individual's health insurance policy number or subscriber ID number
12. Any unique identifier used by a health insurer to identify the individual
13. Any information in an individual's application, including any appeals records

Agent and kynectors must handle this information carefully, not leaving it in public places or areas where others may be able to access it. Discarding of PII should be by shredder, not a trash can or recycling bin. For additional information about Privacy and Security, see the Privacy and Security Quick Reference Guide on TRIS.

### **1.5.3 The Health Insurance Portability and Accountability Act (HIPAA)**

#### **Did You Know?**

“The Office for Civil Rights enforces the two overarching rules of the HIPAA: The Privacy Rule and the Security rule.”

The Health Insurance Portability and Accountability Act (HIPAA) is an overarching federal law which, in part, is intended to protect the privacy of healthcare information and protect against related fraud. According to the US Department of Health & Human Services, The Office for Civil Rights enforces the two overarching rules of the HIPAA: The Privacy Rule and the Security Rule.

The Privacy Rule protects the privacy of personally identifiable health information (defined above in section 2.3.2). At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

The HIPAA Security Rule sets national standards for the security of electronic protected health information and the confidentiality provisions of the Patient Safety Rule. For additional information about HIPAA, please see the U.S. Health and Human Services website:  
<http://www.hhs.gov/ocr/privacy/hipaa/understanding/>

## 1.6 Functions of Agents and kynectors

### 1.6.1 Understanding and Meeting the Needs of Underserved Populations

Kentucky is a culturally diverse area and includes sections of underserved and vulnerable populations. While working with individuals in Kentucky, Agents and kynectors should use an approach that considers cultural and socio-economic differences. This sensitivity is especially important when meeting individuals in their homes or other places of need. The ability to understand and meet their needs is crucial to the success of vulnerable populations obtaining health insurance. The table below is a list of common underserved populations by region of the Commonwealth. Refer to the figure below for details on each region.

### 1.6.2 Underserved Population Information

Population	Region(s)	Sensitivity Approach
Rural	4, 7, 8	<ul style="list-style-type: none"><li>Consider investing additional time in explaining the basics of health insurance, the ACA, and how each individual is affected by the new laws, regulations, and Exchange.</li></ul>
Homeless	3, 5	<ul style="list-style-type: none"><li>Consider investing additional time with outreach activities and in explaining the basics of health insurance, the ACA, and how each individual is affected by the new laws, regulations, and Exchange.</li><li>Seek facilities that members of the homeless population frequently access as a venue for communication.</li><li>Use the kynector or Agent assister dashboards to help a homeless individual apply for coverage. Homeless individuals may or may not have the requisite email addresses to begin an application.</li><li>Work with the local county DCBS office to see if their address can be used for important correspondence.</li></ul>
Medicaid Eligible Blind and Disabled	2, 4, 7, 8	<ul style="list-style-type: none"><li>Assist the members of this population with understanding how they maintain the appropriate amount of specialized coverage through kynect.</li></ul>
Part-Time Workers	5	<ul style="list-style-type: none"><li>Understand and explain the possible insurance options which a part-time worker is offered and qualifies for.</li></ul>

Population	Region(s)	Sensitivity Approach
Population Lacking Basic Prose Level Literacy	All Regions	<ul style="list-style-type: none"> <li>Be willing to read the majority of kynect-associated information and application language aloud to the individual. Sensitivity around the kynector's potential lack of literacy is paramount.</li> </ul>
Households Lacking Conversational English Speaking Skills	All Regions	<ul style="list-style-type: none"> <li>Refer the individual to another resource that is able to clearly communicate with, and assist the individual.</li> </ul>

**Table 1: Underserved Populations and Suggested Approaches**

Please refer to Appendix J detailed data regarding “high need” populations and a regional map. Please refer to Appendix L for a list of possible agencies and contacts that may be able to assist with the populations.



**Figure 2: Commonwealth of Kentucky Medicaid Managed Care Organization Regions**

### 1.6.3 Understanding the Complexities of an Individual's Insurance Needs

Understanding the insurance needs of each individual is critical to understanding how to help them navigate kynect and the associated health insurance options. Agents and kynectors are also expected to help individuals understand how to calculate items like their personal premium costs and expenses via kynect by walking individuals through the tools available within kynect. When walking individuals through these tools, it is very important to remember a key difference between In-Person Assisters (IPAs), Navigators (kynectors), and Certified Applications Counselors (CACs): IPAs and Navigators cannot be biased and suggest a specific plan; CACs may show bias. CACs often work with individuals in hospitals or other healthcare facilities and unlike the other types of kynectors can suggest specific plans to individuals based on the availability of plans where they seek treatment.

There are a number of different perspective Agents and kynectors can consider when recommending plans to individuals. Factors to consider when comparing plans include:

- **Risk Aversion:** Generally a plan with higher cost-sharing (deductible / co-pay / coinsurance / out-of-pocket maximum) and lower premium would be attractive to someone who is willing to “chance” that they will not require significant healthcare services in the year. Somebody who does not like the idea of having such a large unknown financial cost might be more inclined to pay a higher premium every month in exchange for fewer “surprises” by way of lower cost-sharing expenses.
- **Financial Impact:** A key question to ask the individual is if they have the finances and discipline to set aside a pool of money to cover a higher potential out-of-pocket cost.
- **Physical Health:** Generally a healthier individual might consider a plan with higher cost-sharing and lower premiums on the expectation that their requirements for healthcare services will be low.

#### **1.6.4 Selecting a Plan**

kynect has a plan comparison tool that allows the individual to view multiple plans side-by-side, simulating a shopping experience. The comparison tool outlines the costs associated with each plan, the benefits that the individual will receive, and provide links to the issuer’s provider network. The issuer’s website will also include a Summary of Benefits and Coverage document that details a given plan’s coverage options, insurance products, and more.

As an Agent or kynector, you help an individual compare each plan based on these factors (plan benefits, cost, and healthcare needs). As described in section 1.6.3 above, the individual must weigh his or her healthcare needs with costs associated with each plan to make an informed selection.

**Please Note:** Recall that while kynectors can *assist* an individual in comparing plans, they *may not choose or recommend* the plan for the individual. Only Agents may recommend plans for individuals.

For additional information on how to compare plans on kynect, please refer to the Health Insurance Quick Reference Guide.

#### **1.6.5 Submitting Performance Metrics**

Once kynectors are certified through kynect, they are required to submit metrics to KOHBIE to provide updates on education, outreach, and enrollment activities:

- ✓ **When:** Once every month.
- ✓ **How:** Metrics are be submitted to KOHBIE via a provided metrics template.
- ✓ **Who:** The metrics template is be submitted to the KOHBIE Performance Manager by the entity administrator.
- ✓ **What:** Appendix C provides a detailed listing of required performance metrics.

- ✓ **Why:** Metrics are be collected by the Kentucky Office of the Health Benefit and Information Exchange (KOHBE) to monitor entity progress and overall performance of the kynector program, and outreach and education activities.

Please Note: Only contracted organizations are required to submit these metrics.

***Knowledge Check:***

1. What are three key activities of kynectors?
2. What is the relationship between Insurance Agents and kynectors?
3. What is the Health Insurance Portability Act (HIPPA)? Why is it important?
4. Why is it important to understand an individual's financial situation?
5. Why are referrals so important to perform?

## 2. Exploring Kentucky's Health Benefit Exchange: kynect

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Let's take a deeper dive into Kentucky's health insurance exchange, kynect. This chapter provides information regarding important enrollment guidelines and highlight the basic requirements individuals must meet to participate in kynect.

***By the end of this section, you will be able to:***

- 2.1 Understand kynect's functions and the differences between your online system and Worker Portal.
- 2.2 Identify key federal and state operational timelines such as annual open enrolment.
- 2.3 Understand the general requirements for participating on kynect.

## 2.1. Exchange Basics

One of the components of the ACA requires every state to offer residents an online application for health insurance and the ability to compare plans easily. States had a choice to create their own exchange or use the Federal Health Insurance Marketplace. The Commonwealth of Kentucky has built its own exchange, kynect. The following section explains some of the key features of kynect and reviews general exchange information that pertains to all health benefit exchanges.

kynect allows for easy comparison of available insurance plan options offered by participating issuers, based on price, benefits and services, and quality. In addition, individuals can use kynect to determine if they are eligible for new programs or subsidies to make insurance more affordable. These include programs such as premium tax credits or Medicaid expansion and the Children's Health Insurance Program (CHIP).

Health insurance companies, Kentucky individuals, Insurance Agents, kynectors, and Commonwealth employees can access kynect through separate web-based portals. kynect allows user groups to view information they need and interact according to their role: individual, insurance company, Insurance Agents, kynectors or Commonwealth employee.

Through kynect, individuals are able to determine if they are eligible for premium tax credits or other public programs allowing for more affordable coverage.

### 2.1.1. Federal Hub

In 2010 the Patient Protection and Affordable Care Act (ACA) was enacted into law. As part of this Act, states were required to either develop their own health insurance exchange or elect to participate in a Federally Facilitated Marketplace (FFM). The ACA requires the Secretary of Health and Human Services to establish a system of verification, using secure electronic interfaces, through which all State health coverage programs can verify information needed to determine eligibility. The Affordable Care Act specifically directs that the system enable electronic verification of household income and family size with the IRS, citizenship data with SSA, and immigration status with DHS. The Federal Data Services Hub (FDSH) facilitates such electronic verification and acts as a data broker between state healthcare, FFM and external agencies.

## 2.2. Federal and State Operational Timelines

Key dates for kynect are as follows:

1. **January 1, 2015:** State Exchanges must be able to support themselves financially. Previously the Center for Medicaid and Medicare Services under the Federal Health and Human Services department had provided states grants to help fulfill the requirements set out by the ACA.
2. **November 1, 2015– January 31, 2016** The Open Enrollment period occurs (see details below)

### 2.2.1. Open Enrollment (November 1, 2015 – January 31, 2016)

The federal Open Enrollment period for health insurance is offered multiple months a year, allowing individuals to make changes to their insurance coverage. In 2015, Open Enrollment will

be from November 1, 2015 until February 15, 2016. The official dates of the Open Enrollment period for kynect align with the federal Open Enrollment period each year. The table below shows historical Open Enrollment Dates:

Year	Begin Date	End Date
2013	October 1, 2013	March 31, 2014
2014	November 15, 2014	February 15, 2015
2014 Extended Period	March 15, 2015	April 30, 2015
2015	November 1, 2015	January 31, 2016

Individuals purchasing insurance in kynect have a health insurance effective the first of the following month, if they purchased health insurance before the 15<sup>th</sup> of the month. Individuals purchasing health insurance after the 15<sup>th</sup> of the month have an effective date of the first of the second month following enrollment. For example, if you help an individual purchase insurance on November 20<sup>th</sup>, his or her coverage begins January 1<sup>st</sup> the following year. The last date to enroll in insurance or change a plan and have a January 1<sup>st</sup> effective date is December 15, 2015.

### 2.3. General Requirements for Individual's Participation on kynect

#### 2.3.1. Citizenship/Lawful Presence

In order to participate on kynect an individual must be a U.S. Citizen or lawfully present. kynect has an interface with the Federal Data Hub that allows it to check if an individual is a citizen or lawfully present. If citizenship/lawful presence is not verified through Federal and other data sources, or there is a data mismatch error, the individual can provide proper documentation within 90 days to their local county DCBS office or online. Individuals may also upload, mail, or fax verifications. The following documents may be used to verify lawful presence:

Certificate of Citizenship in non-US country	I-571 (Refugee Travel Document), I-766 (Employment Authorization Card)
DS2019 (Certificate of Eligibility for Exchange Visitor (J-1) Status)	I-94 (Arrival/Departure Record), I-94 (Arrival/Departure Record) in Unexpired Foreign Passport
I-20 (Certificate of Eligibility for Nonimmigrant (F-1) Student Status)	Machine Readable Immigrant Visa (with Temporary I-551 Language)

I-327 (Reentry Permit), I-551 (Permanent Resident Card)	Naturalization Certificate, Other Immigration Document
Temporary I-551 Stamp (on passport or I-94)	Unexpired Foreign Passport.

The 90 day limit is for individuals applying for Payment Assistance. Individuals applying for Medicaid will have 30 days to provide appropriate documentation. Agents and kynectors are encouraged to direct individuals who do not have proper verifications to their local DCBS for citizenship and lawfully presence situations. During the pending verification process an individual is able to enroll in a Health Insurance Plan with Payment Assistance benefits (if applicable), but may not be eligible for Medicaid.

If after 90 days appropriate documentation is not provided, the individual will receive a notice notifying the individual of disenrollment if they already enrolled in a plan. Non-citizens/non-lawfully present applicants cannot enroll for coverage on kynect.

Categories of lawfully present include but may not be limited to the following immigration statuses:

- Legal permanent US resident.
- Qualified alien or non-immigrant under the federal Immigration and Nationality Act, Title 8 U.S.C.

For the complete list of lawful presence qualifications, please see Appendix E.

### **2.3.2.Social Security Numbers**

An applicant who has a Social Security number must provide this information to kynect. An individual who is not seeking coverage is not required to provide a Social Security number, with the following exception:

- An application filer must provide the Social Security number of a tax filer who is not an applicant only if the applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be used for verification of household income and family size.
- For example, if only one spouse on an application is applying for financial assistance but the other spouse is a tax filer and their income has to be counted to determine household income, the Social Security number of the spouse not applying for assistance must be on the application.

Agents and kynectors may be required to assist individuals in uploading verification documentation to be compliant with kynect's minimum requirements.

This applies to public programs as well as private HIPs.

### 2.3.3. Incarceration Status

#### Incarceration Status

Using the Federal Data Hub, kynect verifies that an individual is not incarcerated at the time he or she is applying for insurance.

Individuals who are incarcerated are not eligible for insurance affordability programs (Medicaid, CHIP, APTC, and CSR) or to purchase a Health Insurance Plan. Incarceration status is verified by kynect through an exchange with the Federal Data Services. However, if the data source is unavailable for any reason, kynect is to accept his or her attestation without further verification. Regardless of the data source test, an individual can attest to not being incarcerated. If there is a mismatch between the individual's attestation and the data sources, the applicant is required to submit supporting documentation within 90 days to support their attestation of not having an incarceration status. Individuals who are incarcerated are suspended from receiving Medicaid benefits or from enrolling in an MCO.

Please note: Individuals who are pending charges are not considered incarcerated for the purposes of kynect and are still eligible for insurance affordability programs. Individuals in half-way homes are eligible to apply on kynect.

### 2.3.4. State Resident Status

In order to participate on kynect, an individual must be a resident of the Commonwealth of Kentucky. States have the option to require further documentation to verify residency status, but are not required to do so. If there is a mismatch between the individual's attestation and the data sources, the applicant will be required to submit supporting documentation within 90 days to support their attestation. A KOHBIE caseworker will verify the supporting documentation and deem the individual's residency status as acceptable. Kentucky does not have minimum length of residency requirements.

- The Federal Data Service Hub (FDSH) will access the Social Security Administration (SSA) as the primary source of verification for citizenship, SSN, and the individual's status as a national or lawful presence in the U.S.

#### **Knowledge Check:**

1. Does Kentucky use the Federal Health Exchange?
2. When is annual open enrolment for 2015?
3. What requirements must individuals meet to participate on kynect?
4. What is Kentucky's health exchange called?
5. Which individuals must provide their SSN?

# 3. An Introduction to Determining Eligibility

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This section is an introduction of how kynect determines an individual's eligibility for a Health Insurance Plan. To learn about determining eligibility for a specific assistance program, please refer to chapters 4 and 5.

***By the end of this section, you will be able to:***

- 3.1 Understand the basics of determining eligibility for insurance.
- 3.2 Understand when an individual may need to change their coverage due to a change in eligibility.
- 3.3 Recognize cases of mixed or complex eligibility and know how to work with individuals in these situations.
- 3.4 Understand instances when individuals are exempt from purchasing insurance.

### 3.1. How Eligibility is Determined

The ACA requires a coordinated process for determining eligibility across states for all Insurance Affordability Programs including Medicaid (MAGI only), KCHIP and the new healthcare APTC and CSRs. Kynect assesses eligibility for these programs, looking first to the most comprehensive programs, Medicaid, and then KCHIP. If an individual is not found eligible for these programs, the system then evaluates for APTC and CSR. For individuals and households not eligible for assistance programs, kynect uses the individual or household's income to determine their ability to purchase affordable private health insurance plans, or Health Insurance Plans (HIPs).

#### 3.1.1. Modified Adjusted Gross Income (MAGI) Methodology

The ACA streamlined and consolidated the methodology that states across the country use for determining an individual and household's income. This income calculation is called the MAGI methodology and it redefines household composition and how income is calculated using an individual's tax household as the basis for the income calculations. MAGI factors in an individual's estimated yearly income and other factors to come to a final adjusted income calculation.

Special note: Eligibility is determined based on **monthly** earnings for **Medicaid** and **annual** earnings for **payment assistance and Special Discounts**. Kynect completes these calculations, but how they are calculated is something important for Agents and kynectors to know.

Eligibility for insurance affordability programs is based on household income and family size. kynect uses these factors to determine where a household falls on federal poverty level (FPL). Individuals that are offered affordable coverage through their employer that meets the Minimum Essential Coverage requirements, will not be eligible for payment assistance or Special Discounts on kynect. Individuals enrolled for Medicare Part A are considered to have Minimum Essential Coverage and do not qualify to purchase coverage on kynect.

The following sections explain household composition and income requirements in detail.

#### 3.1.2. Household Composition

##### Eligibility

Eligibility is based on two components: Household Composition and Income.

Determining household composition is essential to determining the eligibility of each household member. kynect uses the number of family members and their ages to determine if an individual is eligible for a specific program.

A new formula for determining household composition, based on MAGI, was instituted with the ACA and is based on how an individual files their taxes.

If an individual plans to file his or her own taxes in the upcoming plan year, the individual is considered to be in his or her own household. If individuals plan to file taxes jointly, they are in the same household.

If the individual plans to claim dependents on his or her taxes, those dependents are counted in the same household as the individual.

Similarly, if an individual is claimed as a dependent on someone else's taxes, he or she would be included in the other person's household and not have their own household.

**Note:** “Household” does not mean “family” or those who live in a single home. The household composition is based solely on the applicant’s tax filer status. Households may apply as separate individuals or as one household. However, filing status may affect the total benefits received. Include all members in a tax household even if they do not all need medical coverage.

A non-filer is someone who does not file taxes or does not expect to file a tax return in the coming year. This includes individuals receiving Supplemental Security Income (SSI) or individuals who do not meet the income requirements to file taxes. Under the non-filer rules, children are defined as being under 19 and can be biological, adopted, or step-children. Medicaid household composition for non-filers is described below:

For adults:

- The individual
- The individual’s spouse if living together
- The individual’s children if living together

For children:

- The child
- The child’s parents if living with the child
- Child’s siblings if living with the child
- Child’s spouse if living together
- Child’s children if living with the child

### **3.1.3. Income and Tax Information**

Income (from all taxable sources) is used to project the household’s income for the upcoming plan year. When applying online, kynect prompts an applicant to enter their projected income for each individual within the household for the coming plan year. Please refer to the table in Appendix K of this document and the Income and Tax QRG for additional details on what income is taxable and should be included and what income is not taxable and should not be included.

**Please Note:** Estimating an individual or household’s income using non-taxable income could drastically impact eligibility. Please make special note of what income should be included during estimations or calculations.

### **Income Verification**

After income is entered into kynect, kynect attempts to electronically verify the data with the Federal Hub. The Federal hub uses the SSN of an individual to match the individual to their previous year’s income as reported on their federal taxes. If an individual or household had large financial changes since the previous year, there is a strong chance their income will not be automatically verified through kynect. This requires additional verification to be entered into kynect or through an individual’s local DCBS office.

- If the self-reported income is 10% less than that from the federal hub, the individual is prompted to submit verification to kynect that his or her self-reported income should be used. There is no need to verify if reported income is more than the federal hub income.
- Eligibility is always based on reported income. If verification is needed, eligibility is rerun based on verified income.

- Specific instructions on how to do this are displayed on the screen (and are also covered in Exchange System Training for kynectors).

If the self-reported income and the Federal Hub income are within 10% of each other, the kynect-calculated MAGI income is used to determine eligibility for insurance affordability programs.

Inaccurately reporting income can have two effects on individuals:

- Underreporting income may lead to larger Advanced Premium Tax Credit (APTC) benefits or improper Medicaid eligibility determination.
  - Improper Medicaid eligibility determination may cause someone who is not truly eligible to inadvertently qualify for Medicaid.
  - The APTC error is reconciled when an individual completes his or her taxes and the individual may have to pay back the overpayment of APTCs received during the year.
- Over reporting income may cause an individual to become ineligible for Medicaid when they should in fact qualify. It may also lead to smaller APTC benefits. A tax filer receives a tax credit for any underreporting of APTCs when they file their tax return.

Individuals eligible for Payment Assistance may receive Requests for Information (RFI) to verify their income. If they do not respond to these RFIs within 90 days, kynect will use trusted data sources to attempt to verify income. If the trusted data sources verify income, Payment Assistance will not be discontinued, however if they cannot verify income, the individual will receive a notice of discontinuance.

### 3.1.4.Changes in Eligibility

Life changes may have a substantial impact on individuals’ options or plan choices. For this reason, Agents and kynectors may need to assist individuals outside of the Open Enrollment period. Generally, individuals are allowed a 30-day period to communicate their changes in circumstances to kynect. Some examples of life changes are shown in the table below:

Examples of Changes in an Individual’s Life	Examples of Changes in Eligibility
An increase in income raises the individual’s relation to the federal poverty level <b>from below 138% to above 138%</b> FPL	The individual is now no longer eligible for Medicaid but may be eligible for a Health Insurance Plan with payment assistance.
A decrease in income lowers the individual’s income level <b>from above 138% to below 138%</b>	The individual is now eligible for Medicaid.
Birth of a child	Household composition changes, affecting eligibility and potential subsidies. The child is also eligible for special enrollment.

**Table 2: Changes in Eligibility**

Agents and kynectors are expected to work with individuals to understand when any of these changes occur and communicate how it affects their coverage options. In addition, Agents and kynectors should explain the requirement to report changes that may affect their eligibility when they conduct outreach

activities. This informs the individuals ahead of time of potential events that may occur in the coming year.

***Why is it important to report changes?***

Consider the following scenario:

A mother is Medicaid eligible at 135% of FPL based on her income and a household size of two. Her child moves into a home with her father and the child is now claimed as a dependent on the father's taxes.

Mom's income is then compared to the household size of one, putting her over the income limit for Medicaid. Mom's loss of Medicaid is viewed as a qualifying event; she will be eligible to enroll in a HIP with an APTC, based on her income.

### 3.2. Complex or Mixed Eligibility

Complex or mixed eligibility is when a household, as defined above, has different people eligible for different programs. Specifically, there may be families where some individuals are eligible for Medicaid or KCHIP while others are eligible for payment assistance. kynect is able to determine eligibility for all insurance affordability programs.

As a kynector supporting a complex or mixed eligibility application, your job is the same as before: walk the individual through the application process. kynect uses the household's MAGI income and determines eligibility based on this income and family size. After a determination of eligibility, individuals are able to shop available health plans they are eligible to enroll in. If the individual is Medicaid or KCHIP eligible, they are able to select a managed care organization (MCO). If individuals don't select a MCO while they are shopping for a plan, one will be automatically selected for them. If an individual is eligible for an MCO but does not go shopping, one will be selected for them in 24 hours.

### 3.3. Individual Responsibility Penalties & Exemptions

Under the Affordable Care Act, most individuals are required to have health insurance. Those that remain uninsured may be required to pay a federal tax penalty if they are not exempt. For a detailed flowchart for supporting an individual deciding if they need insurance, please refer to appendix N.

The law allows for certain individuals to be exempt from having health insurance by recognizing nine exemptions (see below). Kentucky relies on HHS to make the determination for exemptions.

Exemption	Definition
Religious Conscience	<ul style="list-style-type: none"> <li>Members of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits</li> </ul>
Healthcare Sharing Ministry	<ul style="list-style-type: none"> <li>Health sharing ministries help share the cost of health insurance but do not provide it</li> </ul>

Exemption	Definition
Native American Tribe	<ul style="list-style-type: none"> <li>Member of a federally recognized Native American tribe</li> </ul>
No Filing Requirement	<ul style="list-style-type: none"> <li>An individual's household income is below the minimum threshold for filing a tax return</li> </ul>
Short Coverage Gap	<ul style="list-style-type: none"> <li>An individual went without coverage for less than three consecutive months during the year</li> </ul>
Hardship	<ul style="list-style-type: none"> <li>An individual has suffered hardship that makes him or her unable to obtain coverage</li> </ul>
Unaffordable Coverage Options	<ul style="list-style-type: none"> <li>An individual can't afford coverage because the minimum amount for the premiums is more than 8% percent of household income</li> </ul>
Incarceration	<ul style="list-style-type: none"> <li>An individual is in jail, prison, or similar penal institution or correctional facility after the disposition of charges</li> </ul>
Not Lawfully Present	<ul style="list-style-type: none"> <li>An individual is neither a U.S. citizen, a U.S. national, nor an alien lawfully present in the U.S.</li> </ul>

**Table 3: Individual Responsibility Exemptions**

For additional information on the subject of Federal exemptions, please see the following website: <http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>.

### 3.4. Grandfathered Plans

Health plans in effect as of March 23, 2010 are grandfathered under the ACA and are considered “qualified coverage”, meeting the individual mandate to have health insurance. Health Insurance plans purchased after March 23, 2010 are considered non-grandfathered plans and must meet all the requirements of the ACA, including the requirement to provide essential health benefits.

In the event that an individual is enrolled in a plan that is no longer considered grandfathered, individuals are required to obtain other insurance that is compliant with the ACA. kynectors may need to help individuals understand how and why they must enroll in appropriate coverage.

**Knowledge Check:**

1. What is an example of a change in eligibility?
2. What are grandfathered plans and why are they relevant to kynectors and Agents?
3. What are three exemption categories that would prevent an individual from having to buy health insurance?
4. Why is it important to report changes in eligibility?
5. What is mixed eligibility?

# 4. Private Health Insurance Options

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Now that you have a basic understanding of kynect and eligibility, we can examine the various insurance options available to individuals. Health Insurance Plans certified on kynect provide essential health benefits (EHBs) and follow established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amounts).

***By the end of this section, you will be able to:***

- 4.1 Compare different Health Insurance Plans.
- 4.3 Define Special Discounts and payment assistance and identify the differences between the benefits associated with both.
- 4.4 Describe the requirements to have dental coverage when purchasing a Health Insurance Plan.

## 4.1. Individual Coverage Options and Health Insurance Plans (HIPs)

The sections below outline the important features and key differences between the various HIPs offered on kynect that are critical to know when helping individuals during enrollment.

### 4.1.1. Health Insurance Plans

The Affordable Care Act (ACA) defines a Health Insurance Plan or Qualified Health Plan as an insurance plan that meets the criteria noted below:

1. Is certified by an Exchange
2. Provides essential health benefits (EHBs):
  - a. Ambulatory patient services;
  - b. Emergency services;
  - c. Hospitalization;
  - d. Maternity and newborn care;
  - e. Mental health and substance use disorder services, including behavioral health;
  - f. Prescription drugs;
  - g. Rehabilitative and habilitative services and devices;
  - h. Laboratory services;
  - i. Preventive and wellness services and chronic disease management; and
  - j. Pediatric services, including oral and vision care.
3. Follows established limits on out-of-pocket spending (such as deductibles, copayments, and out-of-pocket maximums).

These plans must be certified by each Exchange on which they are sold. In Kentucky, the Department of Insurance (DOI) approves plan rates, forms, and networks, and KOHBIE certifies the plans before they are offered on kynect.

### Insurance Companies

Sample insurance companies include Anthem (Blue Cross/Blue Shield), UnitedHealth, Humana, Kentucky Health Cooperative, and more.

There is a tool on kynect's Self-Service Portal that allows individuals to search for plans using different criteria including healthcare providers, plan metal level, and zip code. Individuals can then select up to five plans to compare side by side in order to choose a plan that is best for them. For more information on comparing health plans, please refer to section 9.3 of this manual.

### 4.1.2. Insurance Plans and Metal Levels

There are four standard metal level or "tiers": Bronze, Silver, Gold, and Platinum. An additional Catastrophic level plan is available for those who are under 30 years old or have a hardship exemption. The main difference between these tiers is the amount the individuals spend on receiving care versus the amount that the insurance company spends on providing care.

This should not be confused with the benefits offered through the plans themselves. Each individual issuer defines the benefits for each plan. Aside from essential health benefits, there are no set benefit levels for each plan tier. Therefore, two plans within the same metal level may have very different sets of benefits. These two plans, while different in the sets of benefits they provide, may cost the same amount to the individual. Similarly, two plans of different metal levels may have similar benefits. The difference between the two plans would be in how much the individual would spend on receiving these benefits and how much the issuer would spend.

Coverage Level	Actuarial Value (+/- 2%)
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

**Table 4: ACA Plan Coverage Levels – Actuarial Values**

Aside from Catastrophic level plans, Bronze plans offer the minimum level of coverage required by law. Each metal plan is designed to pay a certain percentage of healthcare expenses for the average person or household. This percentage paid by the plan is called actuarial value. Table 4 shows the actuarial values associated with each metal level. These are defined by the ACA and must be adhered to by all plans sold on kynect.

Generally, premiums are higher as actuarial value increases, deductibles are lower as actuarial value increases, and copays and coinsurance rates are lower as actuarial value increases.

### Catastrophic Plans

The Catastrophic plan is available only for:

- Individuals under the age of 30 at the coverage effective date;
- Individuals with a hardship; or
  - In order to purchase a catastrophic plan due to hardship, individuals must show proof of hardship (which includes a certificate of exemption).
- Individuals without affordable coverage
  - In order to purchase a catastrophic plan due to lack of affordable coverage, individuals must show proof of hardship (which includes a certificate of exemption).

**Catastrophic Plans**  
 Catastrophic plans provide lower premiums and higher cost sharing.

If these qualifications are met, individuals may purchase a Catastrophic plan with the coverage level set at the Health Savings Account (HSA) current law levels. However, 3 primary care visits are exempt from the plan’s deductible. Catastrophic plans are only available in the Individual Market.

### 4.2. Out-of-Pocket Maximums

All individuals and/or households that buy coverage via kynect have a cap (maximum amount) placed on their total possible out-of-pocket spending. This out-of-pocket spending includes **deductibles**,

**copays** and **coinsurance** that are to be paid by the individual. The limits for an individual's contribution toward these costs are determined by the issuers when they design their plans and are called out-of-pocket maximums. Out-of-pocket maximums referred to in this manual apply to essential health benefits only. Health insurance plans may have separate out-of-pocket maximums for non-essential health benefits as well.

***What do out-of-pocket maximums mean to the individuals that I help?***

Out-of-pocket maximums are important to understand because they determine the most that an individual has to pay for healthcare in a plan year. Note that the out-of-pocket maximum is in addition to the premium that the individual pays. Individuals should use this as a point of consideration when comparing two similar plans.

**Example:**

Joe's monthly premium is \$40. This is the standard price he must pay for his health insurance plan. His plan's out-of-pocket maximum is \$4,000 for the plan year. In this plan year, Joe pays no more than \$4,480 for essential health benefits. This is because Joe pays a premium of \$40 per month ( $\$40 \times 12$  months = \$480 in premiums for the year). For all additional covered services, Joe only pays up to \$4,000 in total. Payments that count toward this \$4,000 maximum are his deductible, coinsurance, and may include his copays.

### **4.3. Payment Assistance and Special Discounts**

Key features of kynect are the affordability programs, not only including Medicaid and Kentucky's Children's Health Insurance Program (discussed in the following chapter), but also payment assistance and Special Discounts. The programs are designed to help individuals purchase health insurance.

Payment assistance is a tax credit available on an advanced basis to reduce the costs for eligible individuals who enroll in a Health Insurance Plan (HIP) through kynect. This benefit of payment assistance is also known as an Advanced Premium Tax Credit (APTC).

Special Discounts, on the other hand, provide assistance to reduce cost-sharing obligations, including copays and deductibles. This program is also known as Cost-Sharing Reductions (CSRs).

Payment assistance and Special Discounts are known as Insurance Affordability Programs (IAPs).

#### **4.3.1. Payment Assistance (Advance Premium Tax Credits or APTC)**

Qualified individuals are eligible to receive premium tax credits through kynect to help them purchase a HIP. This includes individuals who are not:

- Eligible for Medicare, Medicaid, or KCHIP;
- Enrolled in VA or TRICARE; or
- Offered Employer Sponsored Insurance (ESI).

This payment assistance may be provided in advance (Advanced Premium Tax Credit or APTC) or taken as a tax credit at the time an individual files their income taxes. This credit is only available through kynect. The tax credit cannot exceed the amount of the premium paid by the individual. Any discrepancies are reconciled in their federal taxes of the same year.



“APTC could help me pay my plan premium. The amount of assistance I receive is based on my income level.”

An individual who wants a higher tier (Gold or Platinum) plan does not receive additional payment assistance for the incremental premium exceeding that of a silver plan.

For individuals whose Silver plan premium amount exceeds the annual premium limit, the payment assistance amount equals the difference between the plan premium and annual premium limit. The annual premium limit is the maximum payable amount for the benchmark plan which is the second lowest-priced silver plan available.

Agents and kynectors should instruct individuals to use caution when selecting the amount of payment assistance applied during the initial shopping period. If 100% of payment assistance is applied and an income increase occurs, the individual may have to pay back the over applied APTC amount.

At the end of the year, the taxpayer’s payment assistance is reconciled with what the taxpayer should have received (using actual household income and family size for the taxable year).

- If the payment assistance was less than the actual premium tax credit, the individual receives an additional refund.
- If the payment assistance was greater than the actual tax credit, the individual owes the excess as an additional tax liability. This is to be included in their federal taxes.
- Individuals who do not file taxes for a year in which they received payment assistance will not be eligible for future assistance

**4.3.2. Special Discounts (or Cost-Sharing Reductions or CSRs)**

Special Discounts reduce an individual’s out-of-pocket costs such as the deductible, copay, and/or coinsurance. Special Discounts are only available if the individual has an income under a certain amount and chooses a **Silver level** plan. Special Discounts have five different categories (A, B, and C), and an individual’s Special Discount category can change during the year if their income changes.

Income level compared to FPL	Special Discount Category	Special Discounts
If income is less than 150% of FPL	A	May pay up to 94%

If income is between 200% and 150% of FPL	B	May pay up to 87%
If income is between 250% and 200% FPL	C	May pay up to 73%
If income is between 0% to 300% FPL and individual is American Indian/Alaska Native	D	May enroll in zero cost sharing plan
If income is between 300% and 400%	E	May pay up to 70%

All other metal level plans (Bronze, Gold and Platinum) have out-of-pocket maximums for each plan offered by the issuer. However, individuals do not receive special discounts on copays, coinsurance, and deductibles for these other metal level plans.

Below is an actuarial value table for silver plans.

Income	Effective Actuarial Value
100 - 150% FPL	94%
150 - 200% FPL	87%
200 - 250% FPL	73%
Above 250% FPL	70%

**Table 5: Out-of-Pocket Maximum for Silver Plan Individuals Based on Income Level**

All other metal level plans (Bronze, Gold and Platinum) have out-of-pocket maximums for each plan offered by the issuer. However, individuals do not receive special discounts on copays, coinsurance, and deductibles for these other metal level plans.

**Payment Assistance = Plan Premium – Annual Premium Limit**

Income	Annual Premium Limit
Up to 138% FPL	2.01% of income
138 - 150% FPL	3.02- 4.02% of income
150 - 200% FPL	4.02 - 6.34% of income
200 - 250% FPL	6.34 - 8.1% of income
250 - 300% FPL	8.1 - 9.56% of income
300 - 400% FPL	9.56% of income

**Table 6: Premium Limits for Individuals Based on Income**

### **Example Individual: Joe Smith**

Joe is a single man with no dependents. He earns an income at 144% of the FPL (\$16,545) and is not offered affordable health insurance by his employer or any other source. If Joe were to purchase a Silver plan which has an annual premium of \$1000 via kynect, his:

- Annual premium limit will be 3.5% of his income or  $.035 * \$16,545 = \$579.09$ .
- Payment assistance = Plan Premium per year – Premium Limit =  $\$1,000 - \$579.09 = \$420.91$ .
- Joe's monthly premium owed =  $\$579.09 / 12 = \$48.26$ .

If Joe were to purchase a Gold plan with plan premium of \$2,000 per year, his payment assistance amount would still be \$420.91. Joe would then be expected to pay the annual balance of \$1,579.09 to meet the \$2,000 plan premium amount, or \$131.59 per month.

For an interactive calculator for payment assistance, please go to: <http://healthbenefitexchange.ky.gov/Pages/Interactive-Calculator.aspx>

## **4.4. Dental Insurance**

Kentucky regulations require individuals under the age of 21 to have pediatric dental benefits. If an individual is under the age of 21 and does not otherwise have dental coverage (as a dependent on a family's plan, under a Health Insurance Plan, etc.), he or she is required to obtain dental insurance. There are two ways to purchase the pediatric dental coverage via kynect:

- By purchasing a Stand-Alone Dental Plan (SADP); or
- Selecting a HIP with dental coverage embedded in it.

SADPs may offer adult dental coverage in addition to the required pediatric dental coverage. However, not all medical plans in kynect include embedded pediatric dental coverage. There are also pediatric-only dental plans offered on kynect.

Plans that include pediatric dental coverage are considered plans with embedded dental coverage. Managed Care Organizations (MCO) always contain a pediatric dental benefit.

If an individual under 21 selects a plan with embedded pediatric dental coverage, they automatically meet the requirement to have dental coverage. If an individual selects a plan that does not have embedded pediatric dental coverage, they are not be able to complete his or her shopping.

Dental out-of-pocket maximums exist for children. For adults, however, out-of-pocket maximums may not apply to dental insurance. Individuals must examine an insurance plan's



**“I just turned 22, so I am not required to purchase dental insurance. However, I still elected to purchase a plan that includes it.”**

schedule of benefits, brochures, or policy to determine if out-of-pocket maximums apply.

Once payment assistance amount has been used to fully cover the EHB portions of the medical plans, any residual payment assistance can be used towards pediatric dental and the pediatric portion of family dental plans.

Starting in October 2015, Medicaid and Medicare Eligible individuals can purchase SADPs through kynect.

#### 4.5. Other Insurance Programs

Veterans' health benefits and TRICARE meet minimum essential coverage requirements for many individuals. An individual enrolled in any of these programs is not required to purchase additional coverage to meet the ACA mandate for individual minimum essential coverage.

##### 4.5.1. Veterans Health Coverage

If the individuals are enrolled in any of VA's programs below, they have coverage under the standards of the health care law:

- Veteran's health care program
- Civilian Health and Medical program (CHAMPVA)
- Spina bifida health care program



“I have TRICARE coverage; therefore I will not be required to buy a new plan on kynect.”

Veterans enrolled in VA care do not need to do anything else. The health care law does not change their Veterans' benefits or out-of-pocket costs. Veterans can continue to enjoy VA health care, which means they have met the new requirement to have health care coverage that meets the minimum standard.

If individuals have other forms of health care coverage, such as a private insurance plan, Medicare, Medicaid or TRICARE, they can continue to use VA along with these plans. kynect is a way to shop for and purchase private health insurance in addition to VA health care programs. Individuals who purchase insurance through kynect may be able to lower the costs of health insurance coverage by paying lower monthly premiums.

If an individual chooses to cancel their VA health care enrollment, they may reapply. However, acceptance is based on eligibility. For more information go to: <http://www.va.gov/healthbenefits/online/>

##### 4.5.2. TRICARE

Formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), TRICARE is a healthcare program that provides civilian health benefits for military personnel, military retirees, and their dependents, including some members of the military Reserves. These benefits include dental and health insurance.

TRICARE operates within the United States Department of Defense Military Health System and makes up the civilian care component of the Military Health System (MHS).

***Knowledge Check:***

1. What are the metal levels of Health Insurance Plans available on kynect? How do they differ from one another?
2. Define Out of Pocket Maximums. What role do premiums play?
3. What is payment assistance and how does it help individuals?
4. What group of individuals is required to purchase dental insurance and what are two ways they can do so via kynect?

# 5. Public Health Insurance Options

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The public health insurance programs outlined in this chapter may be administered by the Federal government, state governments, or both. Federal and *state public programs are in place to help individuals who may be vulnerable or underserved.*

***By the end of this section, you will be able to:***

- 5.1 Identify the minimum requirements an individual must meet when applying for public health insurance programs
- 5.2 Distinguish between the various public health insurance programs available in Kentucky.
- 5.3 Assist in determining eligibility for these public health insurance programs.

## 5.1. Overview of Public Health Insurance Programs Available in Kentucky

The ACA dramatically re-shaped the eligibility processes for Medicaid and the Kentucky Children's Health Insurance Program (KCHIP). It introduced a simplified approach to eligibility determination for Medicaid and KCHIP and extended that simplified approach to newly established insurance affordability programs.



“Though Medicare is a public program, I cannot apply through kynect.”

## 5.2. Medicare

Medicare is a program enacted at the Federal level that provides health insurance for individuals 65 or older, individuals under 65 with certain disabilities, or individuals of any age with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). There are four major parts to the Medicare program:

Part A: Hospital insurance program.

Part B: Medical insurance program.

Part C: Medicare advantage program.

Part D: Outpatient prescription drug benefit.

**Note:** Medicare is not a program that is available via kynect, however, individuals eligible for Medicare can now purchase a Stand-Alone Dental Plan through kynect. Information about Medicare is included here to provide an overview of programs that kynectors may need to familiarize themselves with to fulfill their roles.

### 5.2.1. Medicare organizations

If an individual has questions regarding Medicare please refer them to one of the following organizations:

The Kentucky State Health Insurance Assistance Program (SHIP) provides information, counseling and assistance to seniors and disabled individuals, their family members and caregivers. The organization's mission is to educate seniors on health insurance coverage, benefits and consumer rights.

If an individual would like to lodge a complaint about an issuer or agent, or to find an insurance agent to purchase a Medicare Supplement plan, refer him or her to the Department of Insurance (DOI).

If an individual wants to apply for one of the Adult Medicaid Programs (Waiver Services, SLMB QMB, etc.), please refer him or her to DCBS...

For specific Medicare question or additional Medicare information, direct individuals to call 1-800-medicare, or visit Medicare.gov.

### 5.2.2. Medicare Eligibility

Generally, an individual is eligible for Medicare if they or their spouse worked for at least ten years in Medicare-covered employment and they are 65 years or older and a citizen or permanent resident of the United States. If an individual is not 65 yet, they might also qualify for coverage if they have a disability or end-stage renal disease (permanent kidney failure requiring dialysis or transplant).

#### ***How can kynectors help individuals who qualify for Medicare?***

kynectors will be expected to assist individuals who may be eligible for both Medicare and Medicaid benefits. The basic eligibility requirements for Medicare are listed above. However, because Medicare is not offered through kynect, the kynector must be able to direct the individual (who is interested in receiving Medicare benefits) to the appropriate State Health Insurance Provider (SHIP) coordinator, who can help them apply. SHIP is a program formed to provide information, counseling and assistance to seniors and disabled individuals, their family members and caregivers. SHIP coordinators can be found by visiting the following websites:

<http://chfs.ky.gov/dail/ship.htm> or [www.medicare.gov](http://www.medicare.gov).

### 5.3. Medicaid

Medicaid was enacted in 1965 through amendments to the Social Security Act. Medicaid is a health and long-term care coverage program, jointly funded by state governments and the federal government. Every state establishes and administers its own Medicaid program and determines the type, amount, duration, and scope of services covered within broad federal guidelines. States are required to cover certain mandatory benefits and may choose to provide other optional benefits, as well.

The new Modified Adjusted Gross Income (MAGI) established national regulations on how an individual and household's Medicaid eligibility is calculated for most recipients, see the complete list of impacted demographic groups below.

#### **Medicaid MAGI Eligibility**

The ACA streamlined and consolidated Medicaid income methodology with the introduction of the MAGI rules. The MAGI methodology redefines household composition, income groups, and what income sources are countable based on tax information. The ACA also streamlined and consolidated existing mandatory and optional eligibility groups into three groups, as follows:

#### **MAGI Medicaid Categories**

**Adults age 19-64\***

**Parents/Caretaker relatives (regardless of their age)**

**Healthy Children under the age of 19 (Medicaid and KCHIP)**

**Pregnant Women**

**Table 7: MAGI Medicaid Categories**

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Individuals who can receive both Medicare and Medicaid are considered dual-eligibles.

### **5.3.1. Medicaid Expansion for Adults\***

The Commonwealth of Kentucky chose to expand its Medicaid program by extending Medicaid benefits to adults whose income level is at or below 133% of the federal poverty level. This means that if a household's income is less than 1.33 times the national poverty line, they are eligible for Medicaid benefits.

However, if needed for Medicaid eligibility the 5% federal poverty income disregard is applied effectively raising the eligibility limit to 138% FLP from an individual's income.

### **5.3.2. Medicaid Managed Care Organizations**

Individuals eligible for Medicaid must enroll in a Managed Care Organization (MCO) to receive Medicaid benefits. Enrollment takes place through kynect as part of the individual application process. Medicaid-eligible individuals are able to comparison shop both Health Insurance Plans (HIPs) and MCOs. Each household member is directed to the options available for them by kynect. If an individual enrolls in Medicaid, they must enroll in a MCO. If the individual does not select a MCO, kynect selects one for them automatically. After 90 days, an individual can no longer change an MCO through kynect and will instead be directed to contact DMS.

**Please note:** Automatic selection only applies to MCOs. Individuals are not auto-enrolled in Health Insurance Plans or SHOP plans.

Categories for the aged, blind, and disabled (commonly known as the ABD cases) remain unchanged. Those categories are considered Non-MAGI.

### **5.3.3. MAGI Review**

Remember that an individual's household is determined by their tax household. Here is a helpful list of questions to determine an individual's household. This is the determination that kynect performs based on how individuals answer tax relationship questions.

- A. Does the individual expect to file taxes?**
- B. Does the individual expect to be claimed as a tax dependent?**
- C. Does the individual plan to file taxes jointly?**
- D. If the individual does not expect to file taxes, the household is based on relationships and living arrangement.**

### 5.3.4. Non-MAGI Medicaid Eligibility

The following groups are not subject to the MAGI methodology (they are referred to as Non-MAGI groups):

Non-MAGI
Any individual for whom DCBS Workers are not required to make an income determination of eligibility (e.g., SSI, Title IV-E foster care and adoption assistance recipients).
Medicaid-eligible individuals on the basis of being aged, blind, or disabled.
Individuals receiving benefits based solely on their need for long term care services.
Individuals eligible as Medically needy (Spend Down).

**Figure 3: Non-MAGI Categories**

### 5.4. Kentucky Children's Health Insurance Program (KCHIP)

The Kentucky Children's Health Insurance Program (KCHIP) provides coverage for uninsured children up to age 19 with family income equal to or less than 213% of the FPL or 218% with the 5% disregard. Prior to 2014 Kentucky had a six month waiting period for eligibility if a child dropped private coverage to obtain KCHIP. In 2014 Kentucky elected to drop the waiting period and allow families to drop other coverage and apply for insurance through KCHIP.

Children can qualify for Medicaid if their household income falls at or below 142% of the FPL. KCHIP provides coverage to qualified children with income between the Medicaid limit and 213% FPL (plus a 5% disregard).

Please see the following chart for current KCHIP income limits for 2015.

Number of Household Members (include parents and children)	Total Monthly Family Income (before taxes)	Total Annual Family Income (before taxes)
1	\$2,139	\$25,668
2	\$2,894	\$34,728
3	\$3,650	\$43,800
4	\$4,406	\$52,872
5	\$5,162	\$61,944
6	\$5,917	\$71,004
7	\$6,673	\$80,076
8	\$7,429	\$89,148

**Table 8: 2015 KCHIP Income Limits**

**Note:** Income limits change annually based on the publication of the federal poverty levels (FPL). This table shows the 218% FPL guidelines.

## 5.5. Other Public Assistance Programs

### 5.5.1. Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to low income individuals and families and provides economic benefits to communities. According to the United States Department of Agriculture (USDA), households have to meet specific income tests unless all members are receiving TANF, SSI, or in some places general assistance. Most households must meet both gross and net income tests, but a household with an elderly person or a person who is receiving certain types of disability payments only has to meet the net income test. Households, except those noted, that have income over the amounts listed below cannot get SNAP benefits.

Household size	Gross monthly income (130% of poverty)*	Net monthly income (100% of poverty)*
1	\$1,256	\$973
2	\$1,705	\$1,311
3	\$2,144	\$1,650
4	\$2,584	\$1,988
5	\$3,024	\$2,326
6	\$3,464	\$2,665
7	\$3,904	\$3,003
8	\$4,344	\$3,341
Each additional member	\$440	\$339

**Table 9: SNAP Qualifying Household Income Limits**

\*Per the USDA, gross income means a household's total, nonexcluded income, before any deductions have been made. Net income means gross income minus allowable deductions.

The Department for Community Based Services (DCBS) created a Supplemental Nutrition Assistance Program (SNAP) Web Portal to assist individuals with:

- Prescreening to determine if their household is potentially eligible for SNAP benefits;
- Getting a SNAP application started;
- Reviewing basic information about their case when they are receiving SNAP;
- Communicating changes to their local DCBS office; and
- Viewing notices electronically, if the household chooses to use this portal.

Individuals can also download their SNAP application and submit a hardcopy to the DCBS office. At the end of 2015, individuals will be able to apply for SNAP online via benefind. Look for details later this year about this new feature.

### 5.5.2. SNAP Eligibility

Basic SNAP eligibility requirements in the State of Kentucky are as follows:

## SNAP and K-TAP

SNAP and K-TAP will be available via Benefind at the end of 2015

1. **Citizenship:**  
Only U.S. citizens and some legal foreign residents of the United States may receive food benefits.
2. **Work Registration:**  
Anyone in a household who is 16 to 60 years old and can work must register for, look for and accept work. There are some exceptions to this requirement.
3. **Resources:**  
A household may have no more than \$2,000 in cash and bank account assets. If a member of the household is 60 or older, the household may have no more than \$3,000 in resources. Some resources not used to calculate household assets include the dwelling, its contents and personal belongings. Vehicles also are excluded.

#### 4. **Income:**

The amount of money a household can receive and still be eligible to receive SNAP benefits depends on household size. Money from wages or other payments to any household member is counted as income.

An individual's household may qualify for deductions from the household's income such as rent, utilities, legally obligated child support paid to someone outside the household and babysitting expenses. If a household includes older or disabled members, the household may be able to deduct medical costs.

### **5.5.3. Temporary Assistance for Needy Families (TANF/K-TAP)**

Temporary Assistance for Needy Families is a federal assistance program that provides cash assistance to underprivileged families with dependent children. The funds are distributed through the United States Department of Health and Human Services. The law was enacted in 1997 and aims to provide support to families while helping them become self-sufficient, largely through employment efforts. There is a maximum of 60 months of benefits within a Kentucky resident's lifetime, but some states have instituted shorter periods.

### **5.5.4. TANF (K-TAP) Eligibility**

K-TAP provides a short-term cash benefit to families with children under the age of 18, or under age 19 if a full-time secondary student. Most adults who receive K-TAP must participate in a work activity. Please see the chart below for K-TAP income and resource limits.

Number of Family Members	Monthly Gross Income Limits	Maximum Payment Amounts
1	\$742	\$186
2	\$851	\$225
3	\$974	\$262

4	\$1,096	\$328
5	\$1,218	\$383
6	\$1,340	\$432
7	\$1,462	\$482

**Table 10: K-TAP Income and Resource Limits**

### **5.5.5. Special Supplemental Nutrition Program for Women, Infants and Children (WIC)**

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), is a program that assists individuals who are pregnant, recently had a baby, are breastfeeding, or have a child younger than 5 years of age. WIC provides:

- Nutrition education and services;
- Breastfeeding promotion and education;
- A monthly food prescription of nutritious foods; and
- Access to maternal, prenatal and pediatric health-care services.

The program aims to deliver the following benefits to qualifying and enrolled individuals:

- Improved Birth Outcomes and Savings in Healthcare Costs;
- Improved Diet and Diet-Related Outcomes;
- Improved Infant Feeding Practices;
- Immunization Rates and Regular Source of Medical Care;
- Improved Cognitive Development;
- Improved Preconception Nutritional Status; and
- Other various improved outcomes.

#### **Knowledge Check:**

1. How can kynectors help individuals who qualify for Medicare?
2. What is KCHIP?
3. What percentage of the FPL must families be under to qualify for KCHIP?
4. In Kentucky, what percentage of FPL must families or individuals be under to qualify for Medicaid?

## 6. Understanding Eligibility and Facilitating Enrollment for the Small Business Owner

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Small businesses can provide health plans for employees through kynect. This gives them purchasing power similar to what large businesses have to get better choices and lower prices.

***By the end of this section, you will be able to:***

- 6.1 Understand the Small Business Health Option Program (SHOP).
- 6.2 Understand the participation requirements and administration mechanics of the program.
- 6.3 Help small business employers and employees navigate the SHOP marketplace and make informed decisions regarding their coverage options.
- 6.4 Explain subsidies, penalties and premium tax credits associated with SHOP.

## 6.1 Overview of the Small Business Health Options Program (SHOP) Program

The Commonwealth of Kentucky offers a Small Business Health Insurance Options Program (SHOP) through kynect. SHOP enables small business employers with 50 or fewer employees to provide quality and affordable health insurance options to their employees.

- SHOP allows employers to compare several standardized plans from various carriers on a single screen. Employers can determine which plans are best for their employees without having to visit each issuer's site.
- Employers may choose to offer plans from multiple issuers to their employees.
- Small businesses (50 or fewer employees) are not required to offer health insurance to their employees, so there are no penalties associated with not offering coverage. Regardless of penalties, small businesses are still highly encouraged to offer coverage.
- The Small Business Healthcare Tax Credit program is available to employers with less than 25 full-time equivalent employees to help offset the cost of employee premiums.

SHOP provides a number of benefits for employers who want to provide health insurance to their employees:

- Employer control and choice. All decisions are completely at the discretion of the employer: they set the enrollment period, the level of coverage, the contribution amount, and they decide if they want to offer coverage to spouses or dependents.
- Easy comparisons. kynect lets employers easily compare different health plans from private insurers with filter options, the Plan Comparison Tool, and plan summary and premium detail information.
- Expanded choices. kynect gives employers and employees access to more plans.
- No unexpected costs. Employers can fix the amount they spend on coverage no matter what plan their employees choose when they select a reference or benchmark plan.
- Simple administration. kynect provides employers with one monthly bill.
- Small Business Tax Credits. Employers with 25 or fewer FTE employees may be eligible to receive tax credits to help with the cost of providing coverage to their employees.

Overall, SHOP provides employers with greater flexibility and control, streamlines the application process for both employers and employees, and reduces administrative hassle.

Please refer to regulation 900 KAR 10:020 for more regulatory details regarding the information seen in this section.

## 6.2 SHOP Enrollment Process Overview

Employers are able to submit SHOP applications to kynect through:

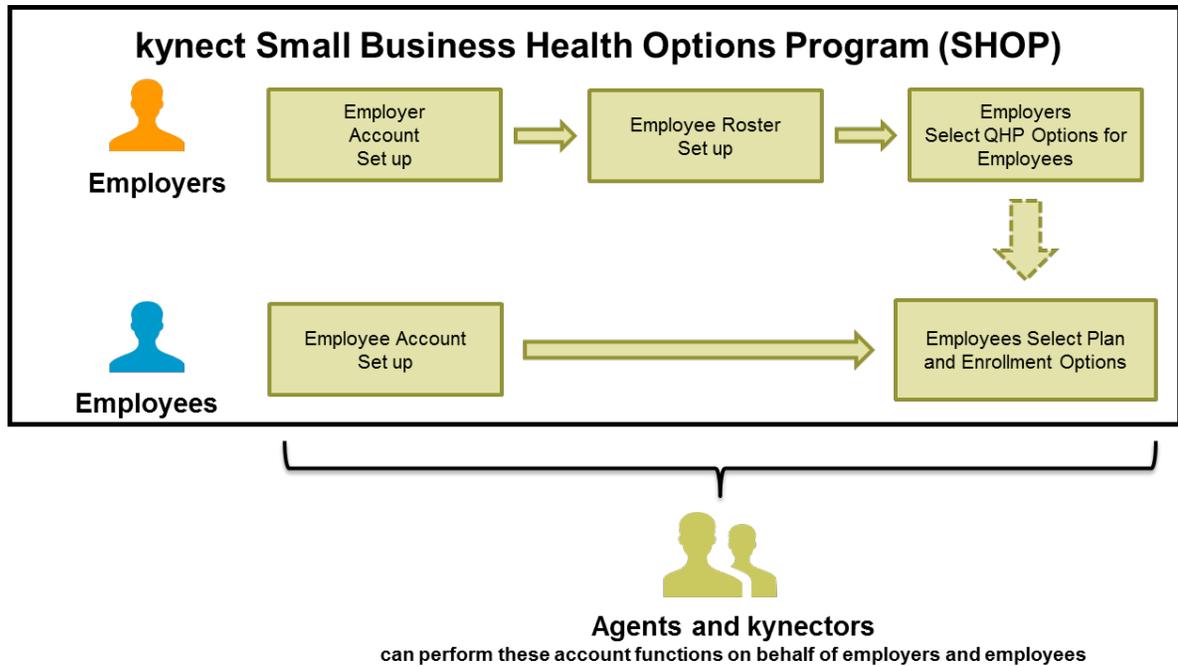
1. Your (Agent and kynector) assistance
2. The online SHOP portal at [kynect.ky.gov](http://kynect.ky.gov)

In order to begin the SHOP enrollment process, employers can create an account on kynect. They can choose to apply and manage the account themselves, or they can find an Agent or kynector to apply and manage the account on their behalf. Employees have three options when it comes to SHOP enrollment: they can go on kynect to create an account and select a plan themselves, they can find an

Agent or kynector to sign them up for a health plan, or they can authorize their employer to choose a plan on their behalf.

In addition to helping with the enrollment process, Agents and kynectors can complete all necessary account activities on behalf of the employer and the employee. The only feature that Agents or kynectors cannot use is the online payments feature, which allows employers to pay their monthly invoices online.

High-level diagram of the enrollment and application process:



### 6.3 Employer and Employee Eligibility

To participate in SHOP, employers must:

- Have a valid federal employer identification number (FEIN)
- Have a primary worksite or business address in Kentucky
- Have at least one common law employee enrolled in SHOP
- Offer all full-time employees coverage
- Contribute a minimum of 50% to the employee's medical coverage
- Have a minimum 75% participation rate of employees in coverage
- Have 50 or fewer full-time employees

On the other hand, to qualify for SHOP coverage as an employee, an individual must be:

- A full-time employee (defined as someone who works an average of 30 hours per week)
- Included on the Employee Roster and marked as an active full-time employee

Both employers and employees have 90 days to appeal an eligibility decision made by kynect.

## Employee Participation Requirement

As previously mentioned, employers must meet a 75% participation rate to participate in SHOP. The participation rate is the number of employees accepting medical coverage under the employer's group health plan plus the number of employees that opted out with a valid reason of being enrolled in other medical coverage. This means employees that opt-out of the SHOP coverage with a valid reason do not hurt the employer's participation rate. Valid opt-out reasons include:

- Covered through spouse's insurance
- Covered through parents' health insurance
- Covered through Medicaid, Medicare, or KCHIP
- Covered by another employer's health insurance plan
- Covered by TRICARE or other Veteran's plan
- Covered by an individual health plan
- Have an exemption from the individual mandate to have insurance

Invalid opt-out reasons, or reasons that would count against the employer's 75% participation rate, include:

- Living outside the health plan service area
- Not wanting to participate
- Employees that take no action during Open Enrollment period

For the most up to date list of opt-out reasons, please refer to regulation 900 KAR 10:020.

Employees are notified immediately if their employer fails to meet the participation rate and informed of their option to participate on the Individual Market on kynect. If the employer has met the requirements, a group enrollment record is sent to issuers for each plan that the employer selected.

## Guaranteed Availability or Amnesty Period

Guaranteed Availability, also known as the Amnesty Period, provides the only exception to the participation and contribution rate requirements for employers. During this period, employers are exempt from the 75% participation rate and the 50% minimum contribution requirements. This means employers that do not meet these two requirements are still eligible to participate in SHOP and can provide coverage to employees who enroll in a plan during Guaranteed Availability.

## 6.4 Employee Roster

In order for employees to select a plan on kynect and receive coverage, employers must create an employee roster. This roster is a list of basic employee information such as name, Social Security Number, employment type, and address.

The employee roster functions as the employee application. Because the employee roster contains all necessary employee information, each employee does not have to create an account and go through the application process. The employee roster streamlines this process for both employers and employees by eliminating the need for multiple, separate applications.

There are two ways that employers (or Agents or kynectors) can submit the employee roster. The first is through a download/upload template method where the employer downloads an Excel file, enters

employee information in the file, and then uploads the file onto kynect. The second method allows the employer to enter employee information directly on the screen fields in kynect.

The download/upload method notifies the employer of any errors in the upload process. If there are errors, a pop-up message displays with the specific error and location of the error in the template. Once the employer identifies the error, they can correct the template and re-upload the document. The employee with the corrected information is then added to the roster.

It is important to note that all full-time employees are required to be on the roster. Employers are required to offer coverage to all employees on the roster who are identified as full-time, regardless of if the employee plans to deny the offer of coverage. Part-time employees and non-eligible employees are **not** required to be listed on the roster, but it is considered best practice to include those part-time and non-eligible employees, as their status might change in the future. If the employer elects not to offer coverage to spouses and dependents, the spouse and dependent information is not required to be on the roster.

If the employer does offer coverage to employee spouses and dependents, (regardless of whether the employer is contributing to spouse and dependent coverage) the spouse and dependent information must be entered on the roster. If the spouse and dependents are not on the roster, the employee cannot elect coverage for them.

### 6.5 Initial Open Enrollment Period and Coverage Effective Dates

Unlike the Individual Market, SHOP has a rolling Open Enrollment period for employers. This means that they can enroll in and purchase SHOP coverage for their employees at any time throughout the year. Employers set the initial Open Enrollment period when they set up a new SHOP account. The default initial Open Enrollment period is from the 1<sup>st</sup> to the 10<sup>th</sup> of the month following the month the application is submitted. The initial Open Enrollment period cannot be less than 10 days.

Employers have flexibility in setting the initial Open Enrollment period and can decide between four different options:

1. Keep the default period
2. Keep the default end date, but move the start date up as early as the day that they submit the SHOP application
3. Keep the default start date, but extend the Open Enrollment to a later end date
4. Move up the Open Enrollment start date **and** extend the end date to a later date

It is important to note that the initial Open Enrollment period affects the employee's coverage effective date, which is the date the employee's health insurance starts. The coverage effective date is the 1<sup>st</sup> of the month following the Open Enrollment end date.

### 6.6 Employer Plan Selection and Premium Contribution

All health plans are classified into one of four metal levels. The categories, listed from least valuable to most valuable, are Bronze, Silver, Gold and Platinum. As the metal level increases in value, so does the percentage of medical expenses that the plan covers. This means that a Platinum-level plan covers the highest portion of medical costs at the time an employee goes to receive care. It also has the highest premium cost.

There is no limit to how many plans an employer can offer, but in order to be offered, the metal levels of each plan must be contiguous, or “touching.” Therefore, an employer is not able to offer only Platinum and Silver plans; instead, he or she must offer a Gold plan in addition to the Platinum and Silver plans in order to make all offered plans contiguous.

During this time in the enrollment process, employers must make several decisions regarding medical and dental coverage for employees, spouses, and dependents. Employers must set the percent amount they wish to contribute to an employee’s medical premium. Since the employer’s minimum contribution amount must be at least 50%, the employer can only choose to increase that contribution amount.

The employer must then make the decision to offer coverage to employee spouses and dependents. If the employer chooses to do so, he or she must then set the contribution amount for the spouses and dependents. However, unlike with the employee’s medical coverage, employers do not have to meet a minimum contribution amount for spouses or dependents. Employers can then select plans to offer their employees.

Employers also need to decide if they want to offer a Stand Alone Dental Plan (SADP) to their employees. Employers are required to offer pediatric dental but can choose to do so through a medical plan with embedded dental.

Employers can also choose to only offer dental coverage, without offering medical coverage. In doing so, the employer can still meet all eligibility requirements and participate in SHOP. There is no minimum contribution amount or participation rate associated with only providing dental coverage.

Employees, spouses, and dependents that are offered coverage through SHOP generally do not qualify for payment assistance through the Individual Market, unless their share of the SHOP premium owed for the employee-only coverage exceeds 9.56% of household income.

## **6.7 Employee Enrollment and Plan Selection**

In order to sign up for coverage, employees can create an account with the Kentucky Online Gateway (KOG). When employees log into kynect using their KOG credentials, they are given two options. They can click “Visit the Marketplace for Individuals and Families” or they can click “Visit the Marketplace for Employees.” To enroll in employer-sponsored insurance, employees must click “Visit the Marketplace for Employees.” Employees do not have to create a KOG account. Agents, kynectors, and their employers can complete employee plan selection and enrollment.

Employees can receive enrollment assistance and information from Agents, kynectors, or Customer Service Center representatives. However, only Agents are able to provide specific advice as to which Health Insurance Plan (HIP) an employee should choose. To complete the enrollment process, employees can access the Self-Service Portal, call the Customer Service Center on the phone, or authorize an Agent, kynector, or authorized representative to enter their selection for them.

Employees are able to change their HIP selection until the close of their Open Enrollment. Once the enrollment period has ended, their choice is locked in for the duration of the plan year, unless they have a qualifying event that triggers a special enrollment period.

## 6.8 Special Enrollment

A Special Enrollment enables an employee to select a new plan or change their existing coverage outside of their employer’s annual Open Enrollment period. To qualify for a Special Enrollment, an employee or an eligible dependent of an employee must have a qualifying event. SHOP qualifying events are slightly different than the qualifying events for Special Enrollment in the individual market. The table below lists qualifying events for SHOP.

<b>Qualifying Event</b>	<b>Special Enrollment Period</b>	<b>Coverage Start Date</b>
<b>Gain of dependent due to marriage</b>	30 days after the date of the event	First of the month following date of event
<b>Gain of dependent due to birth</b>	30 days after the date of the event	Date or birth of 1 <sup>st</sup> of the month following birth
<b>Gain of dependent due to adoption, or placement of adoption</b>	30 days after the date of the event	Date of event
<b>Someone in my household has moved to Kentucky</b>	30 days before and after the date of the event	Mid-month rule
<b>Released from prison</b>	30 days before and after the date of the event	Mid-month rule
<b>New employee joins the employer who is on exchange, or an existing employee that was not previously eligible becomes eligible (e.g. a part-time employee becomes full-time)</b>	See section “Special Enrollment for New Hires”	See section “Special Enrollment for New Hires”
<b>Spouse/Dependent no longer covered in family plan</b>	30 days before the event until 30 days after the date of the event (60 days)	First of the month following date of plan selection
<b>An individual aged out of their parent's plan (Overage dependent)</b>	30 days before the event until 30 days after the date of the event (60 days)	First of the month following date of plan selection
<b>Loss of coverage due to legal separation/divorce</b>	30 days after the date of the event	First of the month following date of plan selection
<b>Loss of coverage for any other reason other than voluntary, non-payment of premiums</b>	30 days after the date of the event	First of the month following date of plan selection

Qualifying Event	Special Enrollment Period	Coverage Start Date
<b>Will lose Medicaid/KCHIP</b>	60 days prior to the date of the event	First of the month following date of event
<b>Has lost Medicaid/KCHIP</b>	60 days after the date of the event	First of the month following plan selection
<b>A qualified employee or dependent who becomes eligible for assistance through the Kentucky Health Insurance Premium Payment Program (KHIPP) may be eligible for special enrollment</b>	No restriction on the Special Enrollment Period	Coverage effective date manually set by SHOP worker only by accessing "create special enrollment" functionality in employer dashboard. Event date is optional.
<b>A qualified employee identifying as an American Indian, as defined by the Indian Health Care Improvement Act</b>	American Indians and Alaskan Natives qualify for Special Enrollment once a month	Mid-month rule
<b>Permanent move that results in access to new HIPs – A qualified employee may be eligible for special enrollment if a permanent move results in their gaining access to new HIPs</b>	30 days after the date of the event	Mid-month rule

### 6.9 Special Enrollment for New Hires and Newly Qualified Employees

The enrollment period and coverage effective dates for employees who are added to the roster or become eligible due to a change in status are slightly unique. If an employer hires a new full-time employee or if an employee's status changes from part-time to full-time, the employer should update the employee roster immediately and initiate an enrollment period.

#### Waiting Period and Enrollment Period

The waiting period and the enrollment period both start on the day the employee becomes a qualified employee. For new hires, this is the date of hire. For employees who switch from part-time to full-time,

this is the date that they make this change. The waiting period can be any multiple of 15 days between 0 and 90 days. If the waiting period is 45 days or under, the enrollment period is 30 days. If the waiting period is greater than 45 days, the enrollment period is 15 days less than the waiting period.

It is important to note that the waiting period may affect a new or newly qualified employee's coverage effective date. The coverage effective date depends on whether or not the plan is selected before or after the most recent mid-month before the end of the enrollment period. The 15<sup>th</sup> of the Month Rule states:

If an employee's enrollment date occurs...	Their coverage begins...
Between the 1 <sup>st</sup> and 15 <sup>th</sup> of the month	On the 1 <sup>st</sup> of the following month
Between the 16 <sup>th</sup> and the end of the month	On the 1 <sup>st</sup> of the <b>second following</b> month

However, there is an exception to the 15<sup>th</sup> of the Month Rule. When a coverage date based on the mid-month rule falls before the end of the waiting period, the coverage effective date would be moved forward to the 1<sup>st</sup> of the following month, unless, doing so results in an employee being unable to obtain coverage within 90 days of being hired.

Employers may find that this scenario is possible the longer the waiting period that is set, i.e. with waiting periods that are 60 or 90 days.

### 6.10 Employee Updates and Changes

Employers must keep their employee roster up-to-date. Employers, Agents, and kynectors are responsible for reporting employee changes to kynect. kynect does not accept changes to employee data from issuers. If an employee wants to make a change to their information, the employer, Agent, or kynector must make that change in the system on their behalf. All changes except for enrollment changes must be done directly on the roster in kynect. These include:

- Name
- Address
- Phone Number
- Dependent Information

Once changes are made, kynect then transmits them to issuers.

Enrollment changes must also be done on kynect, but they are completed within the Enrollment Manager that the employee, employer, agent, kynector has access to. If the individual chooses to disenroll from their current plan, kynect notifies the employer of the disenrollment.

## 6.11 Annual Renewal

kynect automatically calculates the employer Annual Election Period and the employee Annual Open Enrollment period. The system notifies employers and employees when they are required to take action.

### For Employers

Renewals for SHOP coverage happen on an annual basis and occur throughout the year depending on when the employer initially enrolled in coverage. This process begins 3 months prior to coverage ending, with the start of the employer Annual Election Period. During this period, employers have 30 days to actively review and renew coverage options. The employer's renewal effective date is exactly one year after the coverage effective date.

During the employer annual election period, an employer may change:

- Plan offerings
- Contribution rates for employees, spouses, and dependents
- Waiting period for new hires and newly qualified employees
- Offerings to spouses and dependents

### For Employees

Following the Annual Election Period, the Annual Open Enrollment period begins and employees have at least 30 days to make their coverage selection. Employees are passively (automatically) enrolled in their employer plan if the same plan is made available for them and they do not take any action to disenroll in their current plan. If they do want to change their current plan, they can use the Annual Open Enrollment period to enroll in a different plan

Although employees are eligible for passive renewals, they are highly encouraged to look at their plans each year during the Annual Open Enrollment period, as their employer may be offering a different plan that may be a better fit for them and there could be potential premium changes that they should review. They also may risk being terminated from SHOP if their plan is no longer available.

Below is an example renewal timeline for coverage that began on January 1, 2015.

Current Coverage Effective Date	Annual Election Period		Annual Open Enrollment Period		Renewal Coverage Effective Date
1/1/2015	10/01/2015	10/31/2015	11/01/2015	12/10/2015	01/01/2016

## 6.12 Termination of Group in SHOP/Employee Coverage and Disenrollment

Employers may voluntarily request to terminate from SHOP at any time. Termination from SHOP means that the coverage that the employer offers to their employees will end. To begin this process, the employer must provide a notice in writing to KOHBIE. A KOHBIE worker then follows up with the

employee to determine if there is an issue that can be resolved. If there is no issue to be resolved and the employer wants to continue with the termination request, the effective date of the termination is as follows:

- If the termination request is made **before the 15<sup>th</sup> of the month**, then the earliest that coverage can end is the **last calendar day of the month** (e.g. if the request is made on May 7<sup>th</sup>, coverage can end on May 31<sup>st</sup>)
- If the termination request is made **after the 15<sup>th</sup> of the month**, then the earliest that coverage can end is the **last calendar day of the following month** (e.g. if the request is made on March 16<sup>th</sup>, coverage can end on April 30<sup>th</sup>)

As of October of 2015, employers may request termination directly in kynect. The employer is able to choose 1 of 2 dates to terminate enrollment for the year and must also provide a reason for the request. Employers can choose from the following dates:

If the current date is between the 1 <sup>st</sup> and 15 <sup>th</sup> of the month...	If the current date is between the 16 <sup>th</sup> and last calendar day of the month...
<p>The termination date can be...</p> <ol style="list-style-type: none"> <li>1. The last calendar day of the current month</li> <li>2. The last calendar day of the following month</li> </ol>	<p>The termination date can be...</p> <ol style="list-style-type: none"> <li>1. The last calendar day of the following month</li> <li>2. The last calendar day of the second following month</li> </ol>
For example...	
<p>If it is August 2<sup>nd</sup>, the termination date can be:</p> <ol style="list-style-type: none"> <li>1. August 31<sup>st</sup></li> <li>2. September 30<sup>th</sup></li> </ol>	<p>If it is August 20<sup>th</sup>, the termination date can be:</p> <ol style="list-style-type: none"> <li>1. September 30<sup>th</sup></li> <li>2. October 31<sup>st</sup></li> </ol>

Employers may also be terminated from SHOP if they fail to pay premium payments within a 30-day grace period. If termination due to non-payment occurs, employers may request a reinstatement. However, it is important to note that employers are allowed only one reinstatement per plan year. In order to request a reinstatement, the employers must:

- Request the reinstatement
- Pay the entire outstanding balance in full; this includes past due premiums, current premiums, and any adjustments

These two requirements must be fulfilled within 30 days of the employer's termination.

In accordance with the Insurance Code and the ACA, employers can also initiate the termination of an employee's coverage through kynect. Employee coverage can be terminated in two ways:

- Employers can initiate and finalize employee termination from SHOP. If an employee no longer works for the employer, he or she should be terminated on the employee roster. If the employee's status changes from full-time to part-time, their status should be updated on the roster. If the employee is terminated, the effective date of termination is the last calendar day of the month in which the employee was terminated. This date can be 30 days in the future or 30 days in the past. Coverage cannot be terminated retroactively if the employee paid a premium or contributed to the cost of the plan.
- Employees can also choose to disenroll from coverage in kynect. The effective date of termination is on the last calendar day of the month of the requested termination.

In the two scenarios above, kynect sends a notice of the termination request to any applicable issuers so that the issuer may terminate coverage in accordance with state and federal laws. In all termination or disenrollment situations, coverage for an employee's dependents is automatically terminated when the primary subscriber's coverage is terminated from the same plan.

The following notifications may be sent due to disenrollment and termination of coverage:

- Upon termination of an employer group, a notification is sent to the employer, employees, and issuers. kynect sends a notice of Special Enrollment to the individual so that the employee can enroll in coverage in the Individual Market.
- Upon termination of an employee, notifications are sent to the employee and issuers.
- Issuers are required to provide any notices under state or federal law.

### 6.13 Employee Retroactive Coverage

kynect supports mid-month enrollment and disenrollment only in special circumstances. Birth and adoption are examples of qualifying events that may require a retroactive enrollment, i.e., the effective date of coverage may be prior to the date of enrollment. Other qualifying events generally do not require a retroactive enrollment.

The effective date of coverage in the case of a birth, adoption, or placement of adoption must be the day of the date of birth, adoption, or placement of adoption or the 1<sup>st</sup> of the month following the date of birth, adoption, or placement of adoption. In the case of birth, the newborn's premium is not due until 31 days after the date of birth, due to Kentucky DOI Statute 304-17A-139.

kynect supports mid-month terminations in the case of death of an employee or a covered dependent. The effective end date of coverage is the date of death. Death of an employee or covered dependent should be reported within 60 days of its occurrence, although allowance is made for extenuating circumstances on a case-by-case basis.

### 6.14 SHOP Employer Payments

#### SHOP Employer Initial Premium Payment

At the close of Open Enrollment, kynect validates that the employer group has met the minimum requirements to participate in SHOP. If the employer has met the minimum requirements, kynect sends an invoice for initial payment to the employer. The employer receives only one invoice

regardless of how many issuers hold enrollments for their employees. kynect is then responsible for distributing payment to various issuers. The employer's invoice includes the total cost of premiums, including employee contributions. It is up to the employer to collect payment from employees for their contributions toward premiums.

### **Payment Options**

- a. Online with Automated Clearing House (ACH) (\$2 flat fee)
- b. Online by credit card (2.75% fee)
- c. Online by debit card
- d. Mail a check or money order to a Commonwealth of Kentucky lockbox facility\*

SHOP groups are not enrolled until the first payment is paid in full. There is a payment courtesy period of 7 business days for the first payment. Employee enrollments are not sent to the issuer(s) until the first payment has been received in full and processed by kynect. The issuer(s) then process the enrollment files & effectuate coverage in their systems. For this reason, it is highly recommend that the employer make the first premium payment AS SOON AS POSSIBLE.

If an employer mails their payments, payments must be accompanied by the payment coupon from the bottom of the invoice. For the quickest processing time, payments should be mailed in the return envelope provided.

### **Ongoing Payments**

Between the 6<sup>th</sup> and 10<sup>th</sup> of every month, employers can preview their SHOP invoices for month using the online Billing and Payments feature. This feature allows employers to report discrepancies in the invoice and make changes to their roster if needed. Then, on the 11<sup>th</sup> of the month, the actual invoice for the month is generated with payment due on the 20<sup>th</sup> of the month. There is a grace period of 30 days for all ongoing payments. As previously mentioned, employers may follow the reinstatement requirements if terminated.

### **Automatic Payments**

Employers who pay online can also utilize the Auto-Pay feature. If an employer chooses to set up the monthly auto-pay option, the total outstanding balance is deducted the first time they enroll. Thereafter, the monthly balance is deducted on the 18<sup>th</sup> of each month. Online payments should be made through the SHOP employer account. Employers should not schedule a bill pay from their bank.

## 6.15 Subsidies and Small Business Health Care Tax Credits

### Subsidies

Federal subsidies available on the Individual Market, such as payment assistance and special discounts, are not available on the SHOP market.

### Small Business Tax Credits

Small business tax credits are available for small employers who offer SHOP coverage and:

- Have less than 25 full-time equivalent (FTE) employees
- Have an average employee salary of \$50,000 or less
- Pay at least 50% of employees' premium costs

The tax credit is based on the number of employees and average annual wages. The maximum credit is 50% of the employer's contribution to employee premiums for small business and 35% for non-profits.

To get the **maximum credit**, employers must:

- Have 10 or fewer FTEs,
- Have average annual wages of no more than \$50,000, and
- Contribute 50% or more toward self-only (i.e., no spouses or dependents) health insurance for employees

Additional details on small business tax credits can be found on the IRS website at <http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers>.

## 6.16 Declining SHOP Coverage

Payment assistance and special discounts are not available to employees if they decline a SHOP plan that is both affordable and meets the minimum standard. A plan that is affordable means that the cost to an employee of the self-only plan is less than 9.56% of an employee's household income. A plan that meets the minimum standard meets that it covers 60% or more of the expected covered costs of benefits, on average.

In other words, if the employee is offered SHOP coverage that meets these requirements but chooses not to participate in the employer-sponsored plan, the employee can enroll in a HIP in the Individual Market, but they must do so without assistance through kynect.

However, if the plans offered through SHOP are not affordable or they do not meet the minimum standard, the employee can decline coverage and apply for HIPs with payment assistance or special discounts on the Individual Market. It is important to note, however, that payment assistance is not guaranteed and normal eligibility rules apply.

## 6.17 Notifications

kynect provides notifications to both employers and employees that participate in SHOP to inform them of requirements, events, or other circumstances that may require attention. These notifications include:

### **Successful Application Submission Notification**

This notice confirms the employer's eligibility to participate in SHOP on kynect. Once the employer successfully completes and submits an application, an email notification is generated and sent to the employer.

### **Employee Enrollment Notification**

Once the employer's eligibility is approved, the employees can begin to enroll in the plans that the employer has selected. Employees receive a paper notification that provides them with information on their initial Enrollment period and application instructions.

### **Annual Employer Election Period Notification**

Before the employer Annual Election Period, this notice is generated to inform employers of the upcoming renewal period. The timeline for this notice is as follows:

The 1<sup>st</sup> notice is sent 45 days prior to the beginning of annual open enrollment period.

The 2<sup>nd</sup> notice is sent at the beginning of the annual employer election period.

### **Employer Termination from SHOP Notification to Employees**

Upon termination of an employer, a notification is sent to employees notifying them that their employer is no longer a part of kynect and that their coverage will cease to exist. The notification contains information that advises employees on the options they have to seek alternative health insurance coverage through the Individual Market.

### **Employer Termination from SHOP Notification**

Upon termination of an employer, an email is generated to inform them of their termination. The issuers are responsible for ending the coverage of employees of the terminated employer.

### **Employee Participation Summary Notification to Employer**

After the employer selects plans and completes their enrollment process, employees can begin to enroll. After the initial Open Enrollment period, the employer is able to continue to participate in kynect if they have reached the 75% participation rate. This notice provides employers with the final summary of employee enrollment details.

### **Open Enrollment Period Notification to Newly Eligible Employees**

A paper notification is sent to newly eligible employees informing them of their ability to participate in an Open Enrollment period and how to apply.

## Group Annual Open Enrollment Notification

After an employer receives approval to continue participating in SHOP, employees can begin enrolling in the plans their employer has selected. Employees are sent a paper notification five days prior to the Annual Open Enrollment period with information on their coverage renewal options.

### 6.18 Consolidated Omnibus Reconciliation ACT (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. COBRA applies to employers with 20 or more employees. COBRA is not available through kynect.

COBRA benefits are only available when coverage is lost due to certain specific events. For example, the COBRA allows retiring employees to continue group coverage for a limited period of time. This also applies to dependents who lose coverage because of divorce or legal separation, death of the covered employee, or a loss of dependent status under the health plan's provisions. It is important to note that though COBRA is not available through kynect, the issuer or employer responsibilities in the case of COBRA, State Continuation, or Conversion do not change in the Individual and SHOP markets.

To be eligible for COBRA coverage, an individual must have been enrolled in their employer's health plan when they were employed and the health plan must continue to be in effect for currently active employees. COBRA continuation coverage is available after a qualifying event occurs that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage. A qualifying event is defined as any of the following:

COBRA Continuation Coverage Qualifying Events	Covered Individuals	Length of COBRA Continuation Coverage
Termination of employee's employment (except for gross misconduct)	Former employee and covered dependents	18 Months
Reduction of the employee's hours	Former employee and covered dependents	18 Months
Death of a covered employee	Spouse and covered dependents	36 Months
Divorce or legal separation from the covered employee	Spouse and covered dependents	36 Months
Employee becomes entitled to Medicare (Part A, Part B, or both)	Spouse and covered dependents	36 Months

Dependent child covered under plan ceases to be an eligible dependent under the plan	Dependent Child	36 Months
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Following a qualifying event, qualified beneficiaries are given an election period of at least 60 days during which to choose whether or not to elect COBRA continuation coverage. This period is measured from the later of the coverage loss date or the date the COBRA Election Notice is provided.

COBRA continuation coverage begins on the date that healthcare coverage would have been lost. If an individual becomes disabled while they have COBRA coverage, they may be entitled to continuing their coverage for an 11 additional months if they continue to pay premiums.

An individual covered under COBRA usually pays the entire premium amount of their former plan. This premium is the combination of both the portion of the premium that they paid as an active employee and the amount of the employer's contribution. In addition, there may be a 2% administrative fee. Though the combined premiums are likely higher than when the individual was employed, they are still paying group premium rates, which are typically lower than individual rates. An individual electing COBRA coverage has 45 days from the date of election to make the first premium payment. The payment must include retroactive payments dating back to the last day of coverage in the former plan.

### 6.19 State Continuation (KRS 304.18-110)

State Continuation is similar to COBRA coverage. It was enacted to ensure that those who do not qualify for COBRA coverage still have the ability to continue coverage for a defined period of time after termination from a group. State Continuation is not available through kynect. Per Kentucky state law, KRS 304.18-110, an individual and their dependent can continue their group coverage upon termination from the group for up to 18 months if they meet one of the following criteria:

- The individual has been covered by the plan or any plan that it replaced for at least 3 months.
- The individual must notify the insurer and pay the premium at the group rate within 31 days after they receive a notice of their right to continue coverage.

The individual remains insured for up to 18 months after the date that the insurance ended by termination of the individual from the group. After the end of the 18-month period, an individual is allowed to convert to an individual plan that resembles the coverage they had through their continuation plan. Coverage may end early if one of two conditions is met:

- The individual does not make a timely payment to the insurer, or
- The group policy is terminated and not replaced by another policy within 31 days.

If the group policy is terminated and replaced by another policy, the individual can continue to have continuation coverage under the old policy and the timeline of coverage continues uninterrupted.

In addition to the group member, the following individuals are also eligible for continuation of coverage:

- A surviving spouse and children whose coverage under the group policy would end due to the death of the group member.

- A child who has been covered as a dependent under the plan has a right to continuation coverage upon reaching the plan’s age limit for dependent status.
- A former spouse and children in the former spouse’s custody are eligible for continuation benefits when their status as dependents of the group member ends. This status change would result from a court order dissolving the marriage.

On the effective date of termination from the group insurance policy, an individual does not need to be granted continuation of the policy if they are eligible for Medicaid or a new group policy.

## 6.20 Conversion

Conversion occurs when an individual is not eligible for COBRA or State Continuation coverage. Conversion allows an individual to convert a former (or soon to be former) group plan into an individual plan that is similar in terms of the benefits available under the group plan. Conversion comes into play, for example, when a group policy is terminated and not replaced by a new policy. There is no time length related to insurance gained from conversion, but there is also no requirement to keep premiums at the level they were during coverage under the group policy. Conversion is not available through kynect. For more information regarding conversion, please refer to KRS 304.18-114.

## 6.21 SHOP Summary

Outlined below is a summary of what was discussed in the previous section:

Individual	Things You Can Help With	How Does it Benefit Them?	How Can You Add Value?	Resources
Employers (Small Business)	Plan selection and Evaluation	Select the right benefit plan package for their employees	Help employers understand the plans available and benefits they offer.	Section 6
			Help employers compare plans and select a plan that best meets their needs.	
			Help employers evaluate the benefit levels and options offered by each plan.	
Help employers balance costs and plan benefits.				
	Ongoing Administration	Continuing coverage to their employees	Help employers understand the timelines and processes associated with premium payments, employee additions, and changes.	Section 6
	Small Business Tax Credit Program	Offsets the cost of providing coverage to employees	Make small business owners aware of the tax credit and guide them to Form 8941.	<a href="http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers">http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers</a>
Employees		Select a plan that	Help employees understand the plans offered on SHOP portal by	Section 6

		best meets their needs	their employer and the benefit levels associated with each.	
	Plan Selection and Evaluation		Help employees compare costs and evaluate the benefits of enrollment so they can understand their options and make the best choice.	Standardized Summary Of Benefits (SBC's) available for each plan and Health Insurance Quick Reference Guide

**Table 13: SHOP Summary**

For more information about the Small Business Tax Credit, please see Appendix L

**Knowledge Check:**

1. What is the goal of SHOP and who can benefit from it?
2. During what period of time is the SHOP open enrollment period?
3. What are the criteria that a small business must meet to qualify for the Small Business Health Care Tax Credit?
4. What is COBRA and what does it provide?

# 7. Assisting Individuals

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This section outlines scenarios that Agents and kynectors may not deal with day-to-day, but are still very important to know.

## Section Overview and Objectives

***By the end of this section, you will be able to:***

- 7.1 Understand how to make and receive referrals.
- 7.2 Handle complaints in regards to Insurance Agents, kynectors, the kynector program, or kynect.
- 7.3 Assist individuals in reporting fraud on kynect.
- 7.4 Comprehend the overall application mechanics.

## 7.1. Eligibility Determination Document Check List

The following table contains the minimum requirements for determining eligibility and the supporting documentation that may be required.

Information	Supporting Document
Name	<ul style="list-style-type: none"><li>• Government Issued ID</li><li>• Birth Certificate</li><li>• Social Security Card</li></ul>
Income	<ul style="list-style-type: none"><li>• W-2</li><li>• Documentation of unearned income (i.e. Survivors &amp; Disability insurance)</li></ul>

**Table 14: Supporting Documents for Verifying Eligibility**

**Please Note:** When applying via kynect, the individual is told what kind of documentation is accepted at each step in the process.

A complete list of acceptable documents is available on the kynect Self-Service Portal. For additional information on determining eligibility, please refer to chapter 3 of this manual or the Eligibility Quick Reference Guide.

## 7.2. Renewals

As an Agent or kynector, you can educate individuals on the renewal process.

- Encourage the individual to **give kynect consent to connect with the Federal Data Hub** up to five years. This allows kynect to *automatically* contact the Federal Hub each year (for up to five years based on the individuals' choice), verify eligibility information, and automatically renew the plan.
- **Assist the individual through kynect's renewal process and screens.** This is encouraged for individuals who expect to have changes in their incomes or household compositions in the coming year.

## 7.3. Making and Receiving Referrals

Making referrals is a required and important role for Agents and kynectors. In a kynector program, a referral should be made when a given kynector is unable to fulfill their responsibilities for a given individual seeking insurance. If the kynector cannot assist the individual, they must find a suitable alternative resource to assist the individual.

Referrals may be made between Insurance Agents, kynectors, and other resources such as the Customer Service Representative or any other appropriate resource such as the local county DCBS for qualifying individuals. However, exclusive referral arrangements between Agents and kynectors are not permitted. Agents and kynectors may also receive referrals from those who are unable to assist individuals.

You may refer to the Agent/kynector Collaboration Policy for additional information on referrals and best practices for working together.

#### **7.4. Identifying Local Healthcare Professionals**

Agents and kynectors play a role in helping individuals find healthcare providers. Agents and kynectors are expected to proactively make themselves available to those looking for local healthcare providers and also have an up-to-date knowledge of their area's healthcare care resources.

For the most up-to-date information on providers and specific plans and networks, please refer to the insurer's website. kynect updates this information every quarter. However, issuers update their network coverage more regularly. This serves as the best resource for individuals to find providers in their network. For most up to date information on prescription drug formularies, visit the issuer's website as well.

#### **7.5. Handling Complaints, Grievances, and Disputes**

Complaints may be made in regards to Insurance Agents, kynectors, the kynector program, or kynect. Complaints regarding issuers and insurance policies should be filed through the Kentucky Department of Insurance (DOI). Agents and kynectors may help individuals with this process by referring them to the appropriate resource. The DOI's website defines two types of complaints: individual complaints and insurance fraud complaints. The DOI website also outlines the process for filing each of these types of complaints. For additional information, please visit: [https://insurance.ky.gov/static\\_info.aspx?static\\_id=1](https://insurance.ky.gov/static_info.aspx?static_id=1).

### 7.5.1. Filing Complaints and Reporting Fraud on kynect

Within kynect, individuals can access links to file a complaint, request an appeal, and report fraud from their account homepage. The following screen shots outline how Agents or kynectors can assist individuals in doing so.

The **Other** category of a user's home screen has many useful links. Located in the left-hand column, it directs individuals to a screen of contact information and enables users to file a complaint, request an appeal, or report fraud.

The screenshot displays the kynect user interface. At the top, a blue navigation bar includes the kynect logo and links for 'My Account', 'Browse Plans', 'Learn More', 'Get Help', and 'FAQ'. A secondary navigation bar below it features icons for 'Overview', 'Applications', 'Payments', 'Plans & Programs', 'Messages', 'Assisters', and 'Settings'. The main content area is split into a left sidebar and a main panel. The sidebar, titled 'Quick Links', contains several sections: 'Message Center' with an 'Inbox' link; 'Notifications & Alerts' with an 'Address Validation' link; 'Application' with links for 'Download a new application', 'Application pre-screening', and 'Start an application'; 'Contact Information' with links for 'kynect Call Center', 'CHFS Programs', and 'Consumer Assistance'; and 'Other' with links for 'Manage/ Change Appointments', 'Request a Hearing/Appeals', 'File a Complaint', and 'Report Fraud'. The 'Request a Hearing/Appeals', 'File a Complaint', and 'Report Fraud' links are enclosed in a red rectangular box. Below these links is an 'Adobe Reader' download button. The main panel displays three sections: 'Current Benefits' (No current benefits found), 'Ongoing Applications' (Application ID: 200720614, Last Updated: Sep 04, 2015), and 'Request For Information' (Eligibility process is pending, please check later). A progress bar for the application shows steps: Application (completed), Results, Find a Plan, and Enrollment. A green 'Continue Application' button is positioned below the progress bar. At the bottom of the main panel are links for 'View My Documents' and 'Upload'. The footer contains 'Privacy Policy | Terms of Use | ©Copyright 2013', social media icons for Facebook, Twitter, YouTube, and LinkedIn, and contact information: 'Contact Us | www.healthbenefitexchange.ky.gov | 1-855-4kynect (459-6328)'.

You can also direct individuals to the **Contact Us** screen, by navigating to the [kynect.ky.gov](http://kynect.ky.gov) home site and clicking on the **Contact Us** link. The following is a display of this page. Individuals have quick links to submit fraud reports or complaints. Additionally, they are provided with contact information for useful organizations such as kynect’s customer service line, numbers for health insurance companies, and a number for contacting Agents and kynectors.

The screenshot shows the 'Contact Us' page on the kynect website. The page header includes the kynect logo and navigation links: Getting Started, Browse Plans, Learn More, Get Help, and FAQ. A user is logged in as 'Welcome Guest'. The main content area is titled 'Contact Us' and contains introductory text with two links: 'submit a complaint online' and 'submit a fraud report'. Two callout boxes with blue borders and arrows point to these links. The 'submit a report now' box points to the 'submit a fraud report' link, and the 'submit a complaint online' box points to the 'submit a complaint online' link. Below the text is a table for 'kynect' contact information, followed by 'Other Services' and 'Health Insurance Companies' sections, each with their own tables of contact details.

kynect	
kynect Customer Service	1-855-4kynect (459-6328)
TTY	1-855-326-4654
Insurance Agents and kynectors	1-855-326-4650
kynect mailing address	8 Mill Creek Park Frankfort, KY 40601

Other Services	
Ombudsman's Office	1-877-807-4027
Fraud Hotline	1-800-372-2970
KCHIP	1-877-524-4718
Medicare	1-800-633-4227
DCBS	1-855-306-8959
Social Security Administration	1-800-772-1213

Health Insurance Companies	
<b>Anthem</b>	<a href="http://www.anthem.com">www.anthem.com</a>
Individuals and Families	1-855-738-6671
Employees of small employers	1-855-738-6673
Small Employers, Insurance Agents and kynectors	1-855-866-6157
<b>Bluegrass Family Health</b>	<a href="http://www.bgfh.com">www.bgfh.com</a>
Small employers and employees	1-800-787-2680 or 1-859-269-4475
<b>Humana</b>	<a href="http://www.humana.com">www.humana.com</a>
Individuals and families	1-800-833-6917
<b>Kentucky Health Cooperative</b>	<a href="http://www.mykyhc.org">www.mykyhc.org</a>
Individuals, small employers, employees, insurance agents and kynectors.	1-855-OUR-KYHC or 1-855-687-5942
<b>UnitedHealthcare</b>	<a href="http://www.myuhc.com">www.myuhc.com</a>
Employees of small employers	1-877-856-2430

## 7.6. Assisting Individuals with Appeals

Agents and kynectors are only encouraged to help individuals in filing an appeal through kynect but are not responsible for handling the appeal processing. Following eligibility determination,

individuals have the right to appeal the decision. Individuals are able to enter requests for an appeal through kynect (pictured above), mail in an appeal, call the Customer Service Center, or appeal at a DCBS office. If they click on **Request Hearing/Appeal** on their home dashboard, the following page displays:

**Request a Hearing/Appeal**

Kynect takes your concerns seriously. If you have a problem, we would like to know about it. You can **File a Complaint** if you are unhappy with something that has happened. You can **Report Fraud** if you feel you have been deceived for someone else's gain. You can **Request a Hearing/Appeal** if you believe you have been given the wrong answer about your eligibility, costs, or ability to enroll.

**Decisions you can appeal**

You can appeal the following kinds of kynect decisions:

- Whether you're eligible to buy a kynect plan
- Whether you can enroll in a kynect plan outside the regular open enrollment period
- Whether you're eligible for lower cost based on your income
- Whether you are eligible for a different amount of savings
- Whether you're eligible for Medicaid or the Kentucky Children's Health Insurance Program(KCHIP)

To **Request a Hearing/Appeal**, fill out the form below. We will take the information you give us and file an request for a hearing/appeal on your behalf. Your request will be sent to the office that will handle it.

Click to [File a Complaint](#) or to [Report Fraud](#).

Requested By: **BOB MILK** Application Number: **200720615**

\* Appeal Reason:

- Denial of Medicaid
- Denial of Medicaid for 3 Month Period Prior to Application
- Discontinuance of Medicaid
- Denial of KCHIP

Do you need Special Accomodations?

- Visually Impaired Services
- Language Interpreter
- Wheelchair Access

If your health is in immediate danger, you may ask for a faster hearing by selecting this checkbox.

I would like to request a faster hearing.

\* Comments:

I would like to name another person to help with my hearing/appeal.

**Cancel** **Submit**

### 7.7. Special Enrollment (Pregnancy, Divorce, Marriage, Death, etc.)

Special enrollment periods follow certain qualifying events that result in enrollment status changes for an individual or group of individuals. It is important for individuals to be aware of these triggering events and to understand that if a triggering event occurs, they may need to change health insurance.

Below is a table of common qualifying events. For a complete list, please refer to regulation 900 KAR 10:030E (section 7).

<b>Special Enrollment Periods (SEPs) Available Regardless of Whether a Person is Already Enrolled in a QHP</b>			
<b>Qualifying Event (QE)</b>	<b>Who Can Trigger SEP</b>	<b>Who Can Use SEP</b>	<b>Timing and Effective Date</b>
<p>A <u>qualified individual</u> or <u>dependent of a qualified individual</u> loses minimum essential coverage</p> <ul style="list-style-type: none"> <li>• Medicare</li> <li>• TRICARE</li> <li>• VA Coverage</li> <li>• Non-MAGI Medicaid</li> <li>• Loss of coverage due to: <ul style="list-style-type: none"> <li>✓ legal separation or divorce,</li> <li>✓ aging out of dependent plan</li> </ul> </li> </ul> <p><i>Note: Does not include failure to pay premiums or situations involving fraud.</i></p>	<p>Qualified Individual (QI) or Dependent of QI</p>	<p>QI or Dependent of QI</p>	<p>If plan selection before or on date of loss of coverage: 1<sup>st</sup> day of month following loss of coverage.</p> <p>If plan selected after date of loss of coverage: 1<sup>st</sup> day of the month following plan selection</p> <p><i>Has 60 days before and 60 days after the loss of coverage</i></p>
<p>A qualified individual or dependent of a qualified individual loses pregnancy-related coverage through Medicaid</p> <p><i>Note: KY's only category that falls under this QE is presumptive eligibility</i></p>	<p>QI or Dependent of QI</p>	<p>QI or Dependent of QI</p>	<ul style="list-style-type: none"> <li>• Mid-month logic (15<sup>th</sup> rule)</li> </ul> <p><i>Has 60 days before and 60 days after the loss of coverage</i></p>
<p>Expiration of a non-calendar year plan in the individual or group market (i.e., the plan year ends in a month other than December)</p>	<p>QI or Dependent of QI</p>	<p>QI or Dependent of QI</p>	<p>If plan selection before or on date of loss of coverage: 1<sup>st</sup> day of month following loss of coverage.</p>

			<p>If plan selected after date of loss of coverage: 1<sup>st</sup> day of the month following plan selection</p> <p><i>Has 60 days before and 60 days after the loss of coverage</i></p>
<p>Gains a dependent or become a dependent through birth, adoption or placement for adoption or gains a dependent through child support order</p>	<p>QI</p>	<p>QI or Dependent of QI</p>	<ul style="list-style-type: none"> <li>• Retroactive to date of event; or</li> <li>• 1<sup>st</sup> of month following event, if requested by qualified individual.</li> </ul> <p><i>Has up to 60 days following the event</i></p>
<p>A qualified individual or dependent of a qualified individual loses medically needy coverage under Medicaid</p>	<p>QI or Dependent of QI</p>	<p>QI or Dependent of QI</p>	<p>If plan selection before or on date of loss of coverage: 1<sup>st</sup> day of month following loss of coverage</p> <p>If plan selected after date of loss of coverage: 1<sup>st</sup> day of the month following plan selection</p> <p><i>Up to 60 days before and 60 days after loss of coverage</i></p>
<p>Gaining eligible immigration status:</p> <ul style="list-style-type: none"> <li>• Becoming a citizen,</li> <li>• U.S. national, or</li> <li>• Gaining lawfully present status</li> </ul>	<p>QI or Dependent of QI</p>	<p>QI or Dependent of QI</p>	<ul style="list-style-type: none"> <li>• Mid-month logic (15<sup>th</sup> rule)</li> </ul> <p><i>Up to 60 days after gaining status</i></p>

**Table 15: Qualifying Events and Effective Start Dates**

### ***Do special enrollments work the same way as Annual Open Enrollment?***

Special enrollments can happen at any time during the year. Each type of special enrollment has certain rules associated with it.

As an Agent or kynector, you can help the individual transition from their old plan to their new plan. You can take the following steps to ensure that they have a smooth transition process:

- Ask the individual to bring updated income information.
- Ask the individual to update their household composition.
- Facilitate a referral (if applicable).

**Please Note:** Effective dates vary based on qualifying event. For detailed information regarding qualified events and their corresponding dates, please refer to the Special Enrollment and Qualifying Events Quick Reference Guide.

## **7.8. Other Application Options**

### **Paper Applications**

Though individuals are encouraged to apply through kynect, Agents and kynectors can help individuals with paper applications. When performing outreach activities where individuals are signing up via a computer, Agents/kynectors are also required to have a paper copy of the application in case there are any individuals that require it.

In order to receive credit for completed paper application, an Agent or kynector must receive the paper application and enter the individual's information into the Self-Service Portal and associate themselves with that individual. Sending the paper application to KOHBIE may not result in the Agent or kynector receiving credit for completing the form but can facilitate the individual's ability to submit a paper application. Paper applications to kynect should be submitted to:

Kentucky Office of Health Benefit and Information Exchange  
PO Box 2104  
Frankfort KY 40602.

### **kynect Mobile/Tablet Applications**

As of October 2015, Agents and kynectors are able to complete a full application through a kynect mobile or tablet app.

A "chat-style" application collects information necessary to determine eligibility and then allows individuals to shop for and select plans. The app allows anyone without a computer or internet access to complete an application. Individuals also have the option to start application on the web and continue the application at a later time on their iPhone, Android, or tablet.

Beginning in December 2015, Agents, kynectors, and employers can use the Small Business Health Options Program (SHOP) tablet app to complete employer applications and select plans for employee coverage. Agents and kynectors can complete this information on the spot without having to go back to their offices

***Knowledge Check:***

1. What are three examples of special enrollment?
2. What are three things an individual can do if their ID cannot be verified by their credit information?
3. How can an individual report fraud on SSP?
4. Where can Agents/kynectors find information to help them identify healthcare providers for individuals?

# 8. Troubleshooting kynect Related Issues

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As an Agent or kynector, you may be required to assist individuals with kynect related issues such as identity verification. This section provides useful information for navigating kynect's Self Service Portal.

## Section Overview and Objectives

***By the end of this section, you will be able to:***

- 8.1 Help individuals correct failed ID Proofing.
- 8.2 Identify opportunities to further your understanding through SSP training.
- 8.3 Identify resources to contact if you must refer individuals to another party.

## 8.1. Helping Individuals Correct Failed ID Proofing

An individual must create their personal account in the Kentucky Online Gateway (KOG) to access kynect. Their identity (ID) must be verified before they can complete their account registration and start using kynect. An individual's identify is verified using advanced interface technologies to find relevant information from an individual's past. This is similar to the process when applying for a credit card.



“As an individual, I initially failed the ID confirmation check. However, I can work with a kynector in two ways to resolve this issue.”

If an individual's identify cannot be verified electronically additional proof of ID is required. This may happen for various reasons including a lack of public information about a person or simply selecting the wrong answers to questions.

In the situation that an individual's ID check fails, the individual is presented with three options to resolve the failure:

1. The individual sees the ID Proofing company's phone number on the screen (Experian's 1-800 number). An individual may dial this number and ask for assistance directly with the company;
2. An Agent or kynector can help the individual scan in paper documentation to prove their identity; or
3. An individual may request that a kynector, Insurance Agent, DCBS employee, or Customer Service representative complete an application on the individual's behalf after the assister verifies the individual's identity. To do this, the assister may initiate an application through his or her own assister dashboard.
4. An individual may initiate manual ID proofing through a local DCBS office. A DCBS worker can verify the individual's identity with documentation.

The individual has up to 90 days to have their ID verified.

## 8.2. Resolving Verification Inconsistencies in kynect

### Verifications

Similar to resolving failed ID proofing, kynectors help to resolve any issues arising from verification of the following:

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Agents or kynectors can help individuals resolve verification inconsistencies by helping individuals scan and upload supporting documentation.

- State resident status
- Citizenship/lawful presence
- Incarceration status
- Income levels

This failed verification primarily comes from a discrepancy between the individual's entered information and the Federal Hub data. The Federal Hub is a central source of information that stores information about a given individual's profile that includes the items listed above.

In cases of verification inconsistencies, an Agent or kynector guides the individual through steps to correct their information. To correct their information, the individual may submit supporting documentation in the following ways:

1. Scan (if applicable) and upload the documentation directly to kynect;
2. Refer the individual to a DCBS office; or
3. Mail the documentation to the address below:  
PO Box 2104  
Frankfort, Kentucky 40602
4. Fax the documentation to: 1-502-573-2005

### 8.3. Self Service Portal Online Training

There are a number of web-based training courses available for Agents and kynectors. These courses enable Agents and kynectors to acquire additional information that is not outlined in this chapter. Courses are available via TRIS: <http://tris.eku.edu/khbe/default.aspx>

**Please Note:** The kynect health insurance exchange is made up of two main systems the Self-Service portal (SSP) and Worker portal. As an Agent or kynector you are working in SSP, which is referred to as "kynect" throughout this manual. If you work with any DCBS field staff they are working in the Worker portal and viewing different screens.

### 8.4. Important Phone Numbers

If you cannot solve a policy or system question, the number for Support Professionals to call a Customer Service Representative is 1-855-326-4650. kynect's TTY number is 1-855-326-4654.

As stated earlier, Insurance Agents and kynectors may be presented with situations or questions from individuals that require a referral to another individual or organization. Below is a list of phone numbers for important departments or entities that may be utilized by Insurance Agents or kynectors in these cases. This is not a comprehensive list but serves as a starting point in many situations.

Contact Information for Overarching Groups / Services			
<u>Department or Entity Name</u>	<u>Phone Number</u>	<u>Website</u>	<u>Reason to Call</u>
Department of Insurance (DOI)	502-564-3630 (local) 800-595-6053	<a href="http://insurance.ky.gov/">http://insurance.ky.gov/</a>	<ul style="list-style-type: none"> <li>• General insurance questions</li> <li>• Issues or Complaints involving Agents or Issuers</li> </ul>
State Health Insurance Assistance Program	877-293-7447	<a href="http://chfs.ky.gov/dail/ship.htm">http://chfs.ky.gov/dail/ship.htm</a>	The SHIP Program provides assistance to seniors and disabled individuals, their family members and caregivers
CHFS Ombudsman	800-372-2973 800-627-4702 (TTY)	<a href="http://chfs.ky.gov/os/omb/">http://chfs.ky.gov/os/omb/</a>	Questions or issues concerning CHFS programs
Department for Medicaid Services (DMS)	800-635-2570	<a href="http://chfs.ky.gov/dms/">http://chfs.ky.gov/dms/</a>	<ul style="list-style-type: none"> <li>• Questions concerning the Kentucky Medicaid Program</li> <li>• Questions concerning Kentucky Children's Health Insurance Program</li> <li>• Member services information.</li> </ul>
Kentucky Prescription Assistance Program (KPAP)	800-633-8100 502 564-8966 (program manager)	<a href="http://chfs.ky.gov/dph/info/dpqi/KPAP.htm">http://chfs.ky.gov/dph/info/dpqi/KPAP.htm</a>	<ul style="list-style-type: none"> <li>• Questions concerning the KPAP program</li> <li>• How do I access discount drug programs and discount pharmacy programs?</li> </ul>
Department for Community Based Services (DCBS) Each county has its own DCBS office. Please refer to the website for more information.	502-564-3703	<a href="http://chfs.ky.gov/dcbs/">http://chfs.ky.gov/dcbs/</a>	<ul style="list-style-type: none"> <li>• Family support</li> <li>• Child care</li> <li>• Child and adult protection</li> <li>• Administration of an energy cost assistance program</li> <li>• SNAP questions</li> <li>• TANF questions</li> <li>• Medicaid eligibility</li> </ul>
Center for Medicare & Medicaid Services (CMS)	800-635-2570	<a href="http://www.cms.gov/">http://www.cms.gov/</a>	<ul style="list-style-type: none"> <li>• Medicare</li> <li>• Medicaid</li> <li>• Children's Health Insurance Program (CHIP).</li> </ul>
The Cabinet for Health and Family Services (CHFS)	502-564-3703	<a href="http://chfs.ky.gov/">http://chfs.ky.gov/</a>	<p>CHFS consists of several agencies with various functions from internal administration to programs and direct services. Houses programs such as</p> <ul style="list-style-type: none"> <li>• DMS</li> <li>• KOHBIE</li> <li>• DCBS</li> <li>• DPH</li> <li>• DAIL</li> </ul>

Contact Information for Overarching Groups / Services			
<u>Department or Entity Name</u>	<u>Phone Number</u>	<u>Website</u>	<u>Reason to Call</u>
Medicare	(see website)	<a href="http://www.medicare.gov/">http://www.medicare.gov/</a>	For general Medicare questions
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)	800-462-6122 502-564-3827 (local)	<a href="http://chfs.ky.gov/dph/mch/ns/wic.htm">http://chfs.ky.gov/dph/mch/ns/wic.htm</a>	<ul style="list-style-type: none"> <li>• If you are pregnant</li> <li>• Recently had a baby</li> <li>• You are breastfeeding</li> <li>• You have a child younger than 5 years of age</li> </ul>
Supplemental Nutrition Assistance Program (SNAP)	502-564-3440	<a href="http://chfs.ky.gov/dcb/dfs/foodstampsebt.htm">http://chfs.ky.gov/dcb/dfs/foodstampsebt.htm</a>	The Supplemental Nutrition Assistance Program (SNAP) helps people with little or no money buy food for healthy meals at participating stores.
Kentucky Transitional Assistance Program (K-TAP)	502-564-7050	<a href="http://chfs.ky.gov/dcb/dfs/ktap.htm">http://chfs.ky.gov/dcb/dfs/ktap.htm</a>	For questions concerning the Kentucky Transitional Assistance Program (K-TAP)
COBRA (via Kentucky DOI)	502-564-5868	<a href="http://insurance.ky.gov/static_info.aspx?static_id=120&amp;Div_id=16">http://insurance.ky.gov/static_info.aspx?static_id=120&amp;Div_id=16</a>	For questions concerning COBRA
Kentucky Office of the Health Benefit and Information Exchange (kynect)	855-459-6328	<a href="http://healthbenefitexchange.ky.gov/Pages/home.aspx">http://healthbenefitexchange.ky.gov/Pages/home.aspx</a>	If you are experiencing issues with the kynect system

**Table 16: Phone Numbers for Important Entities and Organizations**

Contact Information for MCOs		
<u>MCOs</u>	<u>Phone Number</u>	<u>Hours</u>
General MCO Questions	855-446-1245	<u>Monday – Friday 7 a.m. – 7 p.m. EST</u>
Anthem	855-690-7784	<u>Monday – Friday 7 a.m. – 7 p.m. EST</u>
Coventry	855-300-5528	<u>Monday – Friday 7 a.m. – 7 p.m. EST</u>
CareSource	800-488-0134	<u>Monday – Friday 7 a.m. – 7 p.m. EST</u>
Passport	800-578-0603	<u>Monday – Friday 7 a.m. – 7 p.m. EST</u>
Well Care	877-389-9457	<u>Monday – Friday 7 a.m. – 7 p.m. EST</u>

**Table 17: Important Phone Numbers**

***Knowledge Check:***

1. How do you help individuals correct failed ID proofing?
2. Name three online training courses you can take to learn more about kynect.

# 9. Glossary and Terms

Common health insurance terms and items that are important to know.

Term	Definition
Advanced Premium Tax Credit (APTC)	<ul style="list-style-type: none"> <li>• <b>Referred to in Kentucky as “payment assistance”.</b> Qualified individuals are eligible to receive payment assistance through kynect to help them purchase a Qualified Health Plan.</li> <li>• Provided in advance or taken as a tax credit at the time an individual files their income taxes.</li> <li>• Available exclusively through kynect.</li> </ul>
Aid to Families with Dependent Children (AFDC)	<ul style="list-style-type: none"> <li>• A federal assistance program in effect from 1935 to 1996 created by the Social Security Act that program provided financial assistance to children whose families had low or no income.</li> <li>• Recipients of AFDC automatically received Medicaid.</li> <li>• In 1996, the AFDC program was replaced by the more restrictive Temporary Assistance for Needy Families (TANF) program.</li> <li>• In the 1980’s the Medicaid program was de-linked from cash assistance programs, to allow more flexibility, however Medicaid retained the rules from the AFDC program as an eligibility group known as 1931.</li> </ul>
Annual Maximum	<ul style="list-style-type: none"> <li>• Cap on the benefits an insurance company will pay or provide in a year while an insured person is enrolled in a given HIP.</li> <li>• Caps are sometimes placed on certain services, such as prescriptions, hospitalizations, number of visits etc.</li> <li>• After an annual limit is reached, the insured person must pay all other associated healthcare costs for the remainder of the year.</li> <li>• Annual maximums do not apply to essential health benefits in terms of dollar limits allowed.</li> </ul>

Term	Definition
	<p><b>Example:</b> If a health plan's annual maximum is \$750,000, once the insurance company has paid out \$750,000, they will stop providing benefits afterwards. However, there are no limits placed on receiving benefits within an individual's lifetime. This provision is mandated by the ACA.</p>
Business Rules Engine	<ul style="list-style-type: none"> <li>• Allows non-programmers to add or change how a system makes determinations.</li> <li>• Allows the administrator to change eligibility rules within the system without the help of a programmer.</li> <li>• As changes are made to eligibility and enrollment for kynect, administrators will be able to make the necessary changes in the rules engine so the system appropriately makes eligibility determination.</li> </ul>
Certified Application Counselors (CACs)	<ul style="list-style-type: none"> <li>• Individuals who facilitate enrollment and may offer personal guidance in regards to plans available.</li> <li>• CACs provide information about insurance affordability programs and coverage options; assist individuals and employees to apply for coverage in a qualified health plan and for insurance affordability programs; and help to facilitate enrollment of eligible individuals. They may interact at home or in-person.</li> <li>• Organizations are designated, cannot charge for services, and not required to participate in outreach &amp; education or report metrics to KOHBIE.</li> </ul>
Coinsurance	<ul style="list-style-type: none"> <li>• An insured person's share of the costs of a covered healthcare service.</li> <li>• Calculated as a percent of the allowed amount for the service. An insured person pays co-insurance in addition to any deductibles owed.</li> </ul> <p><b>Example:</b> If the health insurance or plan's allowed amount for an office visit is \$100 (and the insured person has met their deductible), a coinsurance payment of 20% would be \$20. The other \$80 is paid by the insured person's health plan.</p>

Copay	<ul style="list-style-type: none"> <li>• A cost sharing system between the insured and the insurance company.</li> <li>• The insured pays a predetermined flat fee required at the time any covered medical service is received.</li> </ul>
Cost Sharing Reductions (CSR)	<ul style="list-style-type: none"> <li>• <b>Referred to in Kentucky as “Special Discounts”</b></li> <li>• A mechanism, in the form of subsidies, to reduce an individual’s cost of the deductible, co-pay, and / or co-insurance.</li> <li>• Provide health insurance cost sharing assistance for individuals who are not eligible for Medicaid but whose income is between 100% and 250% of the FPL.</li> <li>• Only available for Silver Plans purchased through kynect.</li> <li>• Please Note: Special discounts are meant to reduce the out-of-pocket costs as opposed to payment assistance, which is a premium subsidy.</li> </ul>
Creditable Coverage	<ul style="list-style-type: none"> <li>• Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any established or maintained by a State, the U.S. government, a foreign country); Children’s Health Insurance Program (CHIP) or a state health insurance high risk pool.</li> <li>• If an individual had prior creditable coverage, it will typically reduce the length of a pre-existing condition exclusion period (if applicable) under new job-based coverage.</li> </ul>
Deductible	<ul style="list-style-type: none"> <li>• The amount an insured person owes for healthcare services before their health insurance or plan begins to pay.</li> <li>• An individual only needs to meet his or her minimum deductible once per year and a deductible may not apply to all services.</li> <li>• If an individual switches plans in the middle of the plan year, the amount paid in the form of a deductible starts over and does not carry over to the new plan; the paid deductible amount would be \$0. Even if you have not exhausted the deductible, some preventive care may still be covered.</li> </ul>

**Example:** If your deductible is \$500, you will owe \$500 before your plan begins to pay for most services. If you have a deductible of \$500, and an essential surgery costs \$700, you would have to pay \$500 (as your deductible) and your insurance would cover the rest (\$200). If your surgery is \$300, you would pay the full \$300, and the insurer would pay \$0. In addition, \$200 of your deductible would still remain (\$500 - \$300). This is the amount you would have to pay for any future services within a plan year before the plan starts paying.

Effectuation	<ul style="list-style-type: none"> <li>• A process by which an individual's coverage becomes effective (effective date of coverage).</li> </ul>
Essential Community Provider (ECP)	<ul style="list-style-type: none"> <li>• Providers that serve predominantly low-income, medically underserved individuals.</li> <li>• Healthcare providers defined in section 340B(a)(4) of the PHS Act;</li> <li>• Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8.</li> </ul>
Exclusive Provider Organization (EPO)	<ul style="list-style-type: none"> <li>• A plan where services are covered only if an insured person goes to doctors, specialists, or hospitals in the plan's network (except in an emergency).</li> <li>• These networks tend to be smaller than those of an HMO.</li> </ul>
Eligibility Determination Group (EDG)	<ul style="list-style-type: none"> <li>• Indicates the individuals whose income and resources will be used to determine eligibility.</li> <li>• Eligibility groups identify who is considered in the household (household group), who must apply together (filing group), whose income and resources will be used to determine eligibility (financial group), whose needs are considered (need group) and who will receive benefits (benefit group).</li> </ul>
Family Size	<ul style="list-style-type: none"> <li>• The number of persons in an individual's tax filing household.</li> <li>• For MAGI-related groups, individuals do not need to live together to be included in the same household.</li> </ul>
Federal Data Services Hub (FDSH)	<ul style="list-style-type: none"> <li>• A federally operated data services hub that validates information relating to an individual applying for health insurance coverage or other affordability program benefits through Health Benefit Exchanges.</li> </ul>

	<ul style="list-style-type: none"> <li>For example, verification of citizenship (through SSA), income (through IRS), and immigration status (through Department of Homeland Security) is performed by the hub.</li> </ul>
Health Insurance Issuer or Issuer	<ul style="list-style-type: none"> <li>As defined by 45 CFR 144.103, an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and is subject to state law that regulates insurance (within the meaning of section 514(b)(2) of ERISA).</li> <li>This term does not include a group health plan.</li> </ul>
Health Maintenance Organization (HMO)	<ul style="list-style-type: none"> <li>A type of Health Insurance Plan that limits coverage to services provided by a specific group of doctors.</li> <li>A group of doctors who work for, or are under contract of the HMO.</li> </ul>
Health Savings Account (HSA)	<ul style="list-style-type: none"> <li>A special medical savings account available to taxpaying citizens who are also enrolled in a High Deductible Health Plan.</li> <li>An individual enrolled in an HSA may contribute funds into the account during the year. The funds contributed to the account are not subject to federal income tax at the time of deposit and may only be used for qualified medical expenses.</li> <li>Funds roll over year to year if they are not spent in the current year.</li> </ul>
In-Person Assister (IPA)	<ul style="list-style-type: none"> <li>An individual or organization that is trained and able to provide help to individuals, small businesses, and their employees as they look for health coverage options through kynect, including helping them complete eligibility and enrollment forms. In-person assisters are required to be unbiased, and their services are free to individuals.</li> </ul>
Insurance Affordability Programs	<ul style="list-style-type: none"> <li>Federal and state public programs that are in place to help individuals who may be vulnerable or underserved.</li> <li>Examples include, but are not limited to, Medicaid, Medicare, KCHIP, SNAP, TANF (K-TAP), and WIC.</li> </ul>
kynect	<ul style="list-style-type: none"> <li>Kentucky's health insurance exchange.</li> <li>Designed to make comprehensive Health Insurance Plans (HIPs) available to qualified individuals, including small businesses and their employees.</li> <li>Identifies affordability programs, including Medicaid, Kentucky Children's Health Insurance Program and tax credits for private insurance plans to help support</li> </ul>

residents that may be eligible for help paying for health insurance across the Commonwealth.

- Kynect presents these plans in a “shop and compare” format that allows individuals to make informed decisions. The “shop and compare” format displays health insurance options based on price, benefits, quality, and other features in simple language that is easy for individuals to understand.

Kentucky Health Insurance Premium Payment (KHIPP)	<ul style="list-style-type: none"> <li>• A Kentucky Medicaid program that pays the costs of some or the entire employee portion of employer-sponsored health insurance premiums.</li> </ul>
Kentucky Office of the Health Benefit and Information Exchange (KOHBE)	<ul style="list-style-type: none"> <li>• Kentucky’s new health insurance marketplace</li> <li>• Sits within the Cabinet for Health and Family Services (CHFS), and an Advisory Board to carry out the requirements of a state run health exchange and meet the goals of the Affordable Care Act.</li> </ul>
Managed Care Organizations (MCOs)	<ul style="list-style-type: none"> <li>• Networks that provide services to Medicaid individuals.</li> <li>• Eligible individuals may able to shop and compare the various MCOs in their area, similar to how other individuals can shop and compare Health Insurance Plans and Small Business Health Options Program (SHOP) plans (if applicable).</li> </ul>
Minimum Essential Coverage	<ul style="list-style-type: none"> <li>• The type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA.</li> <li>• Includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage including veterans’ healthcare under chapter 17 or 18 of Title 38 U.S.C. Section 5000A(f).</li> </ul>
Mixed Household	<ul style="list-style-type: none"> <li>• A mixed household is one in which household members are eligible for different levels of assistance.</li> <li>• For example, one member in the household is eligible for Medicaid and another for APTC.</li> </ul>
Multi-State Plans	<ul style="list-style-type: none"> <li>• Healthcare coverage offered through the U.S. Office of Personnel Management for Federal employees, retirees, and their families and deemed qualified health plans under state-based, partnership and federally facilitated exchanges.</li> </ul>
Non-MAGI Individual	<ul style="list-style-type: none"> <li>• An individual who is exempt from income eligibility determinations based upon the Modified Adjusted Gross Income requirements under the ACA (e.g. individuals who are receiving Medicaid benefits as a result of being aged, blind, disabled or committed to (a ward of) the Cabinet for Health and Family Services.</li> </ul>

<p>Non-Tax Filer Group</p>	<ul style="list-style-type: none"> <li>• An individual belongs to the non-filer group if he or she does not intend to file taxes for the benefit year. In addition, an individual who is claimed as a tax dependent and meets any of the following will be classified as a non-filer:             <ol style="list-style-type: none"> <li>1. The individual expects to be claimed as a tax dependent by someone other than the spouse or biological, adopted or stepparent.</li> <li>2. The individual is a child living with both parents, but the parents do not expect to file a joint tax return.</li> <li>3. The individual is a child under the age of 19 and is a full time student who expects to be claimed as a tax dependent by a non-custodial parent.</li> </ol> </li> </ul>
<p>Preferred Provider Organization (PPO)</p>	<ul style="list-style-type: none"> <li>• Type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers.</li> <li>• PPO membership provides a discount below the regularly charged rates of given professionals who are partnered with a health organization.</li> <li>• An individual may still use doctors, hospitals, and providers outside of their PPO network, but these will come at an additional cost.</li> </ul>
<p>Premium</p>	<ul style="list-style-type: none"> <li>• Amount that must be paid for a person's health insurance or plan.</li> <li>• Generally paid on a monthly, quarterly or yearly basis.</li> </ul>
<p>Presumptive Eligibility (PE)</p>	<ul style="list-style-type: none"> <li>• Eligibility granted for Medicaid-covered services to a qualified individual as processed by a qualified entity.</li> </ul>
<p>Primary Tax Filer</p>	<ul style="list-style-type: none"> <li>• An individual who files a tax return and is not claimed as a dependent by any other tax payer.</li> </ul>

Qualified Health Plan (QHP)	<ul style="list-style-type: none"> <li>• <b>Referred to in Kentucky as “Health Insurance Plans (HIPs)”.</b></li> <li>• Under the ACA starting in 2014, an insurance plan that is certified by kynect, including the KOHBIE, provides essential health benefits, follows established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amount(s), and meets other requirements.</li> </ul>
Reasonable Compatibility	<ul style="list-style-type: none"> <li>• The allowable difference between the individual’s self-attested information and the information reported via the Federal Hub.</li> </ul>
Renewal	<ul style="list-style-type: none"> <li>• A review of income and other data to determine eligibility.</li> <li>• This can occur on an annual basis (required) or within a benefit year when new information is obtained and verified.</li> </ul>
Statutory Benefits	<ul style="list-style-type: none"> <li>• Benefits that are mandated by federal or state laws, such as Social Security, Unemployment Insurance, and workers’ compensation.</li> </ul>
Systematic Alien Verification of Eligibility	<ul style="list-style-type: none"> <li>• Intergovernmental initiative designed to assist federal, state, and local benefit-issuing agencies determining the immigration status of benefit applicants, so only those entitled to benefits receive them.</li> </ul>
Self-Attestation	<ul style="list-style-type: none"> <li>• A method of reporting information that allows an individual, an adult in the individual’s household or family, authorized representative, or someone acting responsibly for the individual (if minor or incapacitated) to verbally verify information at the time of application and review, except as required by law for citizenship and immigration.</li> <li>• No further documentation is required, unless it conflicts with information gathered from electronic data matches (see Reasonable Compatibility).</li> </ul>
Small Business Health Options Program (SHOP)	<ul style="list-style-type: none"> <li>• A program operated by Exchanges, including the KOHBIE, through which a qualified employer may provide employees and their dependents with access to one or more qualified health plans (QHPs).</li> </ul>
Tax Dependent	<ul style="list-style-type: none"> <li>• A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.</li> <li>• Under the ACA, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.</li> </ul>

Tax Filer

- An individual who will file a single or joint income tax return for the benefit year.
  - Individuals can file as a head of household; single; married filing jointly; married filing separately; or qualified widow(er) with dependent child. An individual may only be considered a tax dependent on one tax return.
-

# 10. Appendices

## Appendix A: Conflicts of Interest Checklist

An individual serving in the kynector program, shall not:	Applies to:	
	Employee	Entity
Use or attempt to use his or her influence in any matter which involves a substantial conflict between his or her personal or private interest and his or her duties in the public interest.	X	
Provide customers with biased or partial information about plans for which customers are eligible.	X	
Select a plan on behalf of individuals	X	
Use his or her official position to obtain financial gain for himself, herself, or any members of their immediate family.	X	
Use or attempt to use his or her official position to secure or create privileges, exemptions, advantages, or treatment for himself or herself or others in derogation of the public interest at large.	X	
Disclose or use confidential information acquired in the course of his or her official duties as a Navigator or IPA to further their own interests, economic or otherwise.	X	X
Receive direct or indirect payments from any health insurance issuer in connection with the enrollment of individuals or employees in a Health Insurance Plan (HIP) or non-HIP as explicitly prohibited by federal law.	X	X
Receive compensation of any kind from another entity outside of the Kentucky Health Benefit Exchange for facilitating enrollment into health plans.	X	X
Receive any commission or any compensation for referring enrollees to an issuer or Insurance Agent.	X	X
Receive varying compensation based on plans or insurer chosen by the enrollees.	X	X
Receive or have an immediate family member receiving an investment in any note or debt from an insurer, except as to policy loans. Similarly, insurers are prohibited from extending a substantial investment to an individual serving in the kynector program or their immediate family member.	X	X

An individual serving in the kynector program, shall not:	Applies to:	
	Employee	Entity
<p>Work for or have any immediate family members who work for restricted entities or individuals. Restricted entities or individuals include:</p> <ul style="list-style-type: none"> <li>• A health insurance issuer;</li> <li>• A subsidiary of a health insurance issuer;</li> <li>• An association that includes members of, or lobbies on behalf of, the insurance industry; or,</li> <li>• An individual or entity that receives any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees in a HIP or a non-HIP</li> <li>• A provider entity (including, but not limited to, hospitals, clinics, and physician practices) that is directly owned by, a subsidiary of, or exclusively contracts with, a single insurer or its subsidiaries., except in cases where the provider can demonstrate that due to geography or other factors, there are significant limitations on available insurers with whom to contract</li> </ul> <p>An entity with members who would otherwise create a conflict of interest can still potentially serve as a kynector or IPA as long as the specific members do not engage in kynector or IPA activities.<sup>1</sup></p>	X	X
<b>An entity serving in the kynector program, shall not:</b>		
Use or attempt to use its position to secure or create privileges, exemptions, advantages, or treatment for itself or others in derogation of the public interest at large.	X	X

## Appendix B: Agent and kynector Disclosures

### **Agent Disclosure:**

I am an insurance agent that has been trained and registered to participate on kynect. I am licensed insurance agent and I am able to:

\_\_\_\_\_

<sup>1</sup> An entity with members who would otherwise create a conflict of interest can still potentially serve as a kynector as long as the specific members do not engage in kynector activities. For example, Organization X may still be able to act as a kynector entity as long as insurers who are members of the organization do not participate in the kynector activities.

- Help you navigate and answer questions about the kynect website;
- Help you compare the coverages available through kynect including Health Insurance Plans, standalone dental plans, Medicaid and KCHIP offered through kynect;
- Understand and compare Health Insurance Plans or Managed Care plans;
- Help you complete the kynect application;
- Help you apply for public assistance benefits, such as Medicaid and KCHIP; and
- Help you with professional advice.

I may not be appointed or designated to sell all the insurance products on the exchange (list products you can sell or those you cannot sell). My services are provided at no direct cost to you, I receive compensation from the insurance company. If you are interested in a product that I cannot sell, I may need to refer you to another agent.

If you have questions about Medicaid, I may need to refer you to a kynector. If you have questions about appeals or complaints, I may need to refer you to the kynect call center at 1-855-4kynect (1-855-459-6328).

**kynector Disclosure:**

I am a kynector that has been trained and certified by kynect. As a kynector, I can play an important role in facilitating your enrollment in a health insurance plan by providing fair, impartial, and accurate information to assist you with submitting an eligibility application and selecting a health insurance or Medicaid plan. I am not a licensed insurance agent. As a kynector I am able to:

- Help you navigate and answer questions about the kynect website;
- Help you compare the plans available through kynect including Health Insurance Plans, standalone dental plans, Medicaid and KCHIP offered through kynect;
- Help you understand the distinction among the Health Insurance Plans and Managed Care Plans offered through kynect;
- Help you fill out the eligibility application;
- Help you apply for public assistance benefits, such as Medicaid and KCHIP;
- Provide referrals to any consumer assistance office or any other appropriate State agency for any grievances, complaints, or questions regarding your health plan, coverage, or a determination under the plan or coverage

I cannot make eligibility determinations or select a Health Insurance Plan for you or advise you to select a particular Health Insurance Plan. My role only involves kynect so I cannot assist you in any way with any insurance products not offered through kynect.

If at any time during my visit you need additional assistance I can help you find an insurance agent who is licensed to sell all forms of health insurance and is able to give you professional advice. I cannot refer you to a specific agent.

**Certified Application Counselor Disclosure**

I am a Certified Application Counselor that has been trained and certified by the Office of the Kentucky Health Benefit Exchange on the kynect website. I am not a licensed insurance agent. As a Certified Application Counselor I am able to:

- Help you navigate and answer questions about the kynect website;
- Help you compare the coverages available through kynect including Health Insurance Plans, standalone dental plans, Medicaid and KCHIP;
- Help you understand and compare Health Insurance Plans or Managed Care plans;
- Help you complete the kynect application;
- Help you apply for public assistance benefits, such as Medicaid and KCHIP;

I agree to act in the best interest of the applicants and enrollees assisted.

I have disclosed any potential conflicts of interest that I may have to the applicant.

If I cannot provide information in a manner that is accessible to individuals with disabilities I will refer the applicant to an In-Person Assister.

I cannot give you advice or recommend a plan for you. I am not able to sell insurance and I cannot provide information about coverage options for plans not offered through kynect.

If you feel that you need additional assistance I can help you find an insurance agent who is licensed to sell all forms of health insurance and is able to give you professional advice. However, I cannot refer you to a specific agent.

**Appendix C: kynector Performance Measures**

The following are expected performance measures for IPAs. KOHBIE reserves the right to amend measures as needed to better evaluate the kynector program:

Performance Measure Grouping	IPA
1. Coverage Model	# of Applications Started
	# of Applications Completed (Medicaid Eligible)
	# of Applications Completed (Health Insurance Plan Eligible)
	# of Applications In-Progress (Outstanding as of last day of reporting period)
	Total Drive Time
	# of locations that require driving

Performance Measure Grouping	IPA
	# of locations that require driving
2. Focus	# of Unique population segments targeted (of the KOHBIE list of target segments)
	# of Enrollment Related Contacts
	# Hours spent on Enrollment Assistance
	# of Outreach and Education Related Contacts
	# of Referrals Sent and Type of Referral
	# of Referrals Received
3. Outreach	# of Community Events attended for IPA Duties
	# of Person Hours spent at Community Events
	# of Office Hours held
	# of Other Hours Spent on Outreach and Education
	# of Presentations made, both in office and at outreach events
	# of Locations where outreach materials were disseminated
	# of Appointments with Individuals
	# of Direct (phone or in-person) Contacts with Individuals
	# of Follow-Up calls made to Individuals
4. Operations	# of Reported of privacy and security breaches
5. Talent Management	# of IPAs Trained and Certified
	# of Enrollments per IPA Employee
	Average Individual Satisfaction Rating (see below)
6. Cost Effectiveness	\$ Funds used on Enrollment Activities for the reporting month
	\$ Funds used on Enrollment Activities for the reporting month (YTD)
	\$ Funds used on Outreach Activities
	\$ Funds used on Outreach Activities (\$ YTD)

In order to measure Individual Satisfaction Rating, contractors will be required to distribute the following Individual Satisfaction Survey.

Question	1 = Not Satisfied, 5 = Very Satisfied				
Would you consider recommending this person to a friend or family member?	1	2	3	4	5
Would you return to this person if you need assistance in the future?	1	2	3	4	5
Did you receive the information you were looking for from the person?	1	2	3	4	5
Were you able to understand the person when he/she explained the process and components of kynect?	1	2	3	4	5

Complaints are separate from the Individual Satisfaction Survey and will also factor into the evaluation of contractors. The KOHBIE is primarily responsible for taking, recording, and investigating complaints, and contractors are expected to fully comply with all complaint investigations. Any complaints received by contractors must be forwarded to KOHBIE within seven business days of receipt.

## Appendix D: Participation Agreements for Agents

**2016 PARTICIPATION AGREEMENT  
BETWEEN  
KENTUCKY OFFICE OF HEALTH BENEFIT AND INFORMATION EXCHANGE  
(KOHBE)  
AND  
LICENSED KENTUCKY INSURANCE AGENTS**

This Agreement by and between the undersigned Agent and the Kentucky Office of Health Benefit and Information Exchange (KOHBE), together referred to as Parties is intended to conform with the provisions of 45 CFR Section 155.220 to allow Agent to participate as an Agent on the Commonwealth of Kentucky's state-based marketplace known as kynect. This agreement shall be renewed annually in accordance with 900 KAR 10:050.

**WHEREAS**, the KOHBE has determined that it is in the best interest of the citizens of the Commonwealth of Kentucky to allow Agents to participate on kynect to perform the following:

- A. Enroll individuals, employers or employees in any Qualified Health Plan ("QHP") in the individual or small group market offered through kynect;
- B. Enroll qualified individuals in a QHP in a manner that constitutes enrollment through kynect; and
- C. Assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

**WHEREAS**, through a registration process established in 900 KAR 10:050 that includes training and testing, Agent has demonstrated a sufficient understanding of the range of QHP options and insurance affordability programs to participate as an Agent on kynect all as more fully described in 900 KAR 10:050, applicable provisions of KRS Chapter 304, and 45 CFR Sections 155.220 and 155.260 and,

**WHEREAS**, Agent desires to participate on kynect and has been informed of his or her obligations for continuing participation.

**NOW, THEREFORE**, during the term of this agreement, and in consideration for participation on kynect, Agent agrees as follows:

1. To comply with the provisions of 900 KAR 10:050 and 45 C.F.R. Sections 155.220 and 155.260;
2. To maintain an active license with a health line of authority through the Kentucky Department of Insurance ("DOI");
3. To comply with Kentucky state law applicable to agents, including applicable state law related to confidentiality and conflicts of interest;
4. To maintain an appointment with at least two (2) QHP issuers offering coverage through kynect. Unless specifically exempt from this requirement under the provisions of 900 KAR 10:050, Captive agents or in-house agents that are employed exclusively by the QHP issuer are required to maintain the one appointment with that QHP issuer.

5. To comply with the privacy and security standards established in accordance with 45 C.F.R. 155.260, KRS 64.931-934 and any other applicable Kentucky state laws or kynect guidance.
6. To disassociate from an individual or employer's account upon request of the individual or employer through the agent portal/dashboard on the kynect system and take any other steps required by the issuer;
7. To act responsibly if an individual associates himself or herself with an agent and selects a health plan or issuer for which the agent is not appointed. In this event, Agent shall:
  - a. Seek and obtain the appointment with the issuer; or
  - b. Disassociate himself or herself from the individual, inform the individual of the disassociation from him or her as the agent of record, inform the individual of his or her right to seek another agent who does maintain the appointment with the selected issuer or a kynector, or continue the application process on his or her own;
8. To make appropriate referrals as necessary to any available office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under such plan or coverage, such as, including but not limited to the Kentucky Department of Insurance, other KOHBIE assisting agencies, the Department for Community Based Services, the KOHBIE Contact Center, the Cabinet for Health and Family Services (CHFS) Ombudsman's Office, and individual kynectors or kynector entities.
9. To submit a written statement to KOHBIE and notify any associated individual clients, if the Agent no longer wishes to participate on kynect.
10. To maintain a single Kentucky Online Gateway (KOG) account for the associated DOI Agent Credential for the period that the agent remains a registered participating agent.
11. To maintain current account and contact information including email address in the KOG system and KOHBIE Training Records Information System (TRIS).
12. To act in a professional manner and comply with instructions or guidance provided by KOHBIE.
13. To prohibit non-licensed or non-registered staff of the agent from accessing the agent's kynect account and to prohibit non-licensed or non-registered staff from impersonating the registered agent in conducting business with kynect.
14. To comply with existing laws and not impose any charge or fee on an applicant for assistance in completing an application for, or enrolling in, a QHP, an Stand Alone Dental Plan (SADP), or an insurance affordability program.
15. Not to charge a fee associated with a Medicaid enrollment regardless of their capacity (agent, consultant, attorney, financial advisor, broker, or any other person).
16. To allow only authorized users to access the kynect site, or any information accessed through this site, for its intended purpose of assisting individuals, employers or employees in the selection or purchase of health plans or other benefits as agreed upon before entering the kynect site.
17. To, accept responsibility of any actions of a delegate agent acting on a primary agent's behalf, if an agent choses to delegate access to other participating agents.
18. To comply with all applicable Kentucky and federal laws.

## Appendix E: Defining Lawful Presence

### Lawfully present means an individual who is a non-citizen and who—

- (1) Is a qualified non-citizen, as defined in this section;
- (2) Is in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));
- (3) Is paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) Belongs to one of the following classes:
  - (i) Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
  - (ii) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a, and individuals with pending applications for TPS who have been granted employment authorization;
  - (iii) Granted employment authorization under 8 CFR 274a.12(c);
  - (iv) Family Unity beneficiaries in accordance with section 301 of Public Law 101–649, as amended;
  - (v) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
  - (vi) Granted Deferred Action status;
  - (vii) Granted an administrative stay of removal under 8 CFR part 241;
  - (viii) Beneficiary of approved visa petition who has a pending application for adjustment of status;
- (5) Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who—
  - (i) Has been granted employment authorization; or
  - (ii) Is under the age of 14 and has had an application pending for at least 180 days;
- (6) Has been granted withholding of removal under the Convention Against Torture;
- (7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);
- (8) Is lawfully present in American Samoa under the immigration laws of American Samoa;
- (9) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106–386, as amended (22 U.S.C. 7105(b)); or
- (10) Exception. An individual with deferred action under the Department of Homeland Security's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

\* \* \* \* \*

Non-citizen has the same meaning as the term “alien,” as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 U.S.C. 1101(a)(22).

\* \* \* \* \*

Qualified non-citizen has the same meaning as the term “qualified alien” as defined at 8 U.S.C. 1641(b) and (c).

\* \* \* \* \*

**Appendix F: Annual Earnings Federal Poverty Line (FPL) Charts  
for Payment Assistance (APTC)**

Family Size	100%	138%	150%	200%	250%	300%	400%
1	\$11,490.00	\$15,856.20	\$17,235.00	\$22,980.00	\$28,725.00	\$34,470.00	\$45,960.00
2	\$15,510.00	\$21,403.80	\$23,265.00	\$31,020.00	\$38,775.00	\$46,530.00	\$62,040.00
3	\$19,530.00	\$26,951.40	\$29,295.00	\$39,060.00	\$48,825.00	\$58,590.00	\$78,120.00
4	\$23,550.00	\$32,499.00	\$35,325.00	\$47,100.00	\$58,875.00	\$70,650.00	\$94,200.00
5	\$27,570.00	\$38,046.60	\$41,355.00	\$55,140.00	\$68,925.00	\$82,710.00	\$110,280.00
6	\$31,590.00	\$43,594.20	\$47,385.00	\$63,180.00	\$78,975.00	\$94,770.00	\$126,360.00
7	\$35,610.00	\$49,141.80	\$53,415.00	\$71,220.00	\$89,025.00	\$106,830.00	\$142,440.00
8	\$39,630.00	\$54,689.40	\$59,445.00	\$79,260.00	\$99,075.00	\$118,890.00	\$158,520.00

## Appendix G: Underserved and Vulnerable Population Data

### Population Profile

The following table provides summary demographic statistics for each Medicaid region in Kentucky. This information will assist kynectors in preparing to assist Kentucky individuals. The respondent may apply to one (1), several, or all eight (8) regions. “High Need” populations highlighted in green by region indicate segments that have a greater need for enrollment assistance. kynectors are encouraged to be proactive in planning on how they will serve these High Need populations in the regions for which they are assisting.

Please Note: This is 2012 census data and does not account for this past year’s Open Enrollment Period.

#	Population Segment	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
<b>General Demographic Information</b>									
1	Total Population	287,993	402,934	1,236,689	486,478	786,826	416,995	241,556	479,896
2	Households	98,659	152,145	493,748	195,071	335,285	159,321	97,457	188,279
3	Percent Uninsured	15.82%	15.08%	14.13%	17.30%	15.86%	13.12%	15.81%	16.10%
<b>High Need Population Segments – Highlighted cells indicate “High Need” populations for each region</b>									
4	Rural Population	69,012	82,593	116,664	152,920	117,612	32,712	73,611	164,510
5	Homeless Population	263	388	1,909	437	2,094	645	267	598
6	Medicaid Blind and Disabled	9,534	16,867	38,797	29,028	30,774	10,642	17,082	55,862

#	Population Segment	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
7	Part-Time Workers	38,536	53,629	192,062	78,136	152,954	67,389	38,647	56,956
8	Population Lacking Basic Prose Level Literacy	35,677	52,245	117,198	73,346	88,014	41,156	34,703	80,322
9	Households without a Person over the Age of 14 Who Speaks English Well or Very Well	851	1,168	7,505	2,431	5,110	1,523	311	381
<b>Additional Information</b>									
10	Household Density per Square Mile	27	30	93	26	61	133	24	27
11	Median Household Income	\$40,460	\$40,940	\$47,988	\$35,363	\$45,150	\$56,433	\$35,404	\$29,191
12	Percent of Households at or Below 2.00 times the Federal Poverty Level	58.11%	58.42%	50.77%	64.37%	54.05%	43.87%	61.36%	67.17%

#	Population Segment	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8
13	Projected Minimum Number of Households with at Least One Uninsured Person	19,056	24,103	70,117	34,220	51,892	20,979	14,873	29,971
14	Population with Direct Purchase Insurance (Individual Market)	10,711	11,819	58,907	14,518	38,105	17,100	3,432	7,404
15	Number of Employers with 50 or Less Employees	5,200	7,351	26,907	9,053	17,241	7,669	4,176	8,066

## Appendix H: Countable and Non Countable Income

Countable Income	Not Counted Income
Wages, salaries, tips, bonuses, awards	Veteran's disability benefits
Interest income (taxable and non-taxable)	Veteran's pension benefits
Ordinary dividends	Veteran's education benefits
Alimony Received/Spousal Support	Child support received
Business Income	Worker's compensation
Capital gains	SSI benefits
IRA distributions	TANF benefits
Pensions and annuities	Foster care and Adoption Assistance payments
Rental Income	Military allowances
Royalties	Education scholarships, awards, fellowship grants <sup>1</sup>
Partnerships/S-Corporations	Social Security benefits of dependents <sup>2</sup>
Trust Income (as reported on 1040, line 17)	Wages of minors <sup>3</sup>
Farm Income	Employer contributions to certain pretax benefits funded by an employee's elective salary reduction, such as amounts for a flexible spending account or contributions to a retirement account
Unemployment compensation	Black Lung benefits
Social Security benefits (taxable and non-taxable)	Cash rebates from a dealer or manufacturer
Railroad Retirement	Work study income
Gambling Winnings <sup>5</sup>	Refugee cash assistance
Jury Duty payments <sup>5</sup>	Native American benefits and payments
Foreign earned income	Income from a sponsor for a sponsored immigrant
Lump sum income (retro Social Security/Railroad Retirement) <sup>5</sup>	Fringe benefits provided on a pretax basis by an employer
Oil leases/mineral rights	Loans
Waiver payments issued to individual care providers received for a non-household member (related or non-related)	Waiver payments issued to individual care providers received for a household member (related or non-related)
Income derived from gifts/inheritances	Gifts and inheritances
Any remaining portion of a lump sum payment awarded for wrongful death, personal injury, damages, or loss of property not excluded for tax purposes <sup>4,5</sup>	Any portion of a lump sum payment that is awarded for wrongful death, personal injury, damage, or loss of property <sup>4</sup>
State agency payments received for child care	Earned income tax credits
Other income include on 1040, line 21	Employer reimbursement for mileage, meals, etc.

<sup>1</sup> Count any taxable portion used for room and board

<sup>2</sup> Count if dependent has a tax filing requirement, there are some exceptions for Medicaid

<sup>3</sup> Count if dependent has a tax filing requirement, there are some exceptions for Medicaid

<sup>4</sup> Lump sum payments may include countable and non-countable income

<sup>5</sup> For Medicaid, this income is counted only in the month it is received

## Appendix I: Additional Phone Numbers for Kentucky Organizations

Below is a list of phone numbers that may help Insurance Agents or kynectors in assisting specific populations within Kentucky.

Contact Information for Specialized Groups / Services			
<u>Department or Entity Name</u>	<u>Focus</u>	<u>Phone Number</u>	<u>Website</u>
The Department of Labor	COBRA population	502-564-3070	<a href="http://www.labor.ky.gov/Pages/LaborHome.aspx">http://www.labor.ky.gov/Pages/LaborHome.aspx</a>
Veteran's Health Coverage	Veteran population	(see website)	<a href="http://veterans.ky.gov/vahealthservices/Pages/default.aspx">http://veterans.ky.gov/vahealthservices/Pages/default.aspx</a>
TRICARE	Veteran population	1-800-444-5445 (south region)	<a href="http://www.tricare.mil/Welcome/AboutUs/Regions/South.aspx">http://www.tricare.mil/Welcome/AboutUs/Regions/South.aspx</a>
The Center of Excellence in Rural Health	Rural Population	855-859-2374	<a href="http://ruralhealth.med.uky.edu/">http://ruralhealth.med.uky.edu/</a>
The Kentucky Outreach and Information Network (KOIN)	Rural Population	502-564-6786 ext. 3102	<a href="http://healthalerts.ky.gov/koin/Pages/default.aspx">http://healthalerts.ky.gov/koin/Pages/default.aspx</a>
Kentucky Housing Corporation	Homeless Population	800-633-8896 (KY only)	<a href="http://www.kyhousing.org/page.aspx?id=170">http://www.kyhousing.org/page.aspx?id=170</a>
The Kentucky Medicaid Consortium	Medicaid, Blind, and Disabled Population	(see website)	<a href="http://www.advocacyaction.net/Dot_page.asp?Dotid=55">http://www.advocacyaction.net/Dot_page.asp?Dotid=55</a>
The Department for Community Based Services	Medicaid, Blind, and Disabled Population	502-564-3703	<a href="http://chfs.ky.gov/dcbs/">http://chfs.ky.gov/dcbs/</a>
The Department for Medicaid Services	Medicaid, Blind, and Disabled Population	800-635-2570	<a href="http://chfs.ky.gov/dms/">http://chfs.ky.gov/dms/</a>
Kentucky Health Insurance Advocate (KHIA)	Medicaid, Blind, and Disabled Population	877-587-7222	<a href="http://insurance.ky.gov/home.aspx?div_id=16">http://insurance.ky.gov/home.aspx?div_id=16</a>
The Arc of Kentucky	Medicaid, Blind, and Disabled Population	800-281-1272	<a href="http://www.arcofky.org/">http://www.arcofky.org/</a>
The Christian Appalachian Project	Medicaid, Blind, and Disabled Population	866-270-4CAP (4227)	<a href="http://www.christianapp.org/">http://www.christianapp.org/</a>

Contact Information for Specialized Groups / Services			
United 874K Disabilities Coalition	Medicaid, Blind, and Disabled Population	(see website)	<a href="http://www.advocacyaction.net/Dot_page.asp?Dotid=56">http://www.advocacyaction.net/Dot_page.asp?Dotid=56</a>
The Aging Disability Resource Center (Under the CHFS Department of Aging and Independent Living)	Medicaid, Blind, and Disabled Population	(see website)	<a href="http://chfs.ky.gov/dail/areaagenciesonaging.htm">http://chfs.ky.gov/dail/areaagenciesonaging.htm</a>
Area Agencies on Aging (Under the CHFS Department of Aging and Independent Living)	Medicaid, Blind, and Disabled Population	502-564-6930	<a href="http://chfs.ky.gov/dail/">http://chfs.ky.gov/dail/</a>
The CHFS Division of Developmental and Intellectual Disabilities	Medicaid, Blind, and Disabled Population	502-564-7702	<a href="http://dbhdid.ky.gov/ddid/">http://dbhdid.ky.gov/ddid/</a>
The Commonwealth Council on Developmental Disabilities	Medicaid, Blind, and Disabled Population	877-367-5332	<a href="http://chfs.ky.gov/ccdd/">http://chfs.ky.gov/ccdd/</a>
The Kentucky Office for the Blind	Medicaid, Blind, and Disabled Population	800-291-8424	<a href="http://blind.ky.gov/Pages/default.aspx">http://blind.ky.gov/Pages/default.aspx</a>
The State Health Insurance Assistance Program	Medicaid, Blind, and Disabled Population	877-293-7447	<a href="http://www.chfs.ky.gov/dail/ship.htm">http://www.chfs.ky.gov/dail/ship.htm</a>
Burley Tobacco Growers	Part-Time Workers	859-252-3561	<a href="http://www.burleytobacco.com/">http://www.burleytobacco.com/</a>
Community Action Kentucky	Part-Time Workers	800-456-3452	<a href="http://www.communityactionky.org/">http://www.communityactionky.org/</a>
The Home Builders Association of KY	Part-Time Workers	800-489-4225	<a href="http://www.hbak.com/">http://www.hbak.com/</a>
The Kentucky Association of Manufacturers	Part-Time Workers	502-352-2485	<a href="http://www.kam.us.com/">http://www.kam.us.com/</a>
Kentucky Cattlemen's Association	Part-Time Workers	859-278-0899	<a href="http://www.kycattle.org/">http://www.kycattle.org/</a>
The Kentucky Horse Council	Part-Time Workers	859-367-0509	<a href="http://www.kentuckyhorse.org/">http://www.kentuckyhorse.org/</a>
The Kentucky Retail Federation	Part-Time Workers	502-875-1444	<a href="http://www.kyretail.com/">http://www.kyretail.com/</a>
The Kentucky Adult Education Division	Part-Time Workers	(see website)	<a href="http://kentucky.gov/education/pages/adulted.aspx">http://kentucky.gov/education/pages/adulted.aspx</a>

Contact Information for Specialized Groups / Services			
The Kentucky Department of Agriculture	Part-Time Workers	502-564-4696	<a href="http://www.kyagr.com/">http://www.kyagr.com/</a>
The Kentucky Office of Employment and Training	Part-Time Workers	502-564-7456	<a href="http://oet.ky.gov/">http://oet.ky.gov/</a>
The Kentucky Chamber of Commerce	Part-Time Workers	502-695-4700	<a href="http://www.kychamber.com/">http://www.kychamber.com/</a>
The Kentucky Adult Education Division	Population Lacking Basic Prose Level Literacy	(see website)	<a href="http://kentucky.gov/education/pages/adulted.aspx">http://kentucky.gov/education/pages/adulted.aspx</a>
The Kentucky Department of Education	Population Lacking Basic Prose Level Literacy	502-564-4770	<a href="http://education.ky.gov/Pages/default.aspx">http://education.ky.gov/Pages/default.aspx</a>
The Kentucky Chamber of Commerce	Population Lacking Basic Prose Level Literacy	502-695-4700	<a href="http://www.kychamber.com/">http://www.kychamber.com/</a>
The Kentucky World Language Association	Households without a Person over the Age of 14 Who Speaks English Well or Very Well	(see website)	<a href="http://kwla.wikispaces.com/">http://kwla.wikispaces.com/</a>
Asociación de Hispanos Unidos-Lexington Hispanic Association (AHU)	Households without a Person over the Age of 14 Who Speaks English Well or Very Well	859-685-2178	<a href="http://www.ahuky.org/">http://www.ahuky.org/</a>

## Appendix J: KCHIP Application Check List

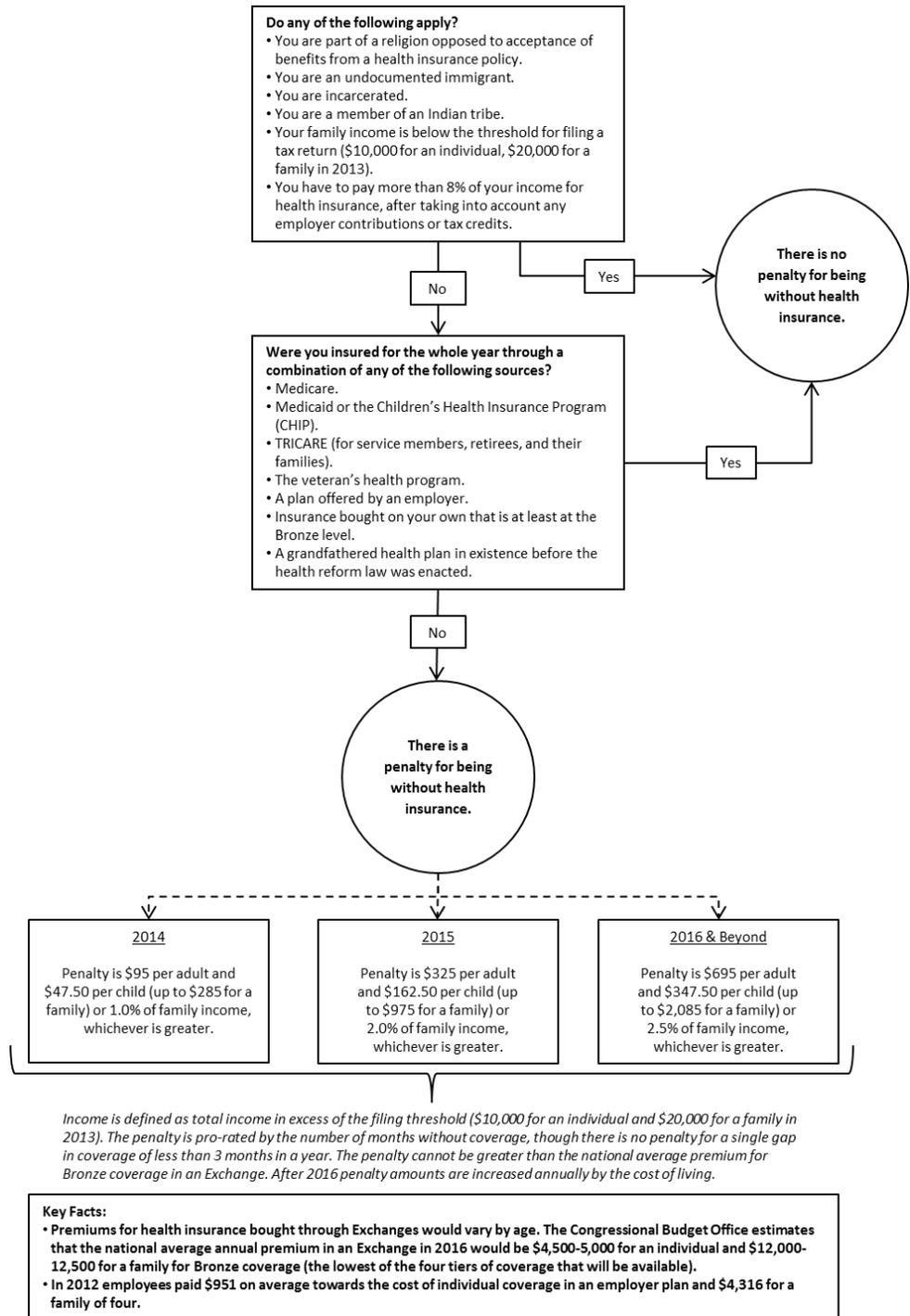
**Individuals will be asked to send proof of documentation for any of the following that apply to their family:**

1. For all applicants, send copies of health insurance cards (front and back).
2. For children born outside Kentucky, send proof of U.S. Citizenship such as a birth certificate, U.S. Passport, or adoption papers.
3. For applicants who are not U.S. citizens, send proof of Permanent Resident Cards (green cards) or other forms from U.S. Citizenship and Immigration Services
4. For all children, send proof of identity. If you are sending a U.S. Passport, a Certificate of Naturalization (DHS Forms N-550 or N-570), or a Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) for items 2 or 3 above, you do not need to send proof of identity. Proof of identity can be:
  - A current state driver's license ;
  - School ID with photo;
  - Military Dependent ID with photo, issued by state, federal or local government;
  - ID issued by state, federal, or local government with photo;
  - School record including report card, day-care, or nursery school record; or
  - Clinic, doctor or hospital record.

If you cannot get any of these documents to prove the identity of children under age 16, an attestation may be signed instead

5. For children and their parents who have earned income, send copies of all pay stubs from the last two (2) months or send a letter from the employer stating the amount that will be paid. If self-employed, send copies of last year's tax return and all schedule attachments. Step-Parents, Grandparents and other non-parent caregivers do not have to send this information.
6. For children and their parents who have unearned income, send proof of gross income (before taxes) for all money that is not from a job like Veteran's Benefits, worker's compensation, and alimony. Proof could be award letters. Step-Parents Grandparents and other non-parent caregivers do not have to send this information.
7. Proof of child care payments such as receipts, statements, etc.
8. Court order and proof of alimony or child support payments. This would include payments being made or received by persons in the home. If it is paid through Child Support Enforcement, you must list as income but do not have to send proof.
9. In some cases, you may be able to get KCHIP/Medicaid coverage for the three (3) months before the application date. If you want to request coverage for the three (3) months before you apply, send proof of income for those months.
10. Please be advised, prior medical bills may not be covered in all situations.

## Appendix K: Helping Individuals Determine if They Need Insurance



**Figure 4: Insurance Determination Flow**

## Appendix L: SHOP Workshop Training Handouts

Included are handouts that were given to Agents and kynectors to use when talking to small business owners about SHOP.

### Special Enrollment, Waiting Periods, and Coverage Effective Dates

#### Overview

As an employer, you want to do what is best for your employees and your business. You may be uncertain about when your employees can sign up for coverage and which life events would make your employees eligible for a Special Enrollment period. This handout will help you understand Special Enrollments, waiting periods, and coverage effective dates.

#### Special Enrollments

To qualify for a Special Enrollment, an employee, a spouse, or a dependent of an employee must have a qualifying event. Though the below list does not include all possible qualifying events, some common examples of SHOP qualifying events are:

- Gaining dependents due to marriage, adoption, or birth
- Moving to Kentucky
- Being hired as a new employee
- Switching from part-time to full-time employment, which means the employee has become newly qualified for employer-sponsored coverage

If an employee becomes eligible for a Special Enrollment, you are encouraged to initiate a Special Enrollment as soon as possible.

#### Special Enrollments and Coverage Effective Dates

The Special Enrollment period may affect an employee's coverage effective dates. The coverage effective date is the date that an employee's health insurance starts for their insurance policy. The coverage effective date generally depends on whether or not the plan is selected before or after the most recent mid-month before the end of the Special Enrollment period.

The following table can help you understand the mid-month rule, also known as the 15<sup>th</sup> of the month rule:

If an employee's enrollment date occurs...	Their coverage begins...
Between the 1 <sup>st</sup> and 15 <sup>th</sup> of the month	On the 1 <sup>st</sup> of the following month
Between the 16 <sup>th</sup> and the end of the month	On the 1 <sup>st</sup> of the <b>second following</b> month

#### New Hire Waiting Period and Enrollment Period

When you applied to SHOP, you selected a waiting period. This is the amount of time that must pass before a new hire or newly qualified employee's coverage is effective. The waiting period and the enrollment period both begin on the day an employee becomes a qualified employee. In kynect, you can choose from **7 different waiting periods** between 0 and 90 days.

- If the waiting period is 45 days or less, the enrollment period is 30 days
- If the waiting period is more than 45 days, the enrollment period is 15 days shorter than the waiting period

<b>Waiting Period (days)</b>	0	15	30	45	60	75	90
<b>Enrollment Period (days)</b>	30	30	30	30	45	60	75

### **New Hire Coverage Effective Dates**

The waiting period may affect an employee's coverage effective dates. The coverage effective date depends on whether or not the plan is selected before or after the most recent mid-month before the end of the enrollment period. Again, the mid-month or 15<sup>th</sup> of the month rule states:

<b>If an employee's enrollment date occurs...</b>	<b>Their coverage begins...</b>
Between the 1 <sup>st</sup> and 15 <sup>th</sup> of the month	On the 1 <sup>st</sup> of the following month
Between the 16 <sup>th</sup> and the end of the month	On the 1 <sup>st</sup> of the <b>second following</b> month

- WHEN a coverage date based on the mid-month rule falls before the end of the waiting period, the coverage effective date would be moved forward to the 1st of the following month, UNLESS
- Doing so results in an employee being unable to obtain coverage within 90 days of being hired.

Employers may find that this scenario is possible with longer waiting periods of 60 to 90 days.

You can find a specific example of how different waiting periods and enrollment periods affect coverage effective dates in the attached appendix of this handout.

**For additional questions or more information,  
visit the [kynect.ky.gov](http://kynect.ky.gov) site, or call the helpline at 1-855-459-6328.**

## Appendix for Special Enrollment, Waiting Periods, and Coverage Effective Dates

Waiting Period	Date of Hire	Enrollment Period	Date of Enrollment	Effective Date of Coverage
0	6/8/2015	6/8/15-7/7/15	6/8/15-6/15/15	7/1/2015
			6/16/15-7/7/15	8/1/2015
0	6/27/2015	6/27/15-7/26/15	6/27/15-7/15/15	8/1/2015
			7/16/15-7/26/15	9/1/2015
15	6/8/2015	6/8/15-7/7/15	6/8/15-6/15/15	7/1/2015
			6/16/15-7/7/15	8/1/2015
15	6/27/2015	6/27/15-7/26/15	6/27/15-7/15/15	8/1/2015
			7/16/15-7/26/15	9/1/2015
30	6/8/2015	6/8/15-7/7/15	6/8/15-6/15/15	8/1/2015
			6/16/15-7/7/15	8/1/2015
30	6/27/2015	6/27/15-7/26/15	6/27/15-7/15/15	8/1/2015
			7/16/15-7/26/15	9/1/2015
45	6/8/2015	6/8/15-7/7/15	6/8/15-6/15/15	8/1/2015
			6/16/15-7/7/15	8/1/2015
45	6/27/2015	6/27/15-7/26/15	6/27/15-7/15/15	9/1/2015
			7/16/15-7/26/15	9/1/2015
60	6/8/2015	6/8/15-7/23/15	6/8/15-7/15/15	9/1/2015
			7/16/15-7/23/15	9/1/2015
60	6/27/2015	6/27/15-8/11/15	6/27/15-7/15/15	9/1/2015
			7/16/15-8/11/15	9/1/2015
75	6/8/2015	6/8/15-8/7/15	6/8/15-7/15/15	9/1/2015
			7/16/15-8/7/15	9/1/2015
75	6/27/2015	6/27/15-8/26/15	6/27/15-8/15/15	9/1/2015
			8/16/15-8/26/15	10/1/2015
90	6/8/2015	6/8/15-8/23/15	6/8/15-8/15/15	9/1/2015
			8/16/15-8/23/15	10/1/2015
90	6/27/2015	6/27/15-9/11/15	6/27/15-8/15/15	9/1/2015
			8/16/15-9/11/15	10/1/2015

### Small Business Tax Credit

#### Overview

As an employer, you want to do what is best for your employees and your business. You may be unsure of the costs associated with providing healthcare to your employees. Small business tax credits can help, and they are one of many benefits to using the Small Business Health Options Program (SHOP).

Small business tax credits are available to employers who meet certain requirements through SHOP on kynect. These tax credits help cover part of the costs of care for your employees.

To qualify for the tax credit, you must:

- Offer coverage to full-time employees through kynect SHOP
- Employ fewer than 25 full-time equivalent (FTE) employees
- Have an average employee salary of \$50,000 (or less) per year
- Pay at least 50% of your full-time employees' premium costs

It is important to note that a full-time employee is an employee that works at least 30 hours per week in a month, and a full-time equivalent employee (FTE) is calculated by adding the hours worked by all part-time employees in a week and dividing by 30. It is also important to note that your wages as the employer are **not** added into the calculation of the average employee salary.

If you meet the above criteria, the tax credit is worth up to 50% of your contribution toward your employees' premium costs and up to 35% of premiums if you are a small non-profit employer. If you have 10 or less FTEs and an average wage of \$25,000 or less, you should qualify for the 50% tax credit.

The last point to keep in mind is that even if you are a small business employer who did not owe tax during the year, you can also carry the credit back or forward to other tax years. However, you can only do this for up to 2 years and it must be 2 years in a row. Matt owns a small landscaping business. He employs 12, full-time equivalent (FTE) employees, who have an annual salary of \$30,000. Matt meets all the tax credit qualifications, and pays \$36,000 in annual premiums.

For his business, Matt is eligible to receive up to an estimated \$15,610 in tax credits.

### **SHOP Calculator**

To see how Matt's tax credit was calculated, and to see how much you might be eligible to receive in tax credits, visit the Healthcare.gov SHOP tax credit calculator at [www.healthcare.gov/shop-calculators-taxcredit/](http://www.healthcare.gov/shop-calculators-taxcredit/). Agents and kynectors can also help you calculate your estimated tax credits.

The SHOP tax credit calculator is a tool that can help you estimate how much you might receive as a tax credit. Using the SHOP calculator is fast and easy and can show you the financial benefits of using SHOP. All you need to do is enter the following information:

- Tax-exempt status
- Number of full-time employees
- Part-time hours entry method
- Total part-time hours
- Total wages paid
- Average wages paid
- Total premiums paid

It is important to note that these tax credits are administered through the Internal Revenue Services (IRS) and not kynect.

**For additional questions or more information, visit the IRS Small Business Health Care Tax Credit site [www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-and-the-SHOP-Marketplace](http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-and-the-SHOP-Marketplace).**

## **Small Business Health Options Program (SHOP) Initial Open Enrollment, Coverage Effective Dates, and Renewals**

### **Overview**

As an employer, you want to do what is best for your employees and your business. You may be unsure of when to sign up, or how the timing for coverage works. The kynect Small Business Health Options Program (SHOP) can help.

kynect SHOP gives small businesses a streamlined way to provide affordable and quality healthcare to employees. Employers make all the important decisions regarding employee coverage, and SHOP helps with the details.

### **SHOP Initial Open Enrollment**

One of the first decisions you make as the employer, is *when* to purchase coverage for your employees. Unlike the Individual Market which has a set Open Enrollment period for individuals

to sign up once a year, SHOP has a rolling enrollment. This means you can sign up at any time during the year and start offering your employees coverage.

You set your initial Open Enrollment period when you first set up your employer SHOP account. Generally, the initial Open Enrollment period begins on the first day of any month and always ends on the 10<sup>th</sup> of any month. However, you can move your Open Enrollment start date up as early as the date of your application. You can also request an extension to make the Open Enrollment period longer and last until the 10<sup>th</sup> of the following month.

### Coverage Effective Dates

The Open Enrollment period you choose impacts the coverage effective dates of your employees. The coverage effective date for an insurance policy is the date the employee's health insurance starts.

For example, let's say you want your employees to have a coverage effective date of December 1<sup>st</sup>, 2015. In this case, you would need to apply to SHOP and complete enrollment setup by October 31<sup>st</sup> at the latest. Once you apply, you would then set your Open Enrollment to begin on November 1<sup>st</sup> and end on November 10<sup>th</sup>.

The chart below shows the coverage effective dates that result from different Open Enrollment periods:

Coverage Effective Date	Must Submit Application By	Open Enrollment Start Date	Open Enrollment Ends
January 1	November 30 (of the previous year)	December 1 (of the previous year)	December 10 (of the previous year)
February 1	December 31 (of the previous year)	January 1	January 10
March 1	January 31	February 1	February 10
April 1	February 28	March 1	March 10
May 1	March 31	April 1	April 10
June 1	April 30	May 1	May 10
July 1	May 31	June 1	June 10
August 1	June 30	July 1	July 10
September 1	July 31	August 1	August 10
October 1	August 31	September 1	September 10
November 1	September 30	October 1	October 10
December 1	October 31	November 1	November 10

### Renewals

Every year employers participate in a renewal process for SHOP coverage. The exact renewal period depends on when you initially enrolled in coverage. The process begins 3 months prior to coverage ending. During this time, known as the Employer **Annual Election Period**, you have **30 days to actively review and renew** the plan options for your employees. You can make changes to plan offerings, contribution rates, the waiting period, and offerings to employee spouses and dependents

After the Annual Election period, the **Annual Open Enrollment** period begins and employees have at least 30 days to make their coverage selection. If the same plan that they had the previous year is available, employees can be **passively (automatically) renewed** into that plan. If they do not want the same plan, employees can cancel their coverage or choose a different plan.

Below is an example renewal timeline:

Current Coverage Effective Date	Annual Election Period		Annual Open Enrollment Period		Renewal Coverage Effective Date
1/1/2015	10/01/2015	10/31/2015	11/01/2015	12/10/2015	01/01/2016

For additional questions or more information, visit the [kynect.ky.gov](http://kynect.ky.gov) site or call 1-855-459-6328.

## **Small Business Health Options Program (SHOP) 101**

### **Overview**

As an employer, you want to do what is best for your employees and your business. You may be unsure of what options are available for you to offer to your employees, or the costs associated with it. The kynect Small Business Health Options Program (SHOP) can help.

kynect SHOP gives small businesses a streamlined way to provide affordable and quality healthcare to employees. Employers with 50 or fewer employees can use kynect to compare a variety of qualified health plans from private insurance companies and decide what to offer. As the employer, you make all the decisions regarding employee coverage.

To help you with this decision, all health plans are classified into one of four metal categories. The categories, listed from least valuable metal to most valuable metal are: Bronze, Silver, Gold and Platinum. As the metal level increases in value, so does the percentage of medical expenses that a plan will cover. This means that the platinum level plan will cover the highest portion of medical costs at the time an employee goes to receive care. It will also have the highest premium cost.

### **SHOP Benefits**

Employer-sponsored health insurance is valuable for many reasons. Many small businesses already offer health coverage. These employers understand that their employees are healthier, happier, and more productive. Not only does offering health insurance help to retain employees, it can help you recruit employees. Using SHOP is also a good business decision because of the tax credits you may be eligible to receive if you have 25 or fewer FTE employees.

kynect makes it easy for you to enjoy these benefits and for you to manage everything. You make the big decisions and kynect helps with the details and billing. With SHOP, you have:

- **Easy comparisons.** kynect lets you easily compare different health plans offered by private insurers.
- **Employer choice.** You decide whether and when to participate in SHOP. You can set the enrollment period, which is the time your employees have to review your coverage options and choose a plan.
- **Employer control.** All decisions are completely yours. You choose the level of coverage, the amount of your contribution toward your employees' coverage, and any amount you may want to contribute to family or dependent care.
- **Expanded choices.** kynect gives you and your employees access to more plans.
- **No unexpected costs.** Your costs remain the same no matter which plans your employees choose because you can control the amount of your contribution. This makes it easy for you to control your budget.
- **Simple administration.** With kynect, you get one monthly bill. You can also continue working with your current, kynect-registered Insurance Agent. If you are not already working with one, kynect can help you find an Insurance Agent or provide other **assistance to you at no cost.**

- **Small Business Tax Credits.** If you are an employer with 25 or fewer FTE employees, you may be eligible to receive tax credits to help with providing coverage to your employees. Ask the licensed Insurance Agent or kynector that you are working with to give you the **Small Business Tax Credit Handout sheet** for more information.

### **Requirements**

In order to participate in SHOP, employers must:

- Have a valid federal employer identification number (FEIN)
- Have a primary business address or worksite in Kentucky
- Have at least one common law employee enrolled in SHOP
- Offer all full-time employees coverage
- Have 50 or fewer full-time employees
- Contribute at least 50% to their employee's medical coverage
- 75% participation rate of employees in coverage

**For additional questions or more information, call the helpline at 1-855-459-6328, or visit the [kynect.ky.gov](http://kynect.ky.gov) site to find an Agent or kynector who can help enroll you in SHOP.**

### **Enhancements to kynect SHOP**

As of August 2015, kynect SHOP has been updated with many exciting changes that make it easier for you, the employer, to manage your employees and the coverage you offer to them. With these enhancements, kynect gives you back more time to focus on your business.

#### **Stand Alone Dental Plans (SADPs)**

Employers now have more control over the coverage options to provide to employees. Previously, you were required to select at least one medical plan and one Stand Alone Dental Plan (SADP) to offer to your employees. Now, employers can choose to offer only a medical plan with embedded dental, or they can offer only a dental plan without offering a medical plan.

Employees also have greater flexibility and can choose to enroll in a SADP without enrolling in a medical plan.

#### **Employee Roster**

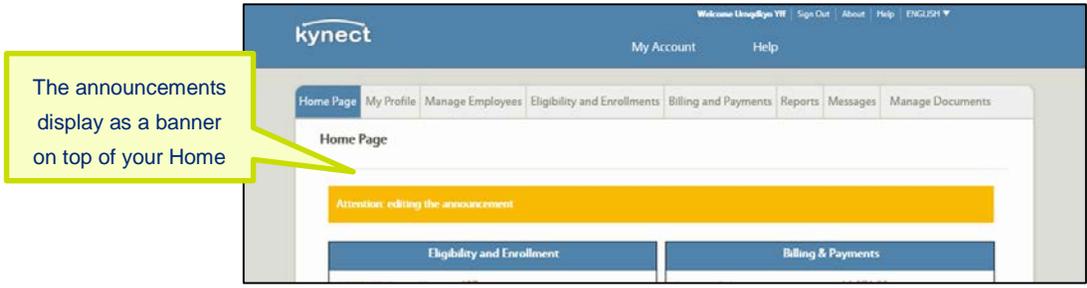
Uploading the roster is now much easier because any and all errors that occur when uploading the roster are automatically highlighted, notifying you of missing or incorrect information.

This is a huge timesaving benefit for employers. It makes it easy for you to see missing or incorrect information and for you to make the appropriate changes. Employers now have greater control and employee management is much easier.

Employers should also remember that kynect-trained and certified Agents and kynectors can help with SHOP enrollments and manage the employee roster at no additional cost to you.

#### **Announcements**

There is also a new announcement feature that displays on your dashboard page. These announcements come directly from the Kentucky Office of Health Benefit and Information Exchange (KOHBIE). KOHBIE uses this feature to communicate important information relevant to you.



The announcements display as a banner on top of your Home

**SHOP is now available in Spanish**

This feature allows employers, Agents, and kynectors to view kynect in English or Spanish. There is a dropdown menu in the upper right-hand corner of the kynect home page where you can select kynect text to display in English or Spanish.



You can use this dropdown menu to select a language

**Billing & Payments: Auto Pay Account Setup**

**Overview**

If you are a small business employer, you may find that you have a lot to manage. Remembering to pay the bill each month for your employees’ healthcare coverage should not be one of them. As part of the kynect Small Business Health Options Program (SHOP), Auto Pay is an automatic way to pay for your monthly healthcare billing. It is easy to set up and easy to use. With Auto Pay, you can focus on the most important task of running your business and looking after your employees.

A few important notes about Auto Pay:

- You must have an online SHOP account to set up Auto Pay
- You can only set up Auto Pay if there is a balance due to your account
- The first payment to Auto Pay is your entire outstanding balance. This may be more than your monthly premium amount if you have missed a payment, did not pay an invoice in full, or have adjustments on your invoice
- Auto Pay deducts your monthly premium, including any adjustments, on the 18<sup>th</sup> of every month

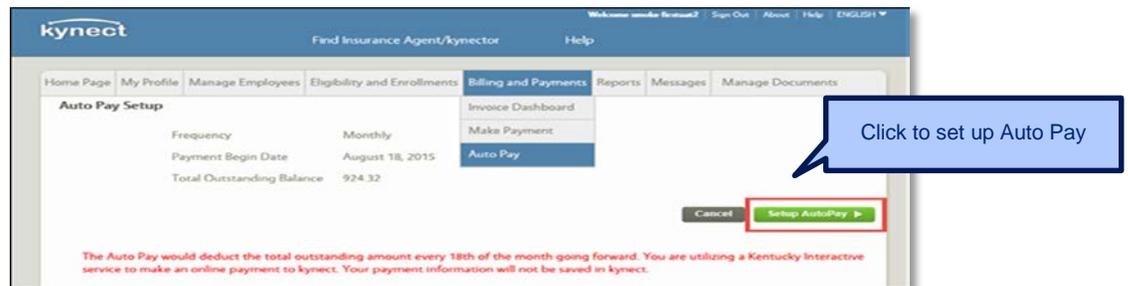
**Auto Pay Setup**

Follow the steps below to setup your Auto Pay account.

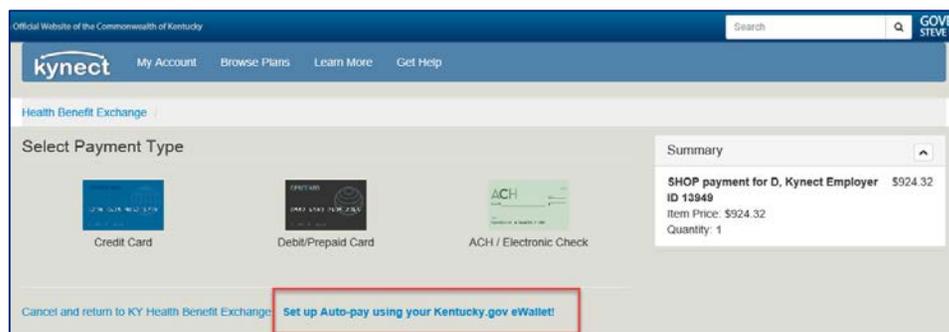
1. Using your **Kentucky Online Gateway (KOG)** credentials, log into SHOP through **kynect.ky.gov**



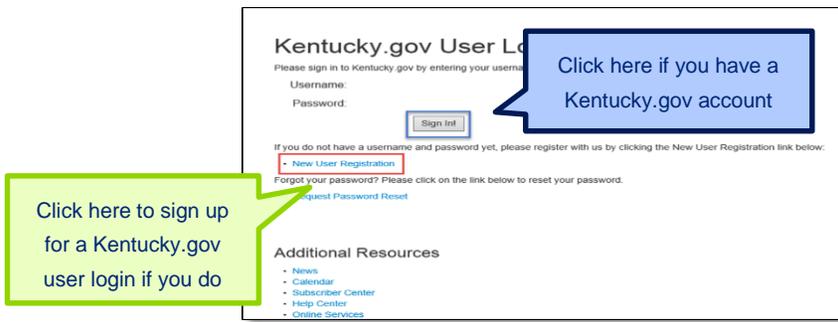
2. Select **Auto Pay** from the **Billing and Payments** tab dropdown. To begin the setup process, click **Setup Auto Pay** in the bottom right corner. A pop up will appear. Click **Yes** to confirm that you want to continue to setup Auto Pay. You will be directed out of kynect to the Kentucky Interactive service. Please note: **kynect does not save payment information.**



3. Click on the **Set up Auto-pay using your Kentucky.gov eWallet!** link at the bottom of the page.



4. After clicking the link in step 3, you land on the Kentucky.gov website. If you have a Kentucky.gov account, click **Sign In!** If you do not have an account, click **New User Registration.** **Note:** the Kentucky.gov account is different from your KOG account.



5. After you have registered and signed in with Kentucky.gov, you return to the **Select Payment Type** screen. From here, you can select which type of payment you wish to use (**Credit Card**, **Debit Card**, or **ACH/Electronic Check**) and then enter your payment information. If you want to save your billing information for future transactions, you must mark the **Save to my eWallet** checkbox.

The screenshot shows the 'Select Payment Type' screen. At the top, there are three tabs: 'Credit Card', 'Debit/Prepaid Card', and 'ACH / Electronic Check'. The 'Credit Card' tab is selected. Below the tabs, there are fields for 'Card Number', 'Expiration Date', and 'Security Code'. Below these fields, there are logos for Discover, Mastercard, and Visa. Below the logos, there are fields for 'Cardholder Details' including 'Name', 'Country', 'Address Line 1', 'Address Line 2', 'City', 'State', and 'Zip Code'. At the bottom, there is a checkbox labeled 'Save to my eWallet' with the text 'What does this mean?' below it. A 'Next' button is located at the bottom left. On the right side, there is a 'Summary' section with a table showing the payment details.

Summary	
SHOP payment for D. Kynect Employer	\$924.32
ID: 13648	
Item Price:	\$924.32
Quantity:	1
Sub Total	\$924.32
Surcharge	\$25.42
<b>Total</b>	<b>\$949.74</b>