Webinar Transcript
February 13, 2024

The Basics of Medicare Eligibility for Ryan White HIV/AIDS Program (RWHAP) Clients

Molly Tasso: Hi folks. Thanks for joining us this afternoon. We are going to give folks maybe one more minute to join, and then we are going to go ahead and get started.

All right. I see the number of folks starting to slow down joining us, so I think we're going to go ahead and get started. Good afternoon everyone. Thank you so much for joining us today for part one of the ACE TA Center's three-part series on Medicare and Medicare and Medicaid dual eligibility. My name is Molly Tasso, I'm a senior consultant at JSI, and I'm the project director of the ACE TA Center, and I'm thrilled to have all of you with us today. So to get us started, I'm just going to share a few tech and logistical details, and then I'll hand it over to our fantastic presenters to get us going on today's content.

So first, on the next slide, attendees are in listen-only mode, but we do encourage you to ask lots of questions using the chat box, so you can submit your questions at any time during the presentation. And then we have a good chunk of time set aside at the end to do a Q&A and we'll take as many questions as we can. You can also always email us questions if something pops up later for you or after webinar ends. Our email is acetacenter@jsi.com. If you have any problems hearing us or if you're experiencing a sound delay, try exiting and reentering the webinar, or you can go ahead and mute your computer audio and call in using your telephone. And the call in number as well as the webinar ID and password are there on the screen, and we'll also chat it out for you to have it handy.

So some of you may be familiar with the ACE TA Center, but for those of you who may be new, welcome. The ACE TA Center is a HRSA funded technical assistance center that helps build the capacity of the Ryan White community, to navigate the changing healthcare landscape, and help people with HIV access, and use their health coverage to ultimately improve health outcomes. So as a TA Center, we support Ryan White recipients and subrecipients to engage, enroll, and retain clients in Medicare, Medicaid, and individual health insurance options, build organizational health insurance literacy, thereby improving clients' capacity to use the healthcare system, and also communicate with clients about how to stay enrolled and how to use health coverage. And we do this by developing and disseminating best practices and supporting resources, and by providing TA and training through national and local activities. Our audiences include Ryan White program staff, clients, program managers, and administrators, and also people who help enroll Ryan White clients into health coverage such as navigators and certified application counselors.

And all of our TA resources, including today's archived webinar, can be found on targethiv.org/ace, and you can see it there on the slide. In addition to the webinar recording, our website houses all of the tools and resources that we are going to discuss and share today so you can always head to our website and find anything there. We'll also be sending, all participants for today's webinar, will be receiving an email when the webinar is posted on our website so then you can go ahead and share it with your colleagues as well.

So as I mentioned, today's webinar is the first in a three-part series. Today, we'll be presenting on the basics of Medicare eligibility, and then in a few weeks on February 27th, we'll be covering Medicare enrollment. And then on March 12th, we'll be presenting the basics of Medicare and Medicaid dual eligibility. You can register for the next two webinars on our website, and we'll also chat out the registration links now, and so you can go ahead and get those on your calendars.

So today, we are going to start. This is just sort of a roadmap for today's presentation. So we are going to start by discussing the changing demographics of Ryan White clients, Medicare eligibility for people with HIV, and then move into the different parts of Medicare including Medicare prescription drug coverage for people with HIV, as well as then the common enrollment pathways. Throughout the presentation and towards the end, we'll be highlighting relevant resources that our TA Center has for you all, and then we'll wrap up again with the Q&A.

So I'm pleased today to be joined by two of my colleagues, Christine and Liesl. Christine is the research and policy associate for the ACE TA Center. She specializes in mixed methods research, health policy analysis, GIS and data visualization, and materials development for Ryan White recipients, clients and a variety of other audiences. And Liesl is the ACE TA Center senior technical advisor, and has been part of the ACE leadership team since 2016. She has extensive experience providing technical assistance to build the capacity of the Ryan White workforce to help clients navigate the healthcare environment and stay engaged in care.

So with that, before we launch into it, we have a quick poll. So we are curious for you all to tell us what are the top challenges that your organization faces related to Medicare enrollment and coverage. And you can go ahead and click any and all that apply. We'll get that popped up here. There you go. So, determining whether clients are eligible for Medicare, assisting clients with deciding when to enroll, figuring out who's eligible for both Medicare and

Medicaid and dual eligibility, helping client transition to Medicare, understanding what Medicare covers, the differences between the different parts of Medicare. And then if there's anything that your organization is challenged with and assign on this list, please do chat it in, and we will read some of those as well. All right. We've got folks answering.

All right. We'll give a few more moments here. I'm also going to check the chat. I see a question. Is this being recorded? Yes, the webinar is being recorded, and we'll send out a copy of the recording once we are finished. All right. Let's go ahead and we can close the poll. Okay. So it looks like... Let's see here. So 52% of folks said assisting clients who are eligible for both Medicare and Medicaid. Yes, of course a tough topic can be complex, so that's the dual eligibility piece. So really strongly encourage anybody who checked that to please do register for the March 12th webinar on dual eligibility. Also, other challenges determining whether clients are eligible for Medicare, understanding what Medicare covers, and helping clients transition to Medicare from other types of coverage. I also see in the chat just enrolling clients from Advantage plans when they sign up for them not understanding what they are.

Yeah, that's real tricky. Trying to determine how ADAP can pay Medicare premiums. We know that's a sort of longstanding challenge. And assisting with referring Medicare and Medicaid patients to other specialties. Medicare exclusion policy for people for incarcerated individuals is a barrier. Absolutely. Awesome. Well, thank you so much. All of these were also anything, keep chatting them in if anything comes to your mind throughout the webinar and we'll be recording those for our own knowledge too. All right. So with that, I'm going to hand it over to Liesl to talk with us about the changing demographics of Ryan White clients.

Liesl Lu: Great. Thanks, Molly. So yeah, let's begin with an overview. So, as many of you know, Medicare is the second-largest source of federal funding for HIV/AIDS care in the United States, and that's behind Medicaid, which is number one. Over a quarter or 28% of people with HIV who are in care get their health coverage through Medicare. And historically, most Medicare beneficiaries living with HIV have been under age 65 and qualified for Medicare because of a disability. However, we know that now there are more older adults living with HIV and served by the Ryan White program than ever before. And in 2021, just over 48% of Ryan White clients were aged 50 years and older, and we've heard that this number is projected to rise to about two-thirds of all Ryan White clients by 2030.

So taking a little bit of a closer look at the data here, you can see the change in the age distribution of Ryan White program clients is shifting towards the right as people living with HIV are living longer and healthier lives. So the chart on the left shows data from 2010, and the chart on the right shows data from 2021. And these numbers include clients in all 50 states and the three territories, Guam, Puerto Rico, and the US Virgin Islands. So specifically looking at the blue and green bars in each of the charts, they're in the middle of each graph. You can see that the percentage of Ryan White program clients ages 35 to 54 decreased over time from 2010 to 2021. So the combined proportion of people in these two age groups decrease from nearly 60% in 2010 to about 42% in 2021.

And then next, let's look further over in each of the graphs to the orange and the yellow bars. So which represent all of Ryan White program clients age 55 and older. So in 2010, just under 17% of Ryan White program clients were 55 years and older. And in 2021, this had increased to over 35%, which is about one in every three clients. So, as we've just mentioned, the proportion of clients age 50 and older is expected to increase in the next decade or so. So this would be to about two in every three clients.

So now let's take a look at the characteristics of people with HIV who are enrolled in the Medicare program. So remember that not all of these people are Ryan White program clients. For this data that we're looking at here, this comes from Kaiser. And also there are lots of people that have been part of the Medicare program for many years for reasons other than age. So the chart on the top shows how current Medicare beneficiaries with HIV first became eligible for Medicare. And so, 61% of Medicare beneficiaries with HIV are under age 65 and qualified due to a disability. And it's interesting to note that this is very different from the general population where only 13% of Medicare beneficiaries qualify based on disability.

The other 39% of Medicare beneficiaries with HIV qualified based on age alone, and this percentage has grown since 2016 when it was only 21% of beneficiaries with HIV who qualified just on age alone. And then moving to the bottom chart, it shows that 61% of Medicare enrollees with HIV are actually dually eligible for both Medicare and Medicaid compared to just 18% of Medicare beneficiaries overall. So hopefully that just gives you a sense of the data and where things lie in terms of people with HIV and Ryan White clients who are aging.

So now let's talk about how people with HIV typically become eligible for Medicare, which I know was one of the top three challenges in the poll that you

all just answered. So to be eligible to enroll in Medicare, an individual must be a U.S. citizen or a legal resident for at least five years with some exceptions. And there are three primary pathways that people with HIV can qualify for Medicare. So being at least 65 years old, being under 65 with a qualifying disability, or having end stage renal disease or ALS at any age. And CMS has a calculator that you can use when working with clients to determine their eligibility. And we'll chat that out right now. And this presentation is mostly going to focus on the first two eligibility pathways, so age and disability.

So certain people under the age of 65 are eligible for Medicare if they have a medical condition that meets the Social Security requirements for disability insurance, also known as SSDI, and they have worked in jobs where they've paid taxes towards Social Security. After a person has received SSDI payments for at least 24 months, it doesn't have to be 24 consecutive months, but 24 total months, they're automatically eligible for Medicare Parts A and B.

And generally to qualify for SSDI, Social Security requires that a person's disability be severe enough to prevent them from doing any sort of substantial gainful employment for at least a year or more. And while HIV is one of the medical conditions that Social Security considers for disability, HIV status alone generally does not qualify someone for SSDI, but people with HIV may qualify when they have either a serious related condition, a qualifying CD4 count, repeated hospitalizations, or repeated manifestations of HIV that result in functional limitations. So just to recap all of that, a person with HIV who does not qualify for SSDI under the HIV rules can still qualify for Medicare coverage by meeting the medical requirements for another physical or mental health condition. And we'll chat out a link that has more information on those disability rules, or it's already been sent out.

So let's move on to the next poll. So, what is the most common reason why your clients at your organization are becoming eligible for Medicare? And you can select one of these. So, is it turning age 65 and aging into Medicare, those who are under 65 with a qualifying disability, or another way that they're becoming eligible? So just give you a couple more moments to respond. But it looks like about 63% of you report that the most common reason is folks who are aging into Medicare, about 35% are folks that are qualifying due to a disability. And then a few of the folks who chatted in one person noted that individual was under a income limits, I'm assuming. So thanks for responding to that. So next, we're going to move on to the Medicare parts, and I will hand it over to Christine.

Christine Luong: Thanks, Liesl. Hi everyone. Yep. So we are going to talk about the different parts of Medicare, what they are, and what they cover. And we're also going to do a comparison of Original Medicare and Medicare Advantage. So I want to start with the Medicare parts. You all may be familiar with this. There are three parts to Medicare, A, B, and D. So let's start with Medicare Part A, which is hospital coverage. This will cover inpatient hospital care, skilled nursing facility care, hospice care, and home healthcare among other things. And most people will qualify for Medicare Part A coverage without having to pay a premium for that coverage. And this is known as premium-free Part A. And this will happen if they work in a job that pays towards Social Security taxes, and when they accumulate 40 Social Security work credits by the time they turn 65.

So if you're not familiar with work credits, basically 40 work credits is equal to approximately 10 years of total work history. So you can earn one work credit per quarter, and up to four credits per year. We'll chat out a link with more information about what Part A covers.

And then moving on to Part B. So Medicare Part B is medical coverage, and that includes services from doctors and other healthcare providers, it includes some preventive services, it includes outpatient care, physician administered medications, home healthcare, and durable medical equipment. And also new this year in 2024, chronic pain management and treatment services, lymphedema compression treatments, outpatient mental health care, and also at-home telehealth services are now covered by Medicare Part B. And we will also chat out a link, a resource that explains what Part B covers.

And then lastly Medicare Part D. This includes coverage for outpatient prescription drugs, which does include all HIV antiretroviral medications. So this isn't new for 2024, but we do want to remind you all don't forget, insulin is now available without a deductible for just $35 a month. And also vaccines that are recommended by the Advisory Committee on Immunization Practices are also available without cost-sharing. So these include vaccines for COVID-19, hepatitis A and B, HPV, RSV, etc. And we'll also chat out a link to what Medicare Part D covers.

Okay. So I've just gone over the three parts, each of which cover different types of services. Now, there are two different ways that someone can get Medicare coverage, either through Original Medicare or through Medicare Advantage. So I'm going to start us off with Original Medicare. You all may have heard of this as traditional Medicare, so those terms are interchangeable. Original Medicare is administered by the federal government by the Social Security Administration

specifically, and it includes Medicare Part A hospital coverage, and Medicare Part B medical coverage. It's important to note that you can have either just Part A or just Part B, or you can have both to be considered an Original Medicare beneficiary. And Original Medicare does not include prescription drug coverage or Part B. So if your client wants to purchase prescription drug coverage, they have to do that separately. And we will explain how that works in a few minutes.

So let's start off with some of the pros of Original Medicare. So, one of the biggest pros is that Original Medicare has a very extensive nationwide network. That means that you can see any doctor, provider, hospital or facility across the U.S. that accepts Medicare. If you have Original Medicare, you do not need to choose a primary care provider or a PCP, and you also generally do not need a referral to see a specialist. And so for these reasons, Original Medicare might be considered a good option for people who value having that provider choice and that flexibility.

Now, on the other hand, Original Medicare does have a lot of hidden out-of-pocket costs, so we'll talk about that. So, most of us here should be familiar with deductibles, we are familiar with these as an annual amount that you have to contribute before your insurance starts to kick in. So for Medicare Part A, the deductible period resets every 90 days, which means you could face that deductible up to four times a year. And in 2024, the Part A deductible is $1,632. So let's say you do meet this deductible, you could still face additional charges for things like hospitalizations, skilled nursing care, and blood products depending on how many days you're admitted to inpatient care. And then if you have Medicare Part B, that deductible is based on an annual benefit period, which most folks are more familiar with. In 2024, the Part B deductible is $240.

However, there is a 20% coinsurance per service after you make that deductible. So just to put that into perspective a little bit. So take for example, let's say you are working with a client with HIV who's aging, and you finds themselves in need of more healthcare services over time. So for example, this client, they might be admitted into the hospital for two weeks for an inpatient stay, they might need home healthcare for a few weeks after they're discharged from the hospital, they might need medical equipment, they might need to follow up with their primary care provider or with a specialist or two for a few months, they might need some labs and outpatient services. And then of course, they're going to meet their regular HIV care and medication. So all of that is going to add up. So if you think about the client having to make the Part A and the Part B deductible amounts, those extra costs for skilled nursing care, medical

equipment, those copays and the coinsurance per service afterwards, all of that can really add up over time. So just to put that into some perspectives.

So if you have Original Medicare, again, either just Part A or just Part B or both, you can choose to purchase and add on a separate Medicare Part D prescription drug plan. All Medicare prescription drug plans must provide a standard level of coverage that's set by Medicare, but they may offer different combinations, coverage and cost-sharing. So these plans might differ in terms of the prescription drugs they cover, how much individuals have to pay for that coverage, and which pharmacies they can use. But rest assured, all Medicare prescription drug plans are required to cover all or nearly all drugs in six protected drug classes. One of those being antiretroviral treatments for HIV. HIV drugs specifically are required to be covered without any utilization management techniques such as prior authorizations or step therapy. But for non-HIV drugs, Medicare Part D plans can have some restrictions including medication not being on the formulary and quantity limit issues. But providers can generally work with the insurance carrier to request a prior authorization or an exception that overrides some of these restrictions.

So again, as I mentioned earlier, Original Medicare enrollees only need to have Medicare Part A or Part B at minimum to purchase a Part D plan. But we do encourage clients to enroll in both Part A and Part B when they first become eligible, unless they have coverage that allows them to defer that enrollment without incurrent a penalty. And we will talk more about penalties during part two in two weeks, so please join us. Another consideration is that Part D premiums can be expensive. So, it's important to work with your clients to see if they're eligible for the federal Extra Help program, which can help people with limited income and resources to pay for some or all of their Medicare prescription drug costs like premiums, deductibles, and coinsurance. And for those who are not eligible for the Extra Help program, they will be responsible for paying a monthly premium for their Part D coverage, but most if not all ADAP programs across the country can pay this premium for their clients who are active in their program.

Okay. So shifting gears a little bit. So you all may have heard about what's called the Medicare donut hole for prescription drug coverage. This is in reference to the coverage gap that happens when individuals have to temporarily pay a little bit more out-of-pocket for their prescription drugs after their plan has contributed a certain amount. And I will emphasize here that this donut hole is only applicable for folks who have Original Medicare and a standalone Part D drug plan. So I'll give a quick overview of how this works. So Part D coverage

works in four phases. And you'll see this in the graphic. So in the deductible phase, you pay full price for your prescription drugs until you reach a specific deductible amount. In 2024, this amount is $545.

Once you've paid that, you move on to the initial coverage period, and that's when you in your plan continue paying towards prescription drug costs until you reach an amount that's called the initial coverage limit. In 2024 this year, the initial coverage limit is $5,030. Once you've reached that number, that's when you enter the donut hole. So in the donut hole, you are responsible for paying a bit more for your medication. So 25% for both brand name and generic drugs until you meet the limit for true out-of-pocket Costs, which we refer to as TrOOP. In 2024, the TrOOP limit is $8,000. Important to note here, ADAP expenditures for clients with Medicare Part D coverage will count towards their TrOOP limit. So this is going to help their clients reach the next level faster, so they'll move out of the donut hole faster. So definitely check with your local ADAP about how they can help clients pay for drug coverage while they're in the donut hole or the coverage path.

So once you've reached the TrOOP amount, that's when you move out of the donut hole, and you move into the last phase, which is called the catastrophic coverage period. And new this year in 2024, when you are in this catastrophic coverage period, you pay zero copayments and coinsurance for the rest of the plan year. This used to be 5% instead of zero. And I know 5% might seem like a very small amount, but when you take into consideration that some medications can cost several thousand dollars per fill, that 5% is really going to add up. And we're going to chat out a link to an article that includes a breakdown of how much Biktarvy would cost out-of-pocket before and after this change. So this change really is a great development, and we're excited to see even more changes coming in 2025. So after moving all of these four phases, your Part D plan is going to reset again the following year. And just a quick note that these dollar amounts that we have in the graphic, these change every year, but this slide is updated with this year's numbers.

Okay. So now let's talk about Medicare supplemental insurance or Medigap policies. Reminder again, this is still applicable only for folks who have Original Medicare. So while Original Medicare pays for most of the coverage services and supplies, Medigap policies can help to cover some of the gaps in Part A and B coverage such as the copays and the deductibles that I was talking about earlier. So in terms of the basics, Medigap policies are sold by private companies. They are standardized by state and federal law and they have to clearly be identified to consumers as Medicare supplemental insurance. So

again, a client has to have Original Medicare in order to enroll in a Medigap policy. And these policies do not cover costs for Part D prescription drug coverage such as copays, coinsurance, deductibles, that is separate like I said earlier.

Medigap beneficiaries, if they choose to enroll in a Medigap plan, they'll have to pay a monthly premium that determines exactly what their out-of-pocket costs will be, if any, and ADAP may be able to help pay this premium amount. In general, the more expensive the Medigap plan, the greater the benefits. But Medigap policies still generally will not cover extra benefits like long-term care, and vision, and dental care. But despite these limitations, someone with Original Medicare might still want to add on a Medigap plan, might still be a good option for those with more complex medical needs, those who travel during the year, and those who anticipate needing to see a provider outside of the country. And you can always help your clients shop for and compare Medigap plans by visiting medicare.gov and using their Medigap plan to find their tool. We will also chat out a link to a page that just has some of the basics of Medigap if you're unfamiliar with it.

Okay. So shifting gears now. I'm going to talk about Medicare Advantage. So Medicare Advantage is also known as Medicare Part C, those terms are also interchangeable. Unlike Original Medicare, Medicare Advantage plans are administered by private insurance companies that contracts with the federal government. And these are basically a single plan that bundles together Part A hospital coverage, Part B medical coverage, and more often than not also Part D prescription drug coverage, all into one plan. So again, important to note, Medicare Advantage plans have pros and cons, just like any other plan, and they might not be right for everyone. So I'll try to outline some of the pros here. Number one, Medicare Advantage plans may or may not have a low monthly premium that you have to pay on top of the Medicare Part B premium, but Ryan White and ADAP may be able to help pay this.

In addition to bundling hospital medical and prescription drug coverage, Medicare Advantage plans may also offer some of those extra benefits that Original Medicare doesn't. So this could include vision, dental, hearing, and even wellness programs like gym memberships. And in general, we've seen that a lot of Medicare Advantage plans are starting to offer more extra benefits than they have in the past, including things like transportation to doctors' visits, for example. Medicare Advantage plans can also have lower out-of-pocket costs for some services compared to Original Medicare. And so in some cases, Medicare Advantage can be considered a better option than Original Medicare for those

with less complex medical needs and clients who wouldn't need to see a provider when traveling out of state.

Now on the flip side, we'll talk about cons now. So Medicare Advantage plans are generally either an HMO plan or a PPO plan, which means they have a specific network of preferred providers. And these networks are going to vary widely from state to state, and so it might be difficult for your client to find an Advantage plan that's accepted by all of their providers. And if they decide to see a provider that's outside of that plan's network, they could see higher out-of-pocket costs, especially so for inpatient care. And so that's why Medicare Advantage plans are not always the best choice for people with HIV because of those more limited provider networks. Clients may also need to get some services approved ahead of time or get a referral to see a specialist. Medicare Advantage plans are also allowed to implement step therapy to manage drug coverage. And in general plan design and plan availability is going to vary really depending on where your client lives, so we do encourage you to take the time to work with your clients to review what's available in their area.

Okay, so I've talked a lot. Let's quickly recap what I've covered so far. So let's start with Original Medicare on the left side of this table here. So Original Medicare, this includes Part A hospital coverage and Part B medical coverage. You can add on Medigap supplemental coverage, and you can add on Part D prescription drug coverage. Original Medicare is administered by the federal government, has an extensive nationwide network, but there may be more cost considerations in terms of deductibles. And then looking at Medicare Advantage on the right side of the table, so Medicare Advantage is one single plan that bundles Part A hospital coverage, Part B medical coverage, and very often also Part D prescription drug coverage. They may or may not have a low monthly premium, but they do have lower out-of-pocket costs for Part A and B covered services. They offer extra benefits that Original Medicare does not, and they are administered by private insurance companies, which means that plan availability and plan coverage varies depending on where you live.

And so when you're comparing Original Medicare and Medicare Advantage, really work with your client to determine which option is the best fit for them based on, number one, what plans are available in their area, and number two, based on their unique healthcare needs. You can shop and compare Original Medicare and Medicare Advantage plans at medicare.gov. And lastly, keep in mind that the Ryan White HIV/AIDS program, including ADAP, can help pay in full or in part for Medicare and/or Medigap premiums, deductibles and

copayments. So really important to check in with your local ADAP to see how they can help with costs because this varies from state to state.

So let's do a quick knowledge check. We can answer the question as it pops up on your screen. Which of the following is true about Medicare Part D prescription drug coverage? It can be purchased separately to add on to Original Medicare, it can be part of a bundled Medicare advantage plan, there is a Part D coverage gap with Original Medicare, or all of the above. So let's give folks a little bit more time to answer which of the following is true about Medicare Part D prescription drug coverage. Okay. I think we can end the poll and see what you all responded. Awesome. So 87% of you said D, all of the above, which is the correct answer. Part D prescription drug coverage, yes, can be purchased separately as an add-on to Original Medicare, yes, it can be part of a single bundled Medicare advantage plan, and there is a coverage gap to be aware of. Awesome. And so now I will pass it back to Liesl to talk about Medicare enrollment. Thank you.

Liesl Lu: Great. Thanks, Christine. So we've talked about what Medicare covers, and now let's move on to the Medicare enrollment pathways. So there are four primary pathways that a client can enroll in Original Medicare or a Medicare Advantage plan based on their age and specific life circumstances. So first, if they receive Social Security Disability Insurance or SSDI or Social Security retirement benefits before the age of 65, they will be automatically enrolled in Medicare Parts A and B when they become eligible for Medicare at age 65. So their Medicare card will come in the mail three months before their 65th birthday, and the earliest that they can start receiving Social Security retirement benefits is age 62. The second option is to enroll through the Initial Enrollment Period. So if a client is about to turn 65 but has not yet started to receive Social Security retirement benefits, they can enroll in Medicare during their Initial Enrollment Period.

And I'm going to talk about this one and the others in more detail in a few minutes. And then the next is there are a number of Special Enrollment Periods that we are going to talk about that allow folks to enroll outside of an IEP or GEP when they're experiencing specific life events such as moving, losing, or changing their health coverage. And finally, there's the General Enrollment Period if a client has missed the Initial Enrollment Period and they don't qualify for an SEP. So let's now take a closer look at the IEP, SEP and GEP in more detail. So the Medicare Initial Enrollment Period or IEP is a seven-month period centered around the month of a person's 65th birthday. And sometimes you'll hear this have people call the IEP the 313 period because it starts three months

before the 65th birthday, it includes the month that the person turns 65, and it ends three months after they turn 65.

So if an individual signs up for Medicare during the first three months of their IEP, their Medicare coverage will begin on the first day of their birthday month, which is the fourth month of the IEP. If they sign up during their birthday month or during the last three months of their IEP, their Medicare coverage will begin on the first day of the month after they enroll. So it's important to note that if a person's birthday falls on the first of the month, their initial enrollment period is shifted one month earlier to include four months prior to the birthday month, the month that the person turns 65, and then the two months after the birthday month.

So now let's talk some more about Special Enrollment Period. So this enrollment option applies if a client is still working... This one specifically for people transferring from employer coverage after 65. And so this applies only to people who are still working past the age of 65 and have employer-sponsored insurance or they have employer coverage through their spouse who is still working. But when a client quits or retires or otherwise loses that employer-sponsored insurance, they will qualify for an eight-month SEP to help them transition to Medicare. And so, the SEP begins when the employer coverage ends. That's really important to remember that.

So I'll just say it again. The SEP begins when the employer coverage ends. And so, if they enroll during that eight month period, their coverage will begin the first day of the month after they sign up. So it's important to keep in mind that COBRA health plans are not considered employer-sponsored coverage. So if a client is currently covered by a COBRA plan, they will not be eligible for a special enrollment period when their COBRA coverage ends, the SEP only applies to when the employer-sponsored insurance ends. And one final thing to note about Medicare and employer-sponsored insurance is that even if a client is keeping their employer coverage, they can actually enroll in just Medicare Part A if they qualify for premium-free Part A. And remember that this is possible if they have 40 work credits or approximately 10 years of work history to get premium-free Part A.

So another SEP that we wanted to mention today is to provide more detail about coordinating with the termination of Medicaid coverage. So with the unwinding taking place, all beneficiaries are having their eligibility redetermined by state Medicaid programs. And if someone is determined to no longer be eligible for Medicaid but is newly eligible for Medicare, they will qualify for this

SEP. And so this SEP will allow individuals to enroll in Medicare after termination of Medicaid coverage, and they won't have to wait until the next Medicare enrollment period. So this SEP allows individuals to choose between retroactive coverage back to the date of termination for Medicaid, but no earlier than January 1st, 2023 or coverage beginning the month after the individual enrolls. And so, if someone selects retroactive coverage, they must pay the premiums for the retroactive coverage time period.

There are a number of other Special Enrollment Periods now available, thanks to a new, it's not new but as seen as rule that was passed last year that allow clients to enroll outside of the enrollment pathways that we just discussed. So these additional new SEPs are listed here, and the first one is an SEP for individuals impacted by an emergency or disaster who may have missed an enrollment opportunity because they were impacted by one of these, and that was declared an official disaster or an emergency by a federal, state, or local government entity.

So this SEP is available for six months after the end of the emergency declaration. There is an SEP for health plan or employer error that will provide relief in instances where an individual can demonstrate that there employer or health plan materially misrepresented information related to enrolling in Medicare in a timely manner. And then there's also now an SEP for formerly incarcerated individuals that will allow folks to enroll following their release from correctional facilities. This SEP is available for up to 12 months post-release, and will allow individuals to choose between retroactive coverage back to their release date, or coverage beginning the month after the month that they enroll.

And if an individual selects retroactive coverage, just as I mentioned with the other one, they must pay the premiums for the retroactive coverage time period. And finally, there's an SEP for other exceptional conditions that will be considered on a case by case basis and grant an enrollment to an individual when circumstances beyond the individual's control prevented them from enrolling during the IEP, GEP or other SEPs. So this SEP would be available for a minimum of a six-month duration. It's not intended to replace equitable relief which offers other additional flexibilities that go beyond the parameters of this SEP.

And then new for this year, so starting on January 1st, 2024, if an individual signs up for Medicare Part A or Part B during a special enrollment period because of an exceptional condition, they will have two months to join a

Medicare Advantage plan with or without drug coverage, or a Medicare Part D drug coverage plan. So their coverage will start the first day of the month after that they've enrolled, when Medicare Advantage receives their enrollment. So we're chatting out two very helpful links with more information about the SEPs. I know I went over them pretty quickly. There's a lot of information, but the resources that we're sharing including how to access the SEPs, which most often is by contacting the Social Security Administration.

So finally, the last enrollment period to highlight is the General Enrollment Period. So if a client misses their initial enrollment period, so that's the one that's centered around when their birthday and when they turn 65. If they miss that, and they also do not qualify for any SEPs, they can enroll during the General Enrollment Period, which runs from January 1st to March 31st every year. And their coverage will begin on the first of the month after the individual enrolls. So during the GEP, they can enroll in Medicare Part A and Part B for the first time.

And new as of this year, as of January 1st, if an individual doesn't qualify for premium-free Part A and has to pay for Part A coverage and they sign up for Part B during the GEP, they can now also sign up for a Medicare drug plan when they sign up for the Part B plan. So they will have two months after signing up for the Part B to join a Medicare drug coverage plan. So their Part D drug coverage plan would then start the first day of the month following the month in which they enroll. And I just saw that someone asked who pays for Part A. So in the case that someone's not eligible for premium-free Part A, then the client would pay or they may be eligible for assistance with the premium.

So let's move on to a quick knowledge check on what you've just learned about the Medicare enrollment processes. So first let's take a look at Keith. Keith is turning 65 this July, and he's currently enrolled in Marketplace coverage. What should he do? Should he, A, keep his marketplace coverage through the end of 2023 and enroll in Medicare during the General Enrollment Period starting in January 2024? Should he, B, enroll in Medicare during the initial enrollment period around his birthday, and then proactively cancel his marketplace plan, or should he, C, enroll in Medicare through a special enrollment period after his 65th birthday? So I'll just give you a few moments to respond.

All right. So, it looks like the majority of you got it correct. The answer was B, to avoid a late enrollment period, he should enroll during his IEP, and then cancel his Marketplace plan after his Medicare coverage begins.

And then let's do one more. So now let's look at Sandra. Sandra missed her IEP and does not qualify for a special enrollment period. She can enroll now during the current General Enrollment Period. So when will her Medicare coverage start, is it, A, February or one month after she enrolls, is it, B, April or three months after she enrolls, or C, July, six months after she enrolls? So I'll give you a few moments to answer that.

Oops, I see the dates on the responses are a little off, but I think you all are generally getting it. So let's close the poll, and the correct answer is A, it's one month after she enroll. Sorry, what I had in my talking points was a little different than what showed up in the knowledge check, but you all rolled with it there, so thank you. So if anyone who enrolls through an annual General Enrollment Period, January through March will start their coverage the month after they enroll. And so, that's a little different because there was a change last year in which folks now, their coverage will start one month after they enroll, they don't have to wait until the end of the enrollment period any longer.

So now I just want to wrap up and recap the four enrollment periods that we talked about. And this here, the enrollment periods are oriented on a timeline along the lifespan to show when someone can enroll in Medicare based on their age and specific life circumstances. So going from the top left to the bottom right, the earliest that someone can enroll in Medicare is through the Social Security pathway by either claiming Social Security disability benefits at any age or receiving retirement benefits as early as age 62, and then automatically becoming enrolled at 65. Then there is the Initial Enrollment Period, which is a seven-month period. Remember it's the 313 period around the month that a person turns 65. And next, there are a number of Special Enrollment Periods which can be activated if someone continues working past age 65, and then loses employer-sponsored coverage.

So that specific one for employer sponsor coverage is an eight-month period. And there are also a number of other SEPs that I highlighted. And then finally there's the General Enrollment Period, which takes place at the beginning of each calendar year for anyone who is otherwise ineligible or unable to enroll through the other pathways. In general, the longer a person waits, the more likely it is that they will have to pay a penalty. So we want to stress again, just how important it is to encourage clients to enroll when they first become eligible. And we'll be going into detail on penalties in the next part two of this webinar series.

So now I'll just take a quick opportunity to highlight some great ACE TA Center tools that could help your clients get enrolled in Medicare. The first three tools are for staff who are helping clients to enroll in Medicare. So the first one is the Basics of Medicare for Ryan White Program Clients, which talks about the common eligibility pathways for people with HIV, and the different parts of Medicare. So it recaps everything that we've gone over today in this webinar. The next one is Medicare Prescription Drug Coverage for Ryan White Clients. And this goes specifically into how to get prescription drug coverage, the donut hole coverage for HIV medications, and how ADAP can help with the costs.

And the third tool for staff is How Medicare Enrollment Works, which goes into detail on the Initial Enrollment Period, Special Enrollment Periods, and the General Enrollment Period, as well as how to avoid penalties and make changes to existing Medicare coverage. And then finally, we have a resource designed specifically for clients and this is called the ABCDs of Medicare Coverage. So this is a brief plain language tool that describes the different parts of Medicare and the difference between Original Medicare and Medicare Advantage. And so, this one is specifically for clients, you can print it out and give it to your clients so that they can take it home with them. It's also helpful to use this focal point for discussion during an appointment with them. So you can find all of these tools and more at targethiv.org/ace/medicare. And now I'll hand it over to Molly to start the Q&A because I know we have so many questions that you have been chatting in.

Molly Tasso: Great. Thank you so much, Liesl and Christine. Yes, to Liesl's point, we have a ton of questions, but we have a good chunk of time, about 30 minutes that we can move through as many as we can get through today. So joining us for the Q&A are Liesl and Christine, but also Amy Killelea. And so, Amy is an independent consultant providing public health policy in finance and expertise to governmental public health agencies, nonprofits, payers and providers. Amy's focus areas include HIV and hepatitis programs, public and private insurance coverage, public health and healthcare financing strategies, and medication access and pricing. So thank you, Amy, for joining us today. We can go ahead, Nikki, and take the slides down, and if folks just want to come on video, if you're able and interested, that would be great. All right. So let's start with the first question. I'm going to have Christine answer this first question. So someone asked, do clients have to sign up for at least Part A Medicare at age 65, or if that person is still working, should they delay that enrollment until they no longer have employer-sponsored insurance?

Christine Luong: Thanks, Molly. Yeah, that's a good question. And I will also note that we will be covering this topic as well as other enrollment scenarios and challenges during part two, which is next, no, sorry, February 27th. So definitely join us then. So to answer that question, the general guidance is that you should be signing up for each Medicare part when you first become eligible for it, and that is in order to avoid a late enrollment penalty, unless you have a good reason to defer enrollment in that specific part. So, one of those good reasons would be if someone has employer-sponsored insurance that provides as much or more coverage than Medicare typically does. And so, for folks who are turning 65 and becoming eligible for Medicare for the first time at age 65, usually yes, it is best if possible to sign up for just the Part A, keep their employer-sponsored insurance, and then later on once they lose the employer-sponsored insurance and retire, then they can sign up for the other Medicare parts that they haven't received yet.

Molly Tasso: Great. Thanks, Christine. Hey, Amy. Thanks for joining us today. I'm going to have a couple questions for you. So first, in terms of the Part D donut hole changes, can you talk a little bit about, again, what these changes are, and what does it mean for Ryan White clients, and maybe contextualize it, like is this a significant change for us?

Amy Killelea: Sure. And hi everybody, it's great to be here this afternoon. So yeah, lots of changes in effect right now and then more to come, and many of these changes are because of a federal law that was passed last August called the Inflation Reduction Act. So, that included a number of changes to Medicare drug coverage in particular. And the one that just went into effect in January affects cost-sharing, particularly for folks like people living with HIV who are on high cost drugs throughout the course of the plan year. So starting in January, we saw a big change that actually eliminates cost-sharing in the catastrophic phase of coverage. So if you remember the phases of coverage that the JSI team just went through, you start with deductible, then you move to your initial coverage phase, then you move to your coverage gap phase, and then up until January, so in 2023, you move to the catastrophic phase where you have much lower cost-sharing, so it was 5% coinsurance in the catastrophic phase.

So starting now, like for your clients right now, there is no more cost-sharing once you hit catastrophic. So what does that mean for an actual person? So, we're going to put a resource in the chat that's actually from folks at Harvard Law School Center for a Health Law and Policy Innovation, and they put out a pretty easy to see guide on this change in particular. And there's actually a case study for someone on Biktarvy, which is an HIV antiretroviral therapy. So for

someone on Biktarvy, under the new rules that went into effect in January, this person now hits the catastrophic phase around May. And whereas last year, even after that, they would've been responsible for about $150 a month just for Biktarvy. Now in May, they're done with their Medicare Part D cost-sharing, there's nothing else.

And the estimate there is that's about $3,300 in cost-sharing from the individual. So that's a pretty big deal. You can see no more cost-sharing after May versus cost-sharing throughout the entire year in years past. So something to watch for your clients moving forward and I think a really good benefit for them. And then just to stay tuned for more, the IRA included a lot of different reforms, and Medicare Part D cost-sharing is going to get even more generous for enrollees starting next year. So we'll have more to talk about then, but for now, a big change already in place.

Molly Tasso: Great. Thank you so much, Amy. I'm going to have you stay off mute. So a great question here on vaccines. So, are vaccines covered at no cost to the patient when administered in an inpatient or outpatient clinical setting and an outpatient pharmacy setting?

Amy Killelea: Yeah, this is a really good question. So this is another piece that the IRA expanded access to vaccines without any cost-sharing. So the IRA included a provision that made recommended vaccines from the CDC Advisory Committee, which included a great number of vaccines that are really relevant to people living with HIV and others on Medicare. And so, those vaccines are free to Medicare enrollees via Medicare Part D, and then sometimes you'll have vaccines covered through the Part B benefit, those are also free. The important thing to remember here, we're talking about Part D and B for Medicare. So when you think about D and B, think outpatient. So those vaccines are going to be available for free in outpatient settings, and they could very well include pharmacies that are able to offer vaccines under their state laws. That's most pharmacies now can do that, but that's one thing that may vary depending on what state you're in.

But note, it's not going to apply to inpatient in hospital settings. That's Part A, right? This is a benefit and a cost-sharing protection that applies in the D and B setting. It's not going to be as relevant to Part A, a lot of these vaccines, they're preventative, you're going to get them in outpatient setting. So it's going to be the exception and not the rule that somebody would get that an inpatient setting. But if that happened, you could see that with a cost-sharing charge. But

they're pretty cheap, so I don't think that would break the bank. But that's the difference there, it's going to be outpatient settings.

Molly Tasso: Great. Thank you so much, Amy. All right. Liesl, a question around Part A, does everyone qualify for premium-free Part A?

Liesl Lu: So, no. Just to review, so Medicare Part A is free if you have at least 40 work credits in any job where you've paid Social Security taxes in the U.S. You can also be eligible for Part A if you are eligible for Railroad Retirement benefits, so that's a small population, or if you have a spouse that qualifies for premium-free Part A. And if you don't meet any of those criteria, then you would likely have to pay a monthly premium for Part A. And your Part A premium will depend on how many years you or your spouse worked in any job at which you paid Social Security taxes in the U.S. So hopefully that helps.

Molly Tasso: Great. Thank you so much, Liesl. Christine, we're going to pivot to this. So a number of you asked for clarifications and questions around annual deductible limits. So Christine, so let's go over, can you remind us again what is the 2024 Medicare Part A and Part B deductibles? And then, can you talk a little bit about max out-of-pockets for Part B?

Christine Luong: Yes. Yes, I can. So for 2024, the Medicare Part A deductible is $1,632. So this deductible amount is based on a 90-day benefit period. And I know we also had a question about how that deductible works, and when it starts over. So I'll just take the opportunity now to answer that one as well. So that 90-day benefit period is a period that begins when you're admitted into an inpatient hospital setting. So that's a 90-day period. Let's say you pay that deductible, the $1,600, you would have to potentially pay a deductible again if you're admitted into the hospital again after the 90-day period.

So it's not calendar based, but I guess you could call it event-based based on a hospital admission. So, Molly, the other question was Part B deductible. So the 2024 Medicare Part B deductible is $240, and this is for outpatient medical services, and there is no out-of-pocket maximum for Part B either. And I can also chat out a link to an article that summarizes the 2024 Medicare costs. It's a pretty easy to read and easy to digest resource. So hopefully that will also help to reinforce some of the information that Amy has shared about Extra Help and these reforms. So I'm going to chat that out now. Molly, did I answer all of your questions?

Molly Tasso: I believe you did, yes. Thank you, Christine. And I also see the request for the article from Shilpi. I have that pulled up, so I'll chat that out in a second. Yes, that will be coming in one second. Yes, Christine, I think that covers all of the questions. All right, thank you. All right. Christine, while I have you, so for folks with 24 months of SSDI, would they automatically qualify for Part D as well?

Christine Luong: Yeah, that's a good question. So, what happens is when you receive your 25th month of SSDI benefits, you are actually automatically enrolled in Medicare Parts A and B, and you can choose to either keep that coverage and pay for it, or you can choose to decline it. If you choose to keep it, you can choose to add on a Part D prescription drug plan because at that point, you would have Original Medicare, so add on the Part D plan, or at a later point, you could switch to a Medicare Advantage plan, that does include prescription drug coverage.

Molly Tasso: Great. Thank you, Christine. Okay. Amy, a couple of questions for you. So back to the max out-of-pocket or out-of-pocket costs. So when we talk about True out-of-pocket, can you talk about what that all includes? Does that include both what the beneficiary would pay out-of-pocket and what an insurance company pays, or only what an individual or beneficiary would pay?

Amy Killelea: Yeah, this is a really good question because it's a little bit different than how we talk about out-of-pocket costs in the commercial space. So true out-of-pocket cost or TrOOP is a Medicare Part D specific term, and it consists of both payments paid by the enrollee. So those are going to be the things that we normally think about when we think about cost-sharing your deductible and other out-of-pocket costs like cost-sharing coinsurance, but it's also going to include other payments that aren't necessarily paid directly by the enrollee.

So this includes ADAP payment, so when ADAP is basically standing in for the enrollee and paying that cost-sharing on the enrollees' behalf, but it's also going to include manufacturer discounts for brand drugs. So, that last piece, that's a little bit different than what we normally think about. And that's a good thing for beneficiaries, for enrollees because that means that we are counting that discount that the manufacturer is getting as part of the calculation that is going to get somebody through to catastrophic coverage quicker. So that's, in general, a really good thing and the shorthand of it, means that enrollees are paying less out of their own pockets because we count the manufacturer discounts in the coverage gap.

Molly Tasso: Great. Thanks, Amy. Let's see here. Amy, pivoting to the Extra Help program. So could you share with us maybe a little overview of what the Extra Help program

is? And then there's also some updates to the Extra Help program that began at the beginning of this year, I'm hoping you can give an overview of that as well.

Amy Killelea: Yeah, absolutely. So two things to note. There is information about Extra Help and some of the new things that are happening with Extra Help starting this year in those two resources that were chatted out, the Medicare Rights Center resource that Christine chatted out, and then the Harvard resource that Molly chatted out. So take a look there and those can be good references for you all. But basically the Extra Help program is a program that helps many low income enrollees to better afford their Part D cost-sharing. And so, it helps qualifying Part D beneficiaries who qualify based on income and assets with their premiums, deductibles, copayments, and coinsurance. So the thing that changed starting in January was that full Extra Help is now available to folks with the incomes less than 150% federal poverty level. Prior to this, we had a two tier system where you would be eligible for full Extra Help if you were super low income, so under 135% FPL, but you'd only be eligible for partial subsidies, partial Extra Help if you were between 135 and 150% FPL.

So it just expands the full program and the full value and generosity of the program for folks all the way up to 150% federal poverty level. I will say, so this is a fairly significant change for low income folks, it streamlines Extra Help, it makes it the full benefit available to more people. It makes it easier to talk about, it's a little bit hard to talk about partial full subsidies, it's a simpler program. Many people do not know about it. So this is sort of a good thing to make sure people are aware of the Extra Help program writ large and they're availing themselves of it. So that's a good sort of action step for assisters who are working directly with clients just to talk about this program, and make sure folks are eligible for it or enrolled.

Molly Tasso: Great. Thanks, Amy. Definitely a wonderful change in update. Amy, a couple of questions around Original Medicare. So folks wondering if Original Medicare offers vision and dental benefits and also an add-on, would cataract surgery be covered under Original Medicare?

Amy Killelea: Yeah. So, on the first question in terms of vision and dental, the short answer is no. Unfortunately vision, dental and hearing the sort of trifecta of services that probably would be very beneficial to be a Medicare benefit are not mandatory covered services under traditional Medicare. And for vision, that's going to include routine eye exams and glasses and contact lenses, things like that.

I will say for those services, vision, dental and hearing aids, some Medicare Advantage plans do offer those services. There's nothing saying that a Medicare Advantage plan can't offer it. They're not required to, but some do, and you could see why they want to encourage people to enroll in those plans. So that's something that's like an added benefit sometimes of going the Medicare Advantage route, though there's always pros and cons on that, but that is something that Medicare Advantage plans may do. In terms of cataract surgery, without being an expert in eye surgery, I will say it's the routine vision services that are not covered by Medicare. If there is a problem or condition or disease related to the eye, it's not an exclusion related to your eyes, it's routine vision that's not covered by Medicare.

Molly Tasso: Awesome. Thanks, Amy. You do sound like you're an expert in eyecare the way you... So great job. Christine, a couple of questions for you. So this is a little bit getting into dual eligibility, which again, we've sort of referenced, but again, we have this third webinar on March 12th. But when we talk about someone being dually eligible, this person asked, are you talking about, excuse me, QMB and SLMB or fully dually eligible? So I think the question here is, Christine, can you give us a very high level overview of what those acronyms are, and what we're talking about when we talk about someone being dually eligible?

Christine Luong: Yeah, sure. So those acronyms, QMB and SLMB, those are two of four different types of what's called Medicare Savings Programs. So Medicare Savings Programs, as a side note, these are programs that are administered by state Medicaid programs that will help Medicare beneficiaries pay for some or all of their Medicare costs. So in that way, someone can be... It is a form of dual eligibility. We will talk about this more in March where we tease out the difference between someone who is considered fully dually eligible, meaning they receive all of the Medicare benefits and all of their state Medicaid benefits. And then on the flip side, partial dual eligibility, which is someone receives Medicare benefits, and either subset of state Medicaid benefits or their state Medicaid program helps them to pay for Medicare costs. So we do get into a lot of nitty-gritty, but in general, to answer your question, when we're talking about dual eligibility, we're talking about both. And don't be afraid of the acronyms, we have resources that can help you out with that. Hope that is helpful, Molly?

Molly Tasso: Yes, helpful. Thank you so much. And Christine, while I have you, so when we were talking about Medigap plans, we talked about folks are frequently travel out of the country, that's something to consider when choosing plans. So can you answer, does Medigap work outside of the country?

Christine Luong: Yes. So, as a reminder, Medigap plans are only compatible with folks who have Original Medicare. So Medigap plans, most of them will offer, I think it's called foreign travel emergency coverage or something to that effect. Most Medigap plans, they're lettered, they have standardized letters. Most Medigap plans will offer it, and that's why we say if you anticipate traveling outside of the country and you have Original Medicare, add that to your list of things to consider. Let me also chat out a link right now. It's a medicare.gov webpage. It has the basics of Medigap, and under step one, there's a hyperlink to see benefits of each plan. There's a really nice comparison table there of Medigap plans by letter and all the different benefits. So that hopefully will be helpful as you work with your clients to see if Medigap is a good option for them.

Molly Tasso: Great. Thanks, Christine. Amy, I'm going to pivot. There's a question in the chat that I think is really instructive for our audience. So someone asked, can ADAP assist clients when they reach the donut hole? And I wonder just if you want to talk a little bit about how the Ryan White program can support and shore up in some ways clients enrolled in Medicare, what that might look like?

Amy Killelea: Yeah, absolutely. And yeah, I think it's good to think about the Ryan White program writ large, and then think about the role that ADAP plays in particular in helping Medicare enrollees, who our ADAP clients afford their coverage. And we should chat out the relevant HRSA policy clarification notice on Ryan White support for all sorts of insurance, but including Medicare because there are some specific parameters around what parts can do what. But basically ADAP can and does help with Medicare beneficiary copayments. Not just in the donut hole, they're helping any prescription related cost-sharing, ADAPs can and do cover on behalf of the enrollee. And I will say, because there was a question about this, historically we've been in the Part D space for antiretroviral drugs because there are oral medications covered by Part D. Now that we have more injectable products, but those physician administered or provider administered drugs are in a Part B benefit, so ADAP is still covering the cost-sharing for folks who are accessing long-acting products.

So that's important to note. There are also Ryan White can, in certain circumstances, pay for the cost-sharing associated with other parts, not Part A, but Part B medical cost-sharing as long as the Ryan White program is also paying for a drug-related cost too, that's all laid out in the policy clarification notice. But the important point here is not limited to the donut hole or coverage gap, ADAP can pay for those prescription copays, coinsurance, deductible throughout all of the coverage phases for the client. And then the other thing just to note, as we said before, ADAP counts as TrOOP so there's no penalty for the client

that ADAP is stepping in and paying those costs, it's still counting to get the client through deductible initial coverage and then into catastrophic.

Molly Tasso: Great. Thanks, Amy. All right. I think we're going to do one more question and then we will wrap up. So I think this is a nice one to end on. So we've given a ton of information on Original Medicare and Medicare Advantage. So stepping back, is there a tool or where can a client go to help figure out and determine which plan is best for them, whether it's Original or Advantage? And then once you get to Advantage, looking at those plan options, how can a person navigate this?

Amy Killelea: Is this one for me, Molly?

Molly Tasso: Oh, yes, sorry.

Amy Killelea: No, you're fine. I have lots to say on it.

Molly Tasso: All right.

Amy Killelea: I think that the short answer is there's no shortcut, it's an individualized inquiry. There's no every Ryan White client should be on traditional Medicare or every Ryan White client should be on Medicare Advantage, it really does depend. We're going to chat out an ACE TA Center resource that lays out some of the considerations that might be helpful to talk through with clients as they're figuring out their options. But I always think about it as kind of a trifecta of considerations, and maybe there's more to this, but number one is that the provider networks are going to be different usually for Medicare Advantage plans and traditional Medicare. So what I have found in working with assisters and working with people in my own family who are enrolling in Medicare, it's often if you are depending on very specific specialty providers, you just want to be very careful that, if you're choosing Medicare Advantage, you're enrolling in a plan that does not have a super narrow network. The traditional Medicare is going to have wider networks usually.

So that's one thing to look at, is my provider going to be available? Is the client's provider going to be available? And then you can look at the cost-sharing, and that might be different depending on your Medicare Advantage plan or Medicare Part B. Someone actually put in one of your questions that in working with clients, they see that Medicare Advantage plans often have higher cost-sharing for services, and that is something to take into consideration. That's going to vary by plan, that's not going to be true across the board, but it is something to consider, and it is something to kind of peek under the hood of

what are going to be the cost-sharing for the services that your client is going to use.

And then the third piece are those added benefits that we talked about, Medicare Advantage plans, the plus about them is that they are adding different services to bring people in. And those can be services that are really advantageous for Ryan White client, I mean, for many people, but for Ryan White client, so they could include the vision and dental services and hearing aids that maybe are not going to be available through traditional Medicare. So that's something to look at too. But it's looking at what are your client's needs, what are the costs, and doing that comparison. And it is hard work, but there's not a great shortcut for it.

Molly Tasso: All right. Thank you so much, Amy, that's super helpful. And Lisa and Christine both chatted a couple helpful links. And then as we've been saying we have a ton of resources on our website, so please do go to our website and check out everything we've got there. Thank you, Amy, Liesl, and Christine, and also thank you to the rest of the ACE team for everything happening behind the scenes. Nikki, can we get the slides back up? We just have two more quick wrap up slides.

So, as we've been mentioning throughout today's presentation, we've got two additional webinars as a part of the series. So the next session is going to be Tuesday, February 27th. And during that one, we'll be discussing the topic of Medicare enrollment and coverage. And then on March 12th, then we'll move into the Medicare and Medicaid dual eligibility. And so, Tricia just chatted out links to register for those there. So please do register and join us for those sessions. Similar to this, we'll have a good amount of time set aside for Q&A, so hoping for it to be really interactive sessions as well.

All right. Well, thank you everyone so much. We are at time. Please go to our website again, check out all of the tools and resources, sign up for our mailing list. You can again access all the tools and resources and download them. And then again, if you have any questions or anything that pops up for you, please don't hesitate to shoot us an email at acetacenter@jsi.com and we'll get back to you. And with that, thank you so much. Have a great afternoon. And if you could fill out the evaluation that is going to pop up, that is super helpful for our planning and making sure that these presentations are useful and relevant to you all and your work. So we really appreciate taking the time to provide feedback. All right. With that, thank you so much, and we will see you in a couple of weeks for part two.