Webinar Transcript

Part I: The Basics of Medicare Eligibility for Ryan White HIV/AIDS Program (RWHAP) Clients + Q&A with Expert Panel

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Welcome to Part I of the ACE TA Center's two-part series on Medicare coverage.

This presentation will cover **"The Basics of Medicare for Ryan White HIV/AIDS Program Clients".**

The second part of this series, which covers **"Medicare Enrollment and Coverage for Ryan White HIV/AIDS Program Clients"** is also available online at targethiv.org/ace

In this presentation, we will discuss the changing demographics of RWHAP clients, Medicare eligibility for people with HIV, the different Parts of Medicare including Medicare prescription drug coverage for people with HIV, and the common Medicare enrollment pathways. We will also highlight relevant ACE TA Center resources on these topics throughout the presentation.

Let's begin with an overview of the changing demographics of RWHAP clients.

Medicare is the largest source of federal funding for HIV/AIDS care in the U.S. and about one-quarter of people with HIV who are in care get their health coverage through Medicare.

Historically, most Medicare beneficiaries living with HIV have been under age 65 and qualified for Medicare because of a disability. However, there are now more older adults living with HIV, and served by the RWHAP, than ever before.

In 2019, 46.8% of RWHAP clients were aged 50 years and older, and this is projected to rise to two-thirds by 2030.

Let's take a closer look at the data. The age distribution of RWHAP clients is shifting towards the right, as people with HIV are living longer and healthier lives.

The chart on the left shows data from 2010, and the chart on the right shows data from 2019. These numbers include clients in all 50 states and three territories - Guam, Puerto Rico, and the U.S. Virgin Islands.

Looking specifically at the blue and green bars, you can see that the percentage of Ryan White program clients aged 35 to 54 decreased over time from 2010 to 2019. Combined, the proportion of people in these two age groups decreased from nearly 60% in 2010 to about 44% in 2019.

Next let's look at the orange and yellow bars, which represent all Ryan White program clients aged 55 and older. In 2010, just under 17% of Ryan White clients were 55 or older. In 2019, this increased to almost 33% - which is about 1 in every 3 clients.

As we've just mentioned, the proportion of clients aged 50 and older is expected to increase in the next decade or so, to about 2 in every 3 clients.

Now let's look at the characteristics of people with HIV who are enrolled in the Medicare program. Remember that not all of these people are Ryan White clients, and also there are lots of people that have been part of the Medicare program for many years, for reasons other than age.

The chart on top shows how current Medicare beneficiaries with HIV first became eligible for Medicare. 79% of Medicare beneficiaries with HIV are under age 65 and qualified due to disability. It is interesting to note that this is very different from the general population, where only 17% of Medicare beneficiaries qualify based on disability. The other 21% of Medicare beneficiaries with HIV qualified based on age alone.

The chart on the bottom shows that 69% of Medicare enrollees with HIV are actually dually eligible for both Medicare and Medicaid.

Next, let's talk about how people with HIV typically become eligible for Medicare.

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. There are three primary ways that people with HIV can qualify for Medicare.

- Being at least 65 years old
- Being under 65 with a qualifying disability
- Having end stage renal disease (at any age)

CMS has a calculator that you can use with your clients to determine Medicare eligibility, but this presentation will focus more on the first two eligibility pathways.

As we've just noted, any U.S. citizen or eligible legal resident qualifies for Medicare when they turn 65.

We'll go into the different parts of Medicare later in the presentation, but it's important to note here that in order to qualify for certain parts of Medicare without paying a monthly premium, the individual must have at least 40 quarters of Social Security work credits. This only applies if they want to get "premium-free" Medicare Part A. They can earn work credits by working in a job and paying Social Security taxes. Work credits are based on the individual's total annual wages or self-employment income.

They can earn one credit every quarter, which is 3 months, for a maximum of 4 credits per year. So 40 quarters or "credits" equals about 10 years worth of work. These credits do not have to be earned consecutively.

If the individual doesn't have enough credits by the time they turn 65, they can still enroll in Medicare Part A, but they may have to pay a premium for Part A coverage. The premium amount varies depending on how many credits the person has so far. They can also continue working past 65 in order to earn the 40 credits needed for "premium-free" Part A.

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 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 does not have to be 24 consecutive months - they are automatically eligible for Medicare Parts A and B.

To qualify for "premium free" Medicare Part A hospital coverage through this pathway, the individual must also have 40 Social Security work credits – which is the same rule we just covered for people age 65 or older.

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. **While HIV is one of the medical conditions that Social Security considers for disability, HIV status alone generally does not qualify someone for SSDI.** People with HIV may qualify when they have either a serious HIV-related condition, a qualifying CD4 count, repeated hospitalizations, or "repeated manifestations" of HIV that result in functional limitations.

To recap, 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.

Now let's go over the different parts of Medicare.

There are three Parts to Medicare. The first is Medicare Part A -- which is hospital coverage. This covers inpatient hospital care, surgery, lab tests, skilled nursing facility care, hospice care, and home health care, among other things.

Medicare Part B includes medical coverage for services from doctors and other health care providers, including outpatient care, some preventive services, and home health care. Medicare Part B also covers medications administered by a physician and durable medical equipment.

Medicare Part D provides coverage for outpatient prescription drugs, including HIV antiretroviral medications. We'll talk more about each of the Medicare Parts throughout the presentation.

So to recap:

- Medicare Part A is hospital coverage for inpatient care.
- Medicare Part B is medical coverage that covers outpatient care, preventative services, and overall routine care.
- Medicare Part D is prescription drug coverage.

Even though there are multiple parts to Medicare, there only two options to get Medicare coverage – Original Medicare and Medicare Advantage. Let's look at those in more detail now.

The first Medicare enrollment option is **Original Medicare**, also known as "traditional" Medicare. Original Medicare plans are administered by the federal government and include Medicare Parts A (hospital coverage) and Part B (medical coverage.)

Original Medicare does **NOT** include prescription drug coverage, or Part D. If an individual wants prescription drug coverage, they must purchase it separately. We'll explain how that works later in the presentation.

If a client opts for **Original Medicare ONLY**, please be advised that there are coverage gaps in Original Medicare, including deductibles and co-insurance.

For example:

- **The Medicare Part A deductible is based on a 90-day benefit period**, which means that the deductible can be applied more than once a year. And even after the Part A deductible is met, they may still be responsible for additional charges for long-term hospitalizations, skilled nursing care, and blood products.
- **Unlike Part A, the Part B deductible is based on an annual period.** However, after the Part B deductible is met, there is still a 20% coinsurance. What this means is Medicare will pay 80% of all approved charges, and the client is responsible for the remaining 20%. Depending on the cost of the service, 20% can add up quickly.

A client can also enroll in Medicare through a **Medicare Advantage** plan. These are plans that "bundle" Part A hospital coverage, Part B medical coverage, and Part D prescription drug coverage all together. Medicare Advantage is also known as Medicare Part C.

These plans may or may not have a monthly premium, and your local RWHAP and AIDS Drug Assistance Program (ADAP) may be able to help pay for this.

In addition to bundling hospital, medical, and prescription drug coverage, Medicare Advantage plans may offer extra benefits that Original Medicare plans do not - such as vision, dental, hearing, and wellness programs like gym memberships. Medicare Advantage plans are starting to offer more extra benefits than they have in the past, like transportation to doctor's visits, for example.

Unlike Original Medicare, Medicare Advantage plans are administered by private insurance companies that contract with the federal government. These plans are generally either an HMO or PPO plan with a specific network of preferred providers. A client may need to get some services approved ahead of time or get a referral to see a specialist. Medicare Advantage plans are also permitted to implement step therapy to manage drug coverage.

Most RWHAP programs recommend that clients enroll in Original Medicare, though this decision really depends on the Medicare Advantage market in your area. It is important to review the Medicare Advantage plans available in your jurisdiction to determine if they are a good option for your clients.

Again, it's important to note that Medicare Advantage plans have pros and cons just like any other plan and they may not be right for everyone.

For example:

- They are not always the best choice for people with HIV because they usually have more limited provider networks. This may make it harder for someone with complex conditions to continue seeing their existing providers, who might not all be in-network.
- Co-pays and co-insurance for services can sometimes be higher under Medicare Advantage plans too.

In some cases, Medicare Advantage can be a good option for those with less complex medical needs and clients who wouldn't need to see a provider when traveling out of state.

Plan design and plan availability vary depending on where a client lives, so take the time to review what's available in their area. You can help clients shop for and compare plans by visiting Medicare.gov using their Plan Compare Tool.

Now, let's talk about Medicare Supplemental Insurance, or Medigap policies. While Original Medicare pays for most of the covered services and supplies, Medigap policies can help cover some of the gaps in Medicare Part A and B coverage, such as copays and deductibles.

Medigap policies are sold by private companies. They are standardized by state and federal law and must clearly be identified to consumers as "Medicare Supplemental Insurance." A client must have Original Medicare – Parts A and B - to enroll in a Medigap policy. **An individual cannot be enrolled in both Medicare Advantage and a Medigap plan.**

These policies do **NOT** cover costs for Medicare Part D prescription drug coverage, such as copays, coinsurance, or deductibles. Part D has to be purchased separately.

Medigap beneficiaries pay a monthly premium that determines exactly what their out-of-pocket costs will be, if any. ADAP may or not be able to pay this. Usually, the more expensive the plan, the greater the benefits. However, Medigap policies generally don't cover things like long-term care, vision, or dental care.

Despite these limitations, Medigap plans may still be a good option for clients with more complex medical needs or clients who travel during the year and anticipate needing to see a provider outside of the country. You can help clients shop for and compare Medigap plans by visiting Medicare.gov and using their Medigap Plan Finder Tool.

Let's recap what we've covered so far.

Starting with Original Medicare on the left side of the table:

- Original Medicare includes Part A hospital coverage and Part B medical coverage.
- For Part A hospital coverage, most people do **NOT** have to pay a premium as long as they have sufficient work credits to qualify for "premium free" Part A. This applies to anyone who qualifies for Medicare due to age or disability. People who don't qualify for premium-free Part A can pay a monthly premium depending on how many work credits they've earned so far.
- Part B medical coverage is **NOT** tied to work credits.
- And finally, clients can add-on Medigap supplemental coverage and Part D prescription drug coverage.

Now let's take a look at Medicare Advantage plans on the right side of the table:

- Medicare Advantage bundles Part A hospital coverage, Part B medical coverage, and Part D prescription drug coverage. They can also offer extra benefits that Original Medicare does not have.
- Advantage plans may or may not have a monthly premium, but they do have a yearly limit on out-of-pocket costs for Medicare Part A and B covered services.
- And finally, remember that an individual cannot buy or use supplemental Medigap policies if they have a Medicare Advantage plan.

Again, it's important to compare plans to see which will be best for your client. You can shop and compare Original Medicare and Medicare Advantage Plans at medicare.gov.

The RWHAP, including ADAP, may help **pay in full or in part** for Medicare premiums, deductibles, and copayments. It is important to check with your local ADAP to determine how it may be able to help with costs as this varies by state.

Now let's take a deeper dive into Medicare Part D prescription drug coverage.

There are two ways to get Medicare prescription drug coverage: either by **purchasing an optional Medicare Part D prescription drug coverage plan** after enrolling in Original Medicare (Parts A or B), or by **enrolling in a Medicare Advantage plan** that bundles the prescription drug coverage along with the Part A and B hospital and medical coverage.

All Medicare prescription drug plans must provide a standard level of coverage set by Medicare, but may offer different combinations of coverage and cost sharing. Medicare drug plans may differ in the prescription drugs they cover, how much individuals have to pay, and which pharmacies they can use.

- All Medicare prescription drug plans are required to cover all or nearly all drugs in six "protected" drug classes, including antiretroviral treatments for HIV.
- HIV drugs are required to be covered without any utilization management such as **prior authorization** (which requires a coverage and utilization review before prescribing a preferred drug regimen) or **step therapy (**which is the process of starting patients on a less expensive treatment regiments and requiring them to "fail" on these options in order to get access to the prescriber's preferred or recommended regimen).

- However, there are some Part D restrictions for non-HIV medications, including “medication not on formulary” and “quantity limit” issues. Providers can generally work with a Part D plan insurance carrier to request a “prior authorization” or “exception” that overrides these restrictions.

Original Medicare enrollees only need to have Medicare Part A or Part B at minimum to purchase a Part D plan, but you should encourage your clients to enroll in both Part A and B when they first become eligible - **UNLESS** they have coverage that allows them to defer enrollment without incurring a penalty. We’ll discuss what that means in just a minute.

Part D premiums may be expensive. It is important to work with your clients to see if they are eligible for the federal Extra Help program, which helps people with limited income and resources to pay for **some or all** of their Medicare prescription drug program costs, like premiums, deductibles, and co-insurance.

Those who are not eligible for Extra Help will have a monthly premium for their Part D plan, but most if not all ADAP programs can pay this premium for clients who are active in their program.

If your client is enrolled in Original Medicare but they choose not to enroll in Part D prescription drug coverage when they first become eligible for it, they will likely have to pay a late enrollment penalty if they choose to enroll later on. However, your client will not have to pay a late enrollment penalty if they have other creditable prescription drug coverage, which is defined as coverage that provides at least as much as Medicare’s standard prescription drug benefits.

Some examples of creditable prescription drug coverage include: TRICARE, the Indian Health Service, Veterans Affairs, coverage from an employer or union, and coverage from the Marketplace. Note that **ADAP is NOT considered creditable coverage**.

If you are unsure whether your client’s current prescription drug coverage is considered “creditable”, you should encourage them to contact their coverage provider directly.

You may have heard about the Medicare "donut hole" or coverage gap for prescription drug coverage. This refers to the gap when an individual's initial Medicare prescription drug coverage has ended, but they don't yet qualify for catastrophic coverage.

- An individual enters the "donut hole" when their total drug costs—including what they have paid and what their plan has paid for prescription drugs - reaches a certain amount, called the initial coverage limit. **In 2021, for example, the initial coverage limit was $4,130.**
- When a person is in the "donut hole," the amount they pay for prescription drugs will be higher until they have met the limit for True Out-of-Pocket Costs, also known as TrOOP. **In 2021, for example, the TrOOP limit was $6,550.**
- Once the individual meets the TrOOP limit, their plan's catastrophic coverage threshold kicks in and from then on, they will pay significantly lower costs for the remainder of the year. The plan resets again the following year.

Note that both the initial coverage limit and the True Out-of-Pocket Costs (TrOOP) limit change every year. You should check Medicare.gov for updated numbers.

ADAP expenditures for clients with Medicare Part D coverage count toward their true-out-of-pocket costs, which helps clients reach their catastrophic coverage level faster. Check with your local ADAP about how they can help clients pay for drug coverage in the coverage gap.

There are four primary ways that a client can enroll in Original Medicare or a Medicare Advantage Plan, based on their age and specific life circumstances.

- First, if they receive **Social Security Disability Insurance (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. Their Medicare card will come in the mail three months before their 65th birthday. 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 (IEP)**. If a client is about to turn 65 but have not yet started to receive Social Security retirement benefits, they can enroll in Medicare during their Initial Enrollment Period.

- If a client is transitioning from employer coverage after age 65, they will qualify for a **Special Enrollment Period (SEP)** after their Initial Enrollment Period has passed.
- And finally, there is a **General Enrollment Period (GEP)** if a client has missed the Initial Enrollment period and they do not qualify for the Special Enrollment Period.

Now let's explore the IEP, SEP, and GEP in more detail.

The Medicare **Initial Enrollment Period**, or IEP, is a seven month period centered around the month of a persons 65th birthday. Some people call the IEP the "3-1-3" period. It starts three months BEFORE the 65th birthday, includes the month the person turns 65, and ends three months AFTER they turn 65.

If an individual signs up for Medicare during the first three months of their IEP, in most cases their coverage will start on the first day of the month they turn 65. If they sign up for Medicare during their birthday month or during the three months afterwards, their coverage will start anywhere between one to three months later, depending on the exact timing of their enrollment.

We want to stress how important the Initial Enrollment Period is, because if an individual misses it, it can mean a lifetime of increased costs in the form of penalties.

For Medicare Part B, if an individual does not sign up for Part B during their IEP when they turn 65 - either through Original Medicare or a Medicare Advantage plan - and they also don't have employer-sponsored insurance, they will be subject to a late enrollment penalty. This penalty is an additional 10% of the standard Part B premium for each 12-month period they were eligible but didn't enroll. This penalty continues forever, for as long as they have Part B coverage.

Medicare Part D also has a late enrollment penalty. It's significantly smaller compared to Part B, but still a lifetime penalty.

If you'd like to learn more about Medicare late enrollment penalties, watch Pt 2 of our two-part series, which is available on the ACE TA Center website.

Now let's talk about the Medicare Special Enrollment Period. This enrollment option applies if a client is still working past age 65 and have employer-sponsored insurance (or have employer coverage through their spouse who's still working).

But when the client quits, retires, or otherwise loses that employer-sponsored insurance, they will qualify for an 8-month SEP to help them transition to Medicare. If they enroll during that 8-month period, their coverage will begin the first month after they sign up.

Please keep in mind, however, that COBRA health plans are NOT considered employer-sponsored coverage. **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.**

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. Remember, this is possible if they have 40 work credits or approximately 10 years of work history.

Finally, if a client misses their Initial Enrollment Period and they also do not qualify for a Special Enrollment Period , they can enroll during the General Enrollment Period, which runs from January 1 to March 31 annually, but their coverage won't begin until July 1 of that year.

During the GEP, they can enroll in Medicare Part A and Part B for the first time. However, they cannot enroll in Medicare Part D during the General Enrollment Period, only when their Part A or B coverage begins in July. By then, they may have already incurred a Part B or Part D late enrollment penalty, which gets added on top of their monthly premium.

Here is a recap of the 4 enrollment pathways we've just described, oriented along the lifespan to show when someone can enroll in Medicare based on their age and specific life circumstances. Going from top left to bottom right:

- The earliest that someone can enroll in Medicare is through the Social Security pathway, either by:
    - 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 7 month period centered around the month that a person turns 65.
- Next is the Special Enrollment Period, which can be triggered if someone continues working past age 65 and then lose employer-sponsored coverage. This is an 8 month period.
- And finally, the General Enrollment Period is takes place at the beginning of each calendar year for anyone who was otherwise ineligible or unable to enroll through the other pathways.

The longer a person waits, the more likely it is they will have to pay a penalty. We want to stress again how important it is to enroll, and encourage your clients to enroll, when they first become eligible.

Your client may want to make changes to their coverage after they have already enrolled in a plan. There are two enrollment periods each year where an individual can make changes to Medicare coverage for the following year.

The Open Enrollment Period for Medicare Advantage and Medicare drug coverage is from Oct. 15 to Dec. 7 annually, also known as the Fall Open Enrollment Period. During this time, an individual who already has Medicare coverage can:

- change from Original Medicare to Medicare Advantage (or vice versa)
- switch from one Medicare Advantage plan to another with or without drug coverage
- join or switch Medicare drug plans
- drop Medicare drug coverage completely

Any changes made during this period will take effect on Jan. 1 the following year.

The Medicare Advantage Open Enrollment Period, also known as the General Enrollment Period from the previous slide, is from Jan. 1 to Mar. 31 annually. During this time, an individual who already has Medicare coverage can:

- switch from one Medicare Advantage plan to another, or
- drop their Medicare Advantage plan and go back to Original Medicare.

Any changes made during this period will take effect on the first of the month after the plan receives the request.

The ACE TA Center has a number of resources to help case managers and other Ryan White staff to learn more about Medicare eligibility, enrollment, and coverage for RWHAP clients and other people with HIV. Much of what was covered in this presentation is described in the following tools.

The first is **The Basics of Medicare for RWHAP Clients**, which talks about the common eligibility pathways for people with HIV and the different parts of Medicare. This resource is also available in Haitian Creole and Spanish.

The second tool is **Medicare Prescription Drug Coverage for RWHAP Clients**, which talks about how to get prescription drug coverage, the donut hole, coverage for HIV medications, and how ADAP can help with costs.

The third tool is **How Medicare Enrollment Works**, which goes into detail about the Initial Enrollment Period, Special Enrollment Period, and General Enrollment Period, as well as how a client can avoid penalties and make changes to their existing Medicare coverage.

Finally, we have a resource designed specifically for clients, called **The ABCDs of Medicare Coverage**. This is a brief, plain language tool that describes the different parts of Medicare and the difference between Original Medicare and Medicare Advantage. You can print this out and give it to your clients to read on their own or to discuss with you during an appointment.

You can find these tools and more at targethiv.org/ace/medicare

We've reached the end of our presentation on **The Basics of Medicare Eligibility for Ryan White HIV/AIDS Program Clients**. Visit the ACE TA Center, sign up for our mailing list, download tools and resources, and more at targethiv.org/ace. If you have questions, you can contact us at acetacenter@jsi.com. Thank you.

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