Webinar Q&A Transcript

Part I: The Basics of Medicare Eligibility and Enrollment for RWHAP Clients

Liesl Lu: So we will move into our Q&A, and... first I'd just like to introduce our panelists today. So I'm joined by Mira Levinson, and Molly Tasso from the ACE TA center. Unfortunately, Christine, our colleague, is out sick today. Amy Killelea has also joined us, and she is an independent consultant providing public health policy and financing expertise to government public health agencies, non-profits, 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. Carrie Rogers is a project manager at Community Catalyst, and she oversees the outreach, and enrollment project organizing for outreach, and also provides technical assistance on other marketplace outreach and enrollment projects. Carrie has worked on Marketplace, and ACA issues for over eight years, and we're happy to have her with us. Anne Callachan is joining us from the Community Research Initiative in Boston, Massachusetts. She's a staff member of the Massachusetts ADAP program, which is called HDAP. And Anne is the team lead for their Bridge Health Insurance Enrollment team...

Liesl Lu: And in coordination with the Massachusetts Department of Public Health, the Bridge team assists people with HIV, and navigating insurance enrollment, supporting access to infectious disease, drug assistance, and preventing gaps in treatment and care. Anne has also completed the Medicare training program, and serves as a certified SHINE counselor. SHINE is known as SHIP, or the State Health Insurance Assistance Program as it's referred to in most states in the country, and SHINE is the term for it here in Massachusetts. So thank you to Amy, Carrie, and Anne for joining us, and let's get started with questions. So let me just see what we have here. So the first question Amy will take. So the question is why are dental and vision not covered under Medicare? And also what about lab work? The person noted that some supplemental plans do offer vision and dental, and they have clients that are both on Medicare and Medicaid. And if something's not covered by Medicare, then it will not be covered by Medicaid. But it seems to me that some clients do not experience this, and they still get covered. So Amy, do you want to take that?

Amy Killelea: Yeah, thanks Liesl. This is a great question, there's multiple parts to it. So on the first part of dental and vision, and why they are not covered under Medicare. Currently, and this could change with federal legislation in the future, but currently dental and vision are not required services under any part of Medicare. And for that matter, nor are hearing benefits. That's another one that often gets noted as a fairly significant gap in coverage. So, but as you mentioned it, and what is true, is that some Medicare Advantage Plans do choose to offer those benefits. That is an option because they are not a required Medicare benefit, but you do find that some Medicare Advantage Plans find that it's in

their best interest to draw folks in by offering those benefits. But that's going to be variable by plan.

Amy Killelea: The second piece in terms of lab benefits, I will say it'd be interesting to know what specific lab benefit you're finding clients are having a hard time accessing via Medicare. But in general, lab services, lab benefits are covered. They're typically covered under the Medicare Part B benefit, B as in boy, and this includes things like HIV and hepatitis screening. As well as immunizations, flu shots. So generally, that's a pretty well covered service area, but again, having specifics as to what's not getting covered would be helpful there. And then finally, your question notes that benefits differ depending on whether the client might be... And you mentioned the Medicaid program in Connecticut. So, depending on whether the client might be covered by both Medicaid and Medicare.

Amy Killelea: So in other words, the client is dually eligible across those two programs, versus when a client is covered solely by Medicare. And you're right to mention that variability, that is absolutely true. Dual eligible beneficiaries may have access to a special set of plans that are called Special Needs Plans, or SNPs, and those plans often cover things like dental, vision, and hearing services that may not be covered by Medicare. So it's a complex world, and it really does kind of vary depending on some of those factors I mentioned. What types of services your clients are going to have access to...

Liesl Lu: Great. Thanks, Amy... And so... Amy, we'll stick with you for the next one, too. So if someone has a Medicare Advantage Plan, they cannot use their straight Medicare, is that correct? Even if their provider doesn't accept the Advantage Plan?

Amy Killelea: So, this is correct. And as the speaker in presentation mentioned, open and special enrollments are an incredibly important time. It is a stressful time, but that's the time that clients select what type of Medicare product they're going to be in, and so it is an either or decision. Individuals can select to either enroll in traditional Medicare, or to choose a Medicare Advantage Plan. And the time to do that is during open or special enrollment periods. So once a client picks either of those two options, unless there's a special circumstance that triggers a special enrollment period, individuals can't change mid-year from a Medicare Advantage Plan to traditional Medicare outside of that enrollment period. And the presenter noted this, and I will just underscore it.

Amy Killelea: It's really, really important to be reviewing provider networks in particular when you're looking at Medicare Advantage Plans before enrolling. It is a fact

dependent, client dependent, geography dependent set of considerations to decide whether Medicare Advantage, or traditional Medicare is going to be best for your client. But one of the themes, one of the things that comes up with Medicare Advantage Plans is that they often have narrower provider, not always, but often they have narrower provider networks than traditional Medicare. So, this question kind of describes exactly that problem. If you end up in a Medicare Advantage Plan and, oh gosh, the provider you need to see is not in it. But that has to be a before you enroll inquiry. To really make sure folks that don't get caught without access to the provider they need to see...

Liesl Lu: Thanks, Amy. And I'll skip down and go to you on a question that's similar to this, just so we can cover these same topics at the same time. So there was a question someone chatted in that their patients are asking to keep us as their provider as they age into Medicare, and how can they ensure that happens? So Anne, is there anything you want to add there to Amy's response?

Anne Callachan: Yeah, I would say just being really careful when you're working with clients. If they're choosing Medicare Advantage Plans to search for a plan where they can keep some, or all of their providers, or to carefully consider their options. If choosing a Medicare Advantage Plan doesn't allow them to do that.

Liesl Lu: Great, thanks. And Anne, I'll stick with you for the next question. So, it's number 26 in our grid. So if someone who's turning 65, but still employed, and has insurance through their employer. Will they be penalized for not enrolling into all parts if they decide to enroll at a later date?

Anne Callachan: So generally, the answer to that question is no. But there might be certain circumstances where employer insurance doesn't meet the criteria that would allow somebody to opt out of Medicare enrollment when they turn 65 without being penalized down the road. So I would say the most important thing is for clients, as they're aging into Medicare, or if they're thinking of staying on employer sponsored insurance. To check with their employer, and see if they're required to opt into any parts of Medicare, meaning Medicare would be their primary payer. A lot of clients do just automatically decide to enroll in Medicare Part A, if it's premium free for them. But again, making sure they understand if they pick the Part A, is Medicare their primary payer, or is they're employer sponsored insurance still their primary payer? And clients can always contact Social Security if they have concerns about whether or not sticking with the employer sponsored insurance is going to result in a penalty down the road...

Liesl Lu: Thank you... So, Amy, I'll go to you next. The question is, why would a person on Medicare not qualify for home health services?...

Amy Killelea: Here I am. So, yeah, that's a good question. Home health services is a covered benefit in Medicare. It's usually covered by Part B, sometimes it's covered by Part A. And not knowing the specifics of a situation, I will just say, and this should be of no surprise because some of these services have a acuity test or needs tests. So generally, to be covered a patient would need a needs assessment completed by a doctor or treating provider. And that needs assessment is going to determine, and offer evidence that the home healthcare services are needed. And specifically, that the beneficiary is homebound, which is a requirement. So that could be one area, but it is generally a covered service. And you just have to figure out if the client meets that needs determination...

Liesl Lu: Thank you. All right... So then Amy, there's one more here for you in terms of when would ADAP not pay for a supplemental plan?

Amy Killelea: Yeah, this is a good question. And I want to sort of caveat this answer with two things that I think the ACE TA folks remind you all a lot, but this is important. One, always, always, always check and reference, and double check, and double reference the HRSA HAB policy clarification notices on these topics. So we're going to chat out PCN 18-01, that is the PCN that was updated a few years ago. And that includes everything one would need to know about the parameters for Ryan White Insurance Purchase Assistance. Including purchase assistance for Medicare, or insurance assistance rather, for Medicare. What I will say, the second piece is always, always, always check with your state's ADAP. This is one of those things that is going to vary by state. If you have seen one ADAP insurance assistance program, you have seen one ADAP insurance assistance program.

Amy Killelea: So that is as first and foremost. Ryan White recipients in that state, Ryan White clients in the state should really be checking with ADAP to know when it comes to... There's a child crying in the back, I apologize for that. But should check with their ADAP to know the specific Medicare cost covered in that state. I will say, so the question here is specifically about supplemental plans, also known as Medigap plans. So those are plans that are designed to help with cost sharing, but they can't wrap around a drug benefit. And so that adds a little bit of a limiting factor. So generally, states have to use non-ADAP funds to pay for these plans. So that's one of the factors that you might see with an ADAP, deciding to, or deciding not to cover that. So again, look at the PCN. It does not specifically cover Medigap plans, but it is still a good resource to really get into the weeds of how... the HRSA HAB requirements when it comes to insurance assistance...

Liesl Lu: Awesome. Thank you. And so now, Anne, turning to you. Do new Medicare enrollers have to first enroll in original Medicare to be able to switch back and forth between original, and Advantage Plans in later years?

Anne Callachan: Yes. So clients must be enrolled in both Medicare Parts A and B before being eligible to enroll in a Medicare Advantage Plan.

Liesl Lu: Okay, thank you. And then we'll just go to the next one there, Anne. And the question is, who determines LEP? Which, I'm having a blank on what that stands for.

Anne Callachan: So the LEP is the late enrollment penalty. So social security would determine whether or not a client's plan... or social security, or Medicare would determine whether or not a client's plan was subject to a late enrollment penalty. Based on whether or not the client didn't opt into the required pieces of Medicare to avoid the penalty, or maybe temporarily lost coverage for nonpayment. And then when they're able to re-enroll into something like Medicare Part B or D during an open enrollment period, or a SEP, whether or not their plan is then subject to have a late enrollment penalty added onto the premium...

Liesl Lu: Great. Thank you, and just to clarify a SEP, or S-E-P, is Special Enrollment Period...

Anne Callachan: Yeah, Thank you.

Liesl Lu: So sure, no problem. So turning, Carrie, to you. There is a question that says can adult with SSDI, Social Security Disability Insurance, only have Medicaid and not Medicare? And this person is in Alabama, which shows not to expand Medicaid.

Carrie Rogers: Sure. So in most case, clients are always auto-enrolled into parts A and B after 24 months of having SSDI. And if the client has been auto-enrolled in Medicare, they're not obligated to keep their Medicare coverage, but they could incur a penalty if they decide to enroll later on. So for people who are eligible for both Medicaid and Medicare, it's often helpful to have them remain dually enrolled in both programs because they'll receive help with the cost of Medicare coverage. Such as through the Medicare Savings Program, prescription drug coverage, behavioral health services, and/or long-term services and supports...

Liesl Lu: Thanks, Carrie... All right. Amy, I think I'm coming back to you with a question... So is there any way that the expansion of Medicare covered benefits of vision and dental, originally include it in the Build Back infrastructure bill, and subsequently cut from that legislation could be restored?

Amy Killelea: Yeah, it's a good question. And I sort of alluded somewhat vaguely to the possibility that the policy choice not to include vision, dental, and hearing benefits could be reversed in another policy choice that that Congress could make. And so the question references Build Back Better, which is a piece of legislation that was passed by the House of Representatives a few weeks ago. It includes significant investment across a bunch of different areas, including healthcare, and including Medicare. So it's certainly something to watch. I mean, I will say, it's just past the House of Representatives. As the questioner notes, when it passed the House of Representatives it only included a new coverage requirement for Medicare to add hearing benefits, but did not include a requirement to also add vision and dental.

Amy Killelea: The legislation is now being considered in the Senate where a lot could still change. So it's early days, I think it's premature to really conjecture all that much about what, or if a final bill will include, or even pass. But it is something to watch, and there are a lot of provisions that would impact Ryan White recipients and clients. So I would just kind of urge people, watch this space, it's unclear exactly what will happen. But I'm sure the ACE TA center will keep folks posted about that as well...

Liesl Lu: Yes, we certainly will. So, Anne, I think I'm coming back to you next. This is about the Extra Help program. And the question is, do we have to ask for the extra help program or do clients... I think the insinuation here is do clients get enrolled automatically?

Anne Callachan: So the Medicare Savings Program would automatically qualify somebody for Extra Help. In addition, clients who have Medicaid, when they become Medicare eligible, would be automatically enrolled into Extra Help and in Medicare Part D plan with a low income subsidy. So once a client has been approved for any of the three Medicare Savings Programs, they receive a purple colored notice from CMS, Center for Medicare Services, informing them that they automatically qualify for Extra Help.

Anne Callachan: And they generally do not need to take any action for these benefits to start. They typically get automatically enrolled in a Medicare Part D plan with that low income subsidy, but clients can also actively enroll in a Part D plan and search for the plan that works best for them. Some clients could lose that Extra Help eligibility if they lose their dual eligibility. So they might need to re-apply to see if they still qualify for Extra Help, even if they're no longer active in Medicaid. And the Extra Help program is not available in Puerto Rico, the US Virgin Islands, Guam, the Northern Mariana Islands, or America's Samoa. And we are going to chat out a link for you about enrolling in Extra Help.

Liesl Lu: Thanks, Anne. And another question for you, the question is, is it correct that you can switch from an Advantage Plan to Medicare by selecting a Part D plan?

Anne Callachan: So, yes, but that would be a simple answer. So generally, one Medicare enrollment trumps the other. Meaning, if during the Medicare open enrollment period you enroll in a Medicare Advantage Plan, and then before that enrollment period ends you enroll in a Part D plan. It would essentially cancel out your Medicare Advantage enrollment. It's whatever the most recent enrollment is. For clients who are active in a Medicare Advantage Plan on January 1st, they can use that Medicare Advantage open enrollment period that runs from January 1st to March 31st, to go back to original Medicare and enroll in a Part D plan. They can make a one time change. They can also, just during that same enrollment period, make a one time change and select a different Medicare Advantage Plan.

Liesl Lu: Thanks for those clarifications. I think that's probably pretty helpful for people. All right. So Amy, the next question is, which plan is recommended for low income clients? Based on the Ryan White Sliding Scale Fee chart? Because it sounds like Advantage plans have more out-of-pocket costs.

Amy Killelea: Yeah, my answer to this question, and I would want a little bit more information. I'm not going to have too much to say in terms of based on the Ryan White Sliding Scale Fee chart. I would say, I'll answer this based on income. And you're right, considerations are going to vary based on income. But I would just say, choosing a Medicare Advantage Plan, choosing a Medicare Part D plan, or choosing between Medicare Advantage, and traditional Medicare is a fact and client specific inquiry always. And so unfortunately, there is no shortcut to provide recommendations that are going to apply across the board, and so I know that is not a very helpful answer. But I would just underscore what I think Anne stated a few times, and what was stated in the presentation is that when you're looking at what plan, or choosing between Medicare Advantage, and traditional Medicare. It's really about looking at the attributes of the plan that are going to be most important to your client.

Amy Killelea: So, for people with HIV, a lot of times it's going to be provider network. And that's why you can get into some trouble with Medicare Advantage narrower provider networks. You want to look at out-of-pocket costs. And so, as the questioner sort of indicates, yeah, sometimes Medicare Advantage Plans can have higher overall out-of-pocket costs than traditional Medicare. That is true. Sometimes they have lower out-of-pocket costs. So that's an important point to look at, or point of comparison to look at.

Amy Killelea: Looking at a Medicare Part D plan, there are a lot of variation. Not in terms of what's covered most of the time, but how much it is, what tier it's going to be on. And the last thing I'll say is the other variable is, it matters what type of insurance assistance program your client has access to. So it does go back to knowing all of the information, as you work with a client to figure out what plan makes most sense. Including what type of Ryan White and ADAP assistance in particular is going to be available...

Liesl Lu: Thanks, Amy. And I'll just keep you on here. The next question is can ADAPs pay for Medicare Advantage Plans?

Amy Killelea: Yeah, this is a very short answer. The answer is yes. They can, and they do.

Liesl Lu: Great, and so some more Medicare Advantage questions. Anne, turning to you, sort of teasing apart what I think some of what Amy was just touching on. But the question is, aren't some Medicare Advantage Plans, the PPO plans, that allow out-of-network services at higher cost?

Anne Callachan: Yeah. So generally the PPO Medicare Advantage Plans do allow clients both to see in-network providers at a set copay, and out-of-network providers at a copay that is generally greater. I think it's always important, when you're choosing a Medicare Advantage Plan. I mean, we can't really stress this enough to make sure that even within the scope of out-of-network providers, what does that mean? Can I see any provider who's not contracted with this plan and pay a higher copay? Or are there some clarifications on that, that you want to make with the insurance carrier? So I would always say, carefully consider those choices. Contact the plan directly to make sure that the provider you might want who's out-of-network is going to be able to allow you to be seen by them with that plan...

Liesl Lu: Great. Thanks, Anne. All right, I know some recent questions just came in, so I think we're looking at addressing those. So in the meantime, let me just... answer some common questions that have come in through this series and previous. So one question has been, does Medicare cover vaccinations? And the answer is yes. Medicare Part B will always cover vaccinations for influenza, pneumonia, hepatitis B, and COVID-19. And then Medicare Part D covers most other vaccines, that Part B doesn't cover, such as shingles. So there's some info there...

Liesl Lu: And... just in terms of looking at coverage. One question is, does Medicare cover services in other countries? And so original Medicare, so parts A and B, does not cover services outside of the country. But if you anticipate traveling

internationally, and you have original Medicare, you can add on a supplemental Medigap plan. Which may cover services out outside the country. There can be some stipulations, so you can have a client contact Medigap Plan for more information on that if folks are traveling and need coverage... And I'm just looking at the questions that are coming in. So just bear with us one moment...

Mira Levinson: Liesl, there's one more question that we're ready to answer.

Liesl Lu: Okay, great... Great. So Anne, this one's for you. If a client turns 65, but doesn't have enough credits for the free Part A. Is it best to enroll them in Medicare Advantage so that ADAP can pay for their premium?

Anne Callachan: So, just to clarify again, clients do need to have both Medicare A and B to enroll in a Medicare Advantage Plan. So while an ADAP program could definitely pay the premium for a Medicare Advantage Plan that somebody enrolled in, the client might still be responsible for paying the premium for their Medicare Part A, and their Medicare Part B. Unless they qualify for one of the buy-in programs that would pay the Medicare premium directly for them.

Liesl Lu: Thanks, Anne... And so one other question that... we have... is the seven month initial enrollment period counted by actual days or calendar months? And that's referred to as an IEP, and so that's based on calendar months for calculating that. So for example, if your client's birthday is in June, and their initial enrollment period includes... Their initial enrollment period would include three months before their birthday month. So starting, for example, March 1st and their birthday month, which is June. And then three months after their birthday month, ending in September 30th. That's why I think you may have heard sometimes, the IEP is sometimes called the 313 period.

Liesl Lu: And the only exception to this is if your client's birthday happens to fall on the first of the month. For example, if your client's birthday is on June 1st, the IEP starts a bit earlier and it includes the four months before their birthday. So starting February 1st, the birthday month, and then the two months after their birthday month ending August 31st. So in this case it's still a seven month period, but the distribution's a little different with a 412 period instead of a 313 period... And just bear with us another minute. I think we're looking at questions, but they have started to slow down. So thank you all so much so far for all of the questions...

Liesl Lu: So another question is, can someone be auto-enrolled in a Medicare Advantage Plan instead of original Medicare? And I don't think we've completely covered this yet, but typically no. So, individuals who enroll in Part A and Part B are not

auto-enrolled in Part C. They must elect to do that during the Medicare open enrollment period, which runs from October 15th to December 7th. And so the one exception is that, in some states, some individuals who are dually eligible for Medicare and Medicaid are auto-enrolled into a special type of Medicare Advantage Plan called a Dual Eligible Special Needs Plan, or D-SNP. But that is not the general policy for the majority of Medicare enrollees. I don't know, Anne. I see you're shaking your head. So I don't know if you have anything to add there. No? Okay... All right. So Amy, I have a question for you that's come in. And the question is, if we're not contracted with Medicare Advantage Plans, can we bill services to Ryan White?

Amy Killelea: Yeah, this is a really good question. And so I'm going to assume that the questioner means, can you add the clients are Medicare eligible, or Medicare enrolled rather? So that's going to be the crux of the question. So I'm making that assumption. And the short answer there is no, or mostly no. Payer of last resort in the Ryan White program is going to require that if the client is covered by Medicare, the clients are going to have to providers who are in-network. And that is why, as you guys probably remember, there was a big push right when ACA was implemented. To ensure that Ryan White providers got in-plan networks for Marketplace plans to avoid this issue where the trusted provider is not contracted with the plan that the client is covered by.

Amy Killelea: And so that's the general answer. I will note that because sometimes clients get into plans that have incredibly narrow networks, such that there are no Ryan White providers in the network. There may be an exception there to payer of last resort. That's generally not the case in Medicare, that happens more in commercial insurance. And when I say more, I know of maybe two examples that I've seen in the past decade of that happening. So that's going to be a very, very narrow exception. So the general rule of thumb there is if you are a Ryan White provider, if you are seeing a lot of Medicare clients, it is important be in that plan network...

Liesl Lu: Thanks, Amy. All right, Anne, I'll turn to you now. So if a person's not eligible for free Part A, can't the person enroll in a Marketplace plan?

Anne Callachan: So, yes, clients who are not eligible for premium free Medicare Part A should be able to enroll in a plan through the Marketplace, or to keep their existing coverage through the Marketplace if they already have it. And be eligible for subsidies...

Liesl Lu: Great. Thanks, Anne. Well, I think we're going to move forward and start to close out, but thank you all so much for all of the questions. And I hope this extended Q&A period was really helpful to you.