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

Molly Tasso: So good afternoon everyone, and welcome to today's webinar on The Basics of Medicare for Ryan White Clients. My name is Molly Tasso, and I'm the Project Director of the ACE TA Center and Consultant at JSI. So today kicks off our four-part series that will cover Medicare, Medicaid, and Medicare Medicaid dual eligibility for Ryan White clients. The second part of this series, which covers Medicare enrollment and coverage for Ryan White clients will be taking place exactly two weeks from today, and we'll also be sharing the dates and registration information for all the webinars and the series towards the end of today's webinar.

So before we get started, here are some technical details for anyone who might be new to our webinars. So first, everyone is in listen only mode, but we encourage everyone to ask a lot of questions using the chat box. You can submit your questions at any time during today's presentation, and we will take as many as we can towards the end of today's session. You can also always email questions to us at acetacenter@jsi.com. The easiest way to listen to our webinar is through your computer. If you can't hear very well or are having trouble, check to make sure that your computer audio is turned on and the volume is turned up. And if you're still having issues, just try to close out and rejoin the webinar session. We'll also put the call in information in the chat box if you do find it easier or more convenient to call in using your phone.

So a little bit about the ACE TA Center. We help 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 specifically, 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 communicate with clients about how to stay enrolled and use health coverage. And this is all done through our development and dissemination of best practices, and supporting resources, and also by providing technical assistance and training through national and localized activities. The audience for the ACE TA Center includes Ryan White program staff, clients, program managers and administrators, and also people who help enroll Ryan White clients such as Navigators, certified application counselors, or SHIP counselors who are experts in Medicare enrollment.

So as always, today's webinar will be archived on our website on TargetHIV, and that website is targethiv.org/ace. And all participants in today's webinar will also receive an email when it is posted so you can share it with your colleagues. Our

website also hosts all of the resources and tools that we're going to be discussing and sharing today. So if you happen to lose a link, or forget, or want to return to something later, please go to our website or you can search the topic library on TargetHIV.

So moving to today's presentation, here on the slide, you'll see a roadmap for what we're going to be doing today. So we'll start by discussing the changing demographics of Ryan White clients and Medicare eligibility for people with HIV. Then we'll move through the different parts of Medicare, including Medicare prescription drug coverage for people with HIV. And then finally, we'll outline the common Medicare enrollment pathways, and we'll also be highlighting relevant resources from the ACE TA Center and other places as well throughout this presentation. And then of course we'll be ending with a Q&A with our panel. So to that point, for today's presentation, I am pleased to be joined by my colleagues at JSI, Christine Luong and Liesl Lu. Liesl is the ACE TA Center Senior Technical Advisor and has been part of the ACE TA 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. 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 and subrecipients, clients, and a variety of other audiences. And then today, for our Q&A session, we're also pleased to have Amy Killelea joining us. Amy is an independent consultant providing public health policy and financing expertise to government public health agencies, nonprofits, and payers and providers. And her focus areas include HIV and hepatitis programs, public and private insurance coverage, public health and healthcare financing strategies, as well as medication access and pricing.

So before we dig into the presentation, I first want to start with a couple of polls. So the first poll that we're going to ask everyone to respond to is to learn a little bit more about your clients and Medicare enrollment. So the question that hopefully you've seen pop up on your screen, has your organization seen an increase in the number of clients who are becoming eligible for Medicare? So yes, no, not sure. And Michelle, whenever you see a consensus or most folks have responded, you can go ahead and close the poll and I'll review the results.

Great. So it looks like about half of respondents are not sure if the organization has seen an increase, but about 44% of folks are indicating that they have seen

an increase in the number of clients becoming eligible for Medicare. So this is certainly obviously an important and relevant topic to be discussing today. The second poll, we're curious, what are the most, or what is the most common reason why clients at your organization are becoming ineligible for Medicare? So is it turning 65 and aging into Medicare, or is it someone who's under 65 with a qualifying disability, or if there's another pathway that they're becoming Medicare eligible, please chat it in the chat box.

I'll give folks a few more seconds to respond. Okay, so it looks like 66% of respondents said that folks are turning 65 and aging into Medicare, and then only about 30% of folks under 65 with a qualifying disability is how people are becoming Medicare eligible. So looks like the aging population that we know taking place is where we're seeing the eligibility, but we're going to be discussing throughout today the different pathways and the impact on Ryan White clients. So with that, I am going to hand it over to my colleague Christine, who's going to be walking us through the data and the snapshot of the change in demographics of Ryan White clients.

Christine Luong: All right. Thank you so much Molly, and hello everyone. Thank you for joining us. So I'm going to start us off by talking about the changing demographics of Ryan White HIV/AIDS program clients. Alrighty. So first off, Medicare is the largest source of federal funding for HIV/AIDS care in the US. And about one fourth of people with HIV who are in care actually get their health coverage through Medicare. Now, historically, most Medicare beneficiaries with HIV have been under the age of 65 and qualified for the Medicare program because of a disability. However, there are now more older adults living with HIV and served by the Ryan White program than ever before. So a quick stat for you all. In 2019, 46.8% of Ryan White clients were age 50 and older. And this number is actually projected to rise to about two thirds by 2030.

So let's take a closer look at the data here. In general, the age distribution of Ryan White clients is shifting towards the right as people with HIV are living longer and healthier lives. So the chart on the left is showing data from 2010, and the chart on the right is showing data from 2021. Now, these numbers include Ryan White clients in all 50 states and three territories, that's Guam, Puerto Rico, and US Virgin Islands. So I want to draw your attention specifically to the light blue and the green bars in the middle of each graph. So you can see that the percentage of Ryan White clients that are aged 35 to 54 has actually decreased over time from 2010 to 2021. Combined, the proportion of people within these two age groups have decreased from about 60% in 2010 to about 42% in 2021. And then now, I want us to take a look at the orange and the

yellow bars that are to the far right of each of these graphs. And those represent all Ryan White clients that are age 55 and older.

So in 2010, as you can see, just under 17% of Ryan White clients were age 55 or older. And then by 2021, this has actually increased to over 35%. So that's a little bit more than one in every three clients. And as I mentioned on the previous slide, the proportion of clients, age 50 and older, is expected to increase in the next decade or so to about two in every three clients. So now, let's take a quick look at the characteristics of people with HIV who are enrolled in the Medicare program. Now remember that for the purposes of this slide, not all of these people are Ryan White clients. And also, there are a lot of people that have been part of the Medicare program for many years for reasons other than age. So on the slide, the chart on the top shows how current Medicare beneficiaries with HIV first became eligible for the program. So 79% of Medicare beneficiaries with HIV are under the age of 65 and qualified due to a disability.

And it is interesting to note that this is actually very different from the general population of folks without HIV, where only 17% of Medicare beneficiaries qualified based on disability. And then the other 21% of Medicare beneficiaries with HIV qualified for the program based on age alone when they turn 65. And then the chart on the bottom of the slide shows that 69% of Medicare enrollees with HIV are actually dually eligible for both Medicare and Medicaid.

So now, let's switch gears a little bit and talk about how people with HIV typically become eligible for the Medicare program. So first and foremost, in order to be eligible to enroll in Medicare, an individual must be a US citizen, or a legal resident for at least five years with a few exceptions, and there are three primary ways that people with HIV can qualify for Medicare. So the first is by being at least 65 years old. The second way is by being under 65 but with a qualifying disability. And the third way is by having end stage renal disease at any age. CMS does have a calculator that you can use with your clients to determine their Medicare eligibility. And we've chatted out the link to that. But just a quick note that our presentation today is going to focus more on the first two eligibility pathways, the age and the qualifying disability pathways.

So as I've just said, any US citizen or eligible legal resident will qualify for Medicare when they turn 65. But I do want to note we're going to talk about the different parts of Medicare later in the presentation. But I want to highlight 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. Now this information only applies if the person wants to

get premium-free Medicare Part A coverage. In general, you can earn work credits by working on a job and paying social security taxes. Those work credits are based on the individual's total annual wages or their self-employment income. You can earn one work credit every quarter, which is every three months, for a maximum of four credits per year. So when we say 40 quarters or 40 credits, that equals about 10 years worth of work.

And these credits do not have to be earned consecutively. Now, if the person doesn't have enough credits by the time they turn 65, by all means they can still enroll in Medicare Part A, but the only difference is that they have to pay a premium for Part A coverage. And then this premium amount is going to vary depending on how many credits the person has so far. They can also continue working past age 65 in order to earn the 40 credits that are needed for premium-free Part A. So to recap, again, the information on this slide is only applicable for Medicare Part A, and we'll also chat out a link to more information about work credits. So you can take a look at that.

Now, certain people under the age of 65 are eligible for Medicare if they have a medical condition that meets the Social Security administration's requirements for disability insurance, which you may know as SSDI, Social Security Disability Insurance benefits, and if that person has worked in jobs where they have paid taxes towards social security. So after a person has been receiving SSDI payments for at least 24 months, this actually does not have to be 24 consecutive months, then that person becomes automatically eligible for Medicare Parts A and B. Now to qualify for premium-free Part A coverage through this pathway, the person must have 40 social security work credits, which is the same rule that I just covered for folks who are 65 or older. And generally, to qualify for SSDI benefits, the Social Security Administration requires that the person's disability be severe enough to prevent them from doing any sort of substantial gainful employment for at least a year or more.

One of the things I want to highlight today here is that while HIV is one of the medical conditions that Social Security will consider for disability, HIV status by itself will generally not qualify someone for SSDI benefits. People with HIV can qualify when they have either a serious HIV related condition, a qualifying CD4 count, repeated hospitalizations, or what's called repeated manifestations of HIV that results in functional limitations. So to recap, a person with HIV who does not qualify for SSDI benefits under these HIV rules can still qualify for Medicare coverage if they meet the medical requirements for another physical or mental health condition. And we've just chatted out a link with more information about that.

All right. So let's take a quick break right now and do a little poll. So the question's going to pop up on your screen, let us know what information would be most helpful for staff in your program to understand about Medicare? For this question, you can check multiple options if you'd like. So let us know what information would be most helpful. Is it the different parts of Medicare, A, B, C, D, the difference between original Medicare, Medicare Advantage, and Medigap policies? Who is eligible for Medicare? When to enroll? How to transition from employer coverage to Medicare? Medicare penalties and how to avoid them? Or Medicare benefits, specifically aging related inpatient and residential services? Or if there's something else which you can chat in and let us know. So let's give folks a few more seconds to read through all those responses and provide their answers. Again, you can check more than one option if you'd like, and you can also chat in something else if it's not on this list.

Alrighty. So let's take a look at the results. So two thirds of the folks who responded to this poll said that information about the different parts of Medicare and the difference between original Medicare, Advantage, and Medigap would be most helpful. And then I'm seeing the next most popular options with about 50% and 49% of respondents is Medicare penalties and how to avoid them, as well as Medicare benefits, specifically aging related inpatient and residential services. So thank you everyone for sharing that. These are all topics that we're going to cover either today or in the rest of the series. Let's close that poll. Thank you. Alrighty. So now let's talk about the different parts of Medicare.

Next slide. Thank you. All right. So there are three parts to Medicare. On this slide we're going to start with Medicare Part A. You may know it as Part A hospital coverage. So this is going to cover inpatient hospital care, surgery, lab tests, skilled nursing, facility care, hospice care, home healthcare, among other things. We'll chat out a link from the Medicare website that talks about what Part A covers. Medicare Part B includes medical coverage for services from doctors and other healthcare providers including outpatient care, some preventive services, and home healthcare. And it also will cover medications that are administered by a physician as well as durable medical equipment. So we'll chat out another link with that information.

And then finally, Medicare Part D provides coverage for outpatient prescription drugs, including HIV antiretroviral medications. And we will talk about each of these Medicare Parts A, B, and D, throughout the presentation. We'll chat out a link now about what Part D covers. So as a quick recap, Part A is hospital coverage for inpatient care, Part B is medical coverage for outpatient care,

preventive services and overall routine care, and then part D is prescription drug coverage. So those are the three coverage options. Now, even though there are these three parts, there's actually only two ways that someone can obtain Medicare coverage. Those two ways are original Medicare and Medicare Advantage. So now, we're going to take a look at those two options in more detail.

All right. So the first enrollment option is original Medicare. You may know it as Traditional Medicare. Those two terms mean the same thing. original Medicare plans are administered by the federal government and it includes Medicare Part A hospital coverage and it includes Part B medical coverage. So original Medicare by itself does not include any prescription drug coverage. Part D is not included. If an individual does want prescription drug coverage, they're going to have to purchase that separately and we will explain how that works later in the presentation. Now, if your client chooses to go with original Medicare only, it is important to keep in mind that there are coverage gaps in original Medicare including deductibles and co-insurance. So for example, the first thing to keep in mind is that the Medicare Part A deductible is based on a 90 day benefit period. And what this means is that the deductible can be applied more than once a year.

And even after the Part A deductible is met, the person may still be responsible for additional charges for long-term hospitalizations, skilled nursing care, and blood products, and things like that. And unlike Part A, the Part B deductible is based on an annual period. But after that Part B deductible amount is met, the beneficiary is still responsible for a 20% co-insurance. So what this means is basically Medicare is going to pay 80% of all approved charges and the client is responsible for the remaining 20%. So depending on the type of service, 20% co-insurance can add up quickly. So just keep that in mind.

Now, the other option for enrolling in Medicare coverage is to get a Medicare Advantage plan. These are basically plans that will bundle Part A hospital coverage, Part B medical coverage, and Part D prescription drug coverage altogether under one plan. These plans are also known as Medicare Part C. So Medicare Advantage equals Medicare Part C. Advantage plans may or may not have a monthly premium, it really depends. And if there is a premium or local Ryan White program and AIDS Drug Assistance Program, or ADAP, may be able to help pay for that. So in addition to bundling hospital medical and prescription drug coverage, Advantage plans may also offer extra benefits that original Medicare generally doesn't. So for example, things like vision, dental, hearing, and wellness programs like gym memberships and things like that. And I will say

that in general, Medicare Advantage plans nowadays are starting to offer more extra benefits than they have in the past.

So just as a quick example, transportation to doctor's visits. Those are some extra benefits that you might see if you're shopping for a Medicare Advantage Plan today. Now, unlike original Medicare, Advantage plans are administered by private insurance companies that contracts with the federal government. Advantage plans are generally either an HMO plan or a PPO plan that has a specific network of preferred providers. So in that case, clients may need to get some services approved ahead of time, or they might have to get a referral in order to see a particular specialist. Advantage plans are also allowed to implement step therapy to manage drug coverage. The last thing I will say here is that most Ryan White programs throughout the country recommend the clients enroll in original Medicare. But the caveat is that, this decision really depends on what the Medicare Advantage market looks like in your area. So therefore, it's very important to work closely with your clients to review what specific Medicare Advantage plans are available in your jurisdiction and determine if that is a better option for your clients.

Now, again, important to note that Medicare Advantage plans have pros and cons, just like any other plan, and they may not be right for everyone. So for example, Advantage plans may not always be the best choice for people with HIV because of more limited provider networks. So this could make it harder for someone with complex conditions to continue seeing their existing providers, especially specialists who might not all be in network with that particular Advantage Plan. And then copay and co-insurance amounts for services can sometimes be a little higher under Advantage plans too. However, the flip side of it is that, in some cases, Advantage plans can be a good option for people with less complex medical needs, as well as for clients who wouldn't need to see a provider if they're traveling out of state. So again, just want to hit home the point that plan design, plan availability, all of that's going to vary depending on where the client lives. So really take the time to sit down with your client and review what's available in your area.

You can do this, you can help clients shop or compare plans by visiting medicare.gov and using their plan compare tool. We will drop a link in the chat with that information. And then finally, I want to talk a little bit about Medicare supplemental insurance, also known as Medigap policies. Basically, Medigap policies are going to help to cover some of the gaps in Medicare Part A and B coverage, and it only works with original Medicare. So Medigap policies, these are sold by private companies. However, they're standardized by state and

federal law, and they have to be clearly identified to consumers as Medicare supplemental insurance. So again, a client must have original Medicare, Parts A and B, to enroll in a Medigap policy. You cannot be enrolled in both Medicare Advantage and Medigap. Those two will not work together though. Medigap policies do not cover costs for Medicare Part D prescription drug coverage such as prescription copays, co-insurance, or deductibles. Again, Part D has to be purchased separately and we'll explain how to do that later in this presentation.

Now, if you have a Medigap policy, you'll have to pay a monthly premium that determines exactly what your out-of-pocket costs will be, if there are any. And your local ADAP program may or may not be able to help you pay this. But in general, the rule of thumb is that, usually, the more expensive the Medigap plan, the greater the benefits will be. On the other hand, Medigap policies will generally not cover things like long-term care, or vision, or dental, but like all things, it's important to weigh all the factors. So despite these limitations, Medigap plans can still be a good option for people who have more complex medical needs, as well as for clients who travel during the year and may need to see a provider outside of the country. So if you have a client who opts for original Medicare and you think that Medigap could be an option for them, you can visit medicare.gov and use their Medigap plan finder tool. So we'll chat out a link to that resource right now.

All right. So basically, I've been talking a lot, so I'm just going to do a quick recap of what we've covered so far. So we're going to start with original Medicare on the left side of the table. What you basically need to keep in mind is that original Medicare includes Part A hospital coverage and Part B medical coverage. For Part A, most people don't need to pay a premium as long as they have enough work credits to qualify for premium-free Part A. This applies to anyone who qualifies for Medicare due to age or disability. And if you don't qualify for premium-free Part A, you can pay a monthly premium depending on how many work credits you've earned so far. For Medicare Part B, that coverage is not tied to work credits in any way. And then finally, if you have original Medicare, you can add on Medigap supplemental coverage.

And you can also add on Part D prescription drug coverage if you would like. Now, let's take a look at Medicare Advantage on the right side of this table. What you need to know is that Medicare Advantage is one plan that bundles Part A hospital coverage, Part B medical coverage, and in most cases, Part D prescription drug coverage. They can also offer extra benefits that original Medicare does not have by itself. Advantage plans may or may not have a monthly premium, but they have a yearly limit on out-of-pocket costs for Part A

and B covered services. And then lastly, if you have Medicare Advantage, you can't buy or use Medigap with it. So again, very important to compare plans and see which will be the best for your clients. You can go to medicare.gov and compare original Medicare versus Advantage plans in your area. And then just keep in mind that the Ryan White program, including ADAP, can help pay in full or in part for any Medicare premiums, deductibles, and co-payments.

So it's very important to check with your local ADAP program to determine how they might be able to help your clients with their Medicare costs as this varies on a state by state basis. So we'll chat out a link where you can find your local ADAP coordinator. And with that, I will turn it over to Liesl to talk about Medicare Part D prescription drug coverage. Liesl.

Liesl Lu: Thanks so much, Christine, and hi everyone. So yeah, let's take a deeper dive into Medicare Part D. So 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, so that's 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. So all Medicare prescription drug plans must provide a standard level of coverage set by Medicare, but they may offer different combinations of coverage and cost sharing. Medicare drug plans may differ in the prescription drugs that they cover, and 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 the 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 regimens and then requiring them to fail in these options in order to get access to the prescriber's preferred or recommended HIV drug.

So again, HIV drugs are required to be covered without any of those options for utilization management. So however, there are some Part D restrictions for non HIV medications, including medication not on a formulary and quarterly limit issues. And providers can generally work with a Part D plan insurance carrier to request a prior authorization or exception that overrides these restrictions.

So 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 Part B when they first become eligible, unless they have coverage that allows them to defer enrollment without incurring a penalty. And so we'll discuss what that means in just a minute. Part D premiums may be expensive, so it's important to work with your clients to see if they're 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. And 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 their clients who are active in their ADAP 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, this is defined as coverage that provides at least as much as Medicare's standard prescription drug benefits. So some examples of creditable prescription drug coverage include TRICARE, the Indian Health Service, Veterans Affair, coverage from an employer or union, and coverage from the marketplace. I want to note that ADAP is not considered creditable coverage. If you are unsure whether your client's current prescription drug coverage is considered creditable, you can encourage them to contact their coverage provider directly. So that would either be original Medicare or their Medicare Advantage plan.

So you may have heard about the Medicare donut hole or coverage gap for prescription drug coverage, and 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. So an individual enters the donut hole when their total drug costs, including what they have paid and what their plan has paid for prescription drug coverage reaches a certain amount called their initial coverage limit. And 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. So once the individual meets the TrOOP limit, their plans' catastrophic coverage threshold kicks in, and from then on, they will pay a significantly lower cost for the remainder of the year. And then the plan resets the following year.

So note that both the initial coverage limit and the true out-of-pocket costs, the TrOOP limit, change every year, and you should check medicare.gov for updated numbers. ADAP expenditures for clients with Medicare Part D coverage count towards their true out-of-pocket costs, which helps clients reach that catastrophic coverage level faster. So you can check with your local ADAP about how they can help clients pay for drug coverage in the coverage gap.

So let's stop and do a quick knowledge check. And so the question that we have for you now is, which of the following are true about Medicare Part D prescription drug coverage? Is it, A, it can be purchased separately from original Medicare. B, it can be part of a bundle of Medicare Advantage plan. C, there is a late enrollment penalty for people who do not have creditable prescription drug coverage and who do not enroll when they're first eligible. Or D, all of the above. So let's give everyone a few more moments, but it looks like everyone, for the most part, most people are getting this correct, which is D, all of the above. So Medicare prescription drug coverage can be purchased separately from original Medicare, it's bundled with Medicare Advantage plan, and there is a later enrollment penalty for people who do not have creditable prescription drug coverage.

All right. Let's move on to Medicare enrollment pathways. So we've talked about what Medicare covers, and let's now talk about the ways that people become eligible to enroll. So there are four primary pathways that a client can enroll into original Medicare or a Medicare Advantage plan based on their age and specific life circumstances. First, if they receive Social Security Disability Insurance, or SSDI, or Social Security retirement benefits before the age of 65, they'll 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, 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, or IEP. 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.

There are a number of SEPs, including new SEPs just released by the Centers for Medicare and Medicaid Services that have shortened the waiting periods to gain coverage after enrollment and expand special enrollment periods. So we aren't going to go into all of the new SEPs today, but I will call your attention to some of these changes as we go, and I will speak specifically about transitioning from employer coverage after age 65 and being terminated by Medicaid. And so then finally, there's the general enrollment period, is for if a client has missed the

initial enrollment and they do not qualify for any of the special enrollment periods. So now, let's talk more about the IEP, the SEPs, and the GEP. So the Medicare Initial Enrollment Period, or the IEP, is a seven month period created around the month of a person's 65th birthday. So some people call the IEP the 3-1-3 period. It starts three months before the 65th birthday, then includes the month that the person turns 65, and then ends three months after they turn 65.

And with the recent CMS ruling, the coverage gap has been shortened in the last three months of the IEP. So let me show you. 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, and that's the fourth month of the IEP. So this portion of the IEP has remained the same. 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 the coverage gap has been shortened here. Prior to this, they had to wait longer to start their coverage. 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 the four months prior to the birthday month, the month the person turned 65, and then the two months after the birthday month. So that's just for folks whose birthday's on the first of the month.

So again, just to repeat the change here, due to the CMS ruling that came about earlier this month, if a person signs up during their birthday month or during the last three months of their IEP, their coverage will begin on the first day of the month after that they enroll. Next slide please. We want to stress how important the initial 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, and if an individual does not sign up for Part B during their IEP when they turn 65, and that's either through original Medicare, or Medicare Advantage, or Medicare Advantage plan, and they also don't have employer insurance, they will be subject to a late enrollment penalty. And this penalty is an additional 10% of the standard Part B premium for each 12 month period they were eligible but didn't enroll. And 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 the Part B, but it is also a lifetime penalty. And if you'd like to learn more about Medicare late enrollment penalties, join us two weeks from today, on January 31st, for the next webinar in the series, and we'll be chatting out a link later on to register. So now, let's talk about some of the Medicare Special Enrollment Period. So the first one is for a client who is still working past the age

of 65 and has employer-sponsored insurance, or they have employer coverage through their spouse who's still working. But when the client quits, retires, or otherwise, loses that employer-sponsored insurance, they'll qualify for an eight month SEP to help them transition to Medicare. So the SEP begins when the employer coverage ends. If they enroll during the eight month, their coverage will begin the first day of the month after they sign up.

And so you'll see this as a common change in the new changes that have come about with the recent CMS ruling, is that many times, when the individual enrolls the following month, they will receive the coverage. So please keep in mind, however, that the COBRA health plans aren't considered employer-sponsored coverage. So if a client is currently covered by a COBRA plan, they will not be eligible for this Special Enrollment Period when their coverage ends. And another thing, a final note about the Medicare and the 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, this is possible if they have 40 work credits or approximately 10 years of working history, which Christine explained earlier.

So now, let's talk about one of the new SEPs that we do want to provide more details on today. And this is the SEP to coordinate with the termination of Medicaid coverage. So this will be particularly helpful with the upcoming Medicaid unwinding that is set to begin on April 1st. So as a reminder, the public health emergency has allowed all Medicaid enrollees to remain continually enrolled in the program. However, once April 1st arrives, all beneficiaries will have their eligibility redetermined by state Medicaid programs. So if the individual is determined to no longer be eligible for Medicaid but is newly eligible for Medicare, they will qualify for this new SEP. This SEP will allow individuals to enroll in Medicare after a termination of Medicaid eligibility, so they won't have to wait until the next Medicare enrollment period. And this SEP will allow individuals to choose between retroactive coverage back to the date of termination from Medicaid, or coverage beginning the month after the individual enrolls.

If an individual selects the retroactive coverage, they will have to pay the premiums for the retroactive coverage time period. So it's important that Ryan White case managers and program staff take steps now to ensure eligible clients don't lose their Medicaid coverage by making sure paperwork is up to date. And we will be releasing a blog later this week that goes into details on the steps you can be taking right now to help your clients and how to prepare for the April 1

Medicaid unwinding. So if you aren't signed up for our mailing list, I encourage you to do so. We'll chat out a link right now for you to sign up.

So finally, if a client misses their Initial Enrollment Period and they also do not qualify for a Special Enrollment Period, they can enroll during their General Enrollment Period, which runs from January 1st to March 31st annually, and their coverage would begin on the first of the month after an individual enrolls. So previously, before the CMS changed this month, clients had to wait until July 1 for their coverage to begin, but CMS eliminated the four to six month coverage gap with the recent ruling. So this is a really great change for not having to wait for coverage to begin. So during the GEP, clients can enroll in Medicare Part A and Part B for the first time, and the CMS ruling also reduce the gap for when clients can enroll in Medicare Part D. So once a client's coverage starts on the first of the following month after their enrollment into Medicare Part A or B, they can then enroll into Medicare Part D.

Okay. So I know that was a lot on different enrollment periods. Let's do a couple knowledge checks and see what you've just learned about the process. So first let's 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 starting in January of 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 after his 65th birthday? So I'll give you a few moments.

So great, about half of you have responded so far, and about those who have responded, 60% have gotten it right. The answer is B, that's correct, to avoid a late enrollment penalty, Keith should enroll during his IEP, or Initial Enrollment Period, and then cancel his market plan after his Medicare coverage begins. All right. Let's do another knowledge. So now, let's look at Sandra. Sandra missed her IEP, or Initial Enrollment Period, and does not qualify for a Special Enrollment Period. She can enroll now during the current general enrollment. So when will her Medicare coverage start? Is it, A, February, or one month after she enrolls? B, April, or three months after she enrolls? Or C, July, six month after she enrolls.

Great. So it looks like almost half a few have responded and the majority of you have gotten this correct. The right answer is A, February, 2023. So anyone who enrolls through the annual General Enrollment Period, January through March, will start their coverage the month after they enroll. Great job. All right. So let's

just do a quick recap of the four enrollment pathways that I've just described. And this recap here is oriented along the lifespan to show when someone can enroll in Medicare based on their age and specific life circumstances. So moving from the top left to the bottom right, the earliest that someone can enroll in Medicare is through the social security pathway, either by claiming a social... sorry, by claiming social security disability benefits at any age, or receiving retirement benefits as early as age 62 and then automatically becoming enrolled at age 65.

Then there is the Initial Enrollment Period, which is a seven month period centered around the month that a person turns 65. Next is the Special Enrollment Period for people over 65 transitioning from employer coverage. This can be triggered if someone continues working past age 65 and then they lose employer-sponsored coverage, and this is an eight month period. And finally, the General Enrollment Period takes place at the beginning of each calendar year for anyone who is otherwise ineligible or unable to enroll through the other pathways. So the longer a person waits, the more likely it is that they'll have to pay a penalty. And we just want to stress how important it is to enroll and encourage your clients to enroll when they first become eligible.

And there are a number of additional special enrollment periods that are now available, thanks to the new CMS rules that allow clients to enroll outside of the enrollment pathways that I just discussed. So beyond the two SEPs that I've already gone over, which was those for individuals transferring from employer coverage after age 65, and for those to enroll in Medicare after termination of Medicaid eligibility. So those are two special enrollment periods. And the additional ones that we're not going to go into more detail today, but I just wanted to quickly touch on is, one of the new ones is for individuals impacted by an emergency or disaster. So this applies to someone who missed an enrollment opportunity because they're impacted by a disaster or other emergency that's been declared by a federal, state, or local government. So this includes the current COVID PHE, the SEP is available six months after the end of that emergency declaration.

There's also a new SEP for health plan or employer error that will provide relief in instances where a person can demonstrate that their employer or their health plan materially misrepresented information related to enrolling in Medicare in a timely manner. There is also a new SEP for formerly incarcerated individuals that will allow individuals to enroll following their release from correctional facilities. And this SEP is available 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 of enrollment. And like I've mentioned before, if an individual selects that retroactive coverage, they must pay the premiums for the retroactive covered time period. And finally, there's a new SEP for other exceptional conditions, and this is on a case by case basis that will provide grant enrollment period to an individual when circumstances beyond the individual's control prevent them from enrolling during IEP, GEP, or other SEPs.

So this SEP will be available for a minimum by six month duration, but does require documentation to receive. This SEPs not intended to replace equitable relief, which offers additional flexibility that goes beyond the parameters of this SEP. So we'll chat out two very helpful links with more information about the SEPs, including how to access them, which is most often, right now, indicated to contact the Social Security Administration to access the SEP and request one. So we'll chat out a link to medicare.gov on Special Enrollment Periods, and to the Medicare Rights Center, which has a different additional information about how to access these SEPs.

So finally, in terms of covering key enrollment pathways, your client may want to make changes to their coverage after they've already enrolled in a plan. So there are two open enrollment periods each year where a client can make changes to their Medicare coverage. The first one on the left is the open enrollment period from October 15th to December 7th each year, also known as the Fall Open Enrollment, or there are many other terms that people use for this open enrollment period. So this is the only time someone with original Medicare can make changes to their coverage. People with a Medicare Advantage can also make changes during this time as well. So during this time, an individual who already has Medicare coverage can change from original Medicare to Medicare Advantage or vice versa. They can switch from one Medicare Advantage plan to another, with or without drug coverage, and also join or switch Medicare drug plans.

They can drop Medicare drug coverage completely during this time, and any changes that are made during this open enrollment period will take effect on January 1st of the following year. So on the right, you can see the Medicare Advantage open enrollment period is from January 1st to March 31st annually. And this is the same timeframe as the general enrollment period, but it is a different open enrollment period. So this open enrollment period is only for individuals who already have Medicare Advantage, and during this time, they can switch from one Medicare Advantage plan to another, with or without drug coverage, or they can drop their Medicare Advantage plan and go back or sign

up for original Medicare. So any changes made during this period will take effect on the first of the month after the plan receives the request or the enrollment is taken place.

All right. So that was a lot of information on the different enrollment pathways. So now, let's take a look at some resources that support much of the information that we've shared today. So we at the ACE TA Center have a number of resources to help case managers and other Ryan White staff learn more about Medicare eligibility, enrollment, and coverage for Ryan White clients and other people with HIV. And much of what was covered in this presentation is described in the following tools, and we also have additional Medicare resources beyond these three. So the first one highlighted here is the basics of Medicare for Ryan White clients, which talks about the common eligibility pathways that I just went over... or that Christine and I have gone over for people with HIV, and the different parts of Medicare. And this resource is also available in Haitian Creole and Spanish.

The second tool is Medicare prescription drug coverage for Ryan White clients. And that gets into many of the details around the drug coverage, the donut hole, and coverage for HIV medications and how ADAP can help with the costs. The third tool on the right is how Medicare enrollment works, which goes into detail about the Initial Enrollment Period, Special Enrollment Periods, and the General Enrollment Period, as well as how a client can avoid penalties and make changes to their existing coverage. We did make some updates just recently to this tool based on the recent CMS ruling and included additional details on some of the special enrollment periods, but it doesn't include details on all of the newly available SEPs, just some of them, specifically folks who remain on employer coverage after 65. So these three resources really support most of the information we shared here today and really encourage you to download them and share them amongst your staff to help with training staff and supporting clients enrolling in Medicare.

And then finally, we have a resource designed specifically for clients called the ABCDs of Medicare coverage. So this is a brief plain language tool that describes the different parts of Medicare, the difference between original Medicare and Medicare Advantage. So you can print this out and give it to your clients for them to read on their own or for you to discuss with them during an appointment, or you can download it and email it to clients as a PDF. But this is a client facing tool that will be helpful for you. And we're going to chat out a link now, you can find all four of these tools and more at

targethiv.org/ace/medicare. And so with that, I will hand it back over to Molly to start our Q&A.

Molly Tasso: Great. Thank you so much Liesl and Christine for all of that incredible information. We've received many questions, so we're going to work through those over the next half an hour or so. I do want to also just invite Dori Molozanov, excuse me, from NASTAD, who has joined us for the Q&A. Dory's a Senior Manager on the Health Systems Integration Team at NASTAD, where her work is focused on monitoring and responding to health system changes and supporting NASTAD members in navigating insurance enrollment, assessing coverage options, and ensuring medication access for insured individuals. Okay. So I'm just going to get into the Q&A deck here. So the first question I'm going to have Amy tackle, and we've combined a couple of questions here. So we're talking about qualifying conditions for Medicare through the disability pathway. So someone asked, "Is ALS a qualifying condition for Medicare through the disability pathway?" And also, "Is a diagnosis of AIDS considered a qualifying condition for Medicare through the disability pathway?"

Amy Killelea: Yeah. Hi everyone, and thanks for that question. So for the first question about ALS, the answer is yes, and that's actually fairly recent and after some very concerted advocacy from ALS patient group. So now, someone with ALS can enroll in Medicare in the first month that they start receiving SSDI. So it's not only that automatic qualification, but it's also immediate, and I think that's really important. The only other automatically qualifying condition for Medicaid is endstage renal disease, and that's been longstanding, so that's been in existence for a while. ALS is a little bit newer. But importantly, those are the only two automatically qualifying conditions. For the rest of any number of chronic or complex conditions, folks have to go through the disability process to found to be eligible of having a disability from the Social Security Administration.

So for HIV or AIDS, having a diagnosis of either HIV or AIDS does not automatically qualify someone for SSDI, and it does not automatically meet the disability criteria or definition. Importantly there, and we're going to chat out a great resource from our friends at the Duke AIDS Law Project, they're called the listings. It's basically the definition that the Social Security Administration uses to determine if somebody meets the disability criteria, was updated fairly recently and was updated specifically to bring the HIV portion, so where the disability listings don't automatically qualify HIV, but talk about HIV to bring those in line with current treatment standards and just what we currently know about disease progression for HIV. That's actually been a good thing. Again, it's

not automatically qualifying, somebody still has to meet what is best described as a totality of circumstances, set of criteria where the Social Security Administration is going to take into account all of the comorbidities and other conditions that are contributing along with HIV to being disabled according to the definition.

So we've got that resource out there and please feel free to take a look at that. I'll also, just in the spirit of efficiency, add on some thoughts about the question that was raised about the poll question that folks responded to, asking folks to note what proportion of clients are qualifying for Medicare based on age or based on disability. And participants, I believe, said something like two thirds of Medicare eligible patients are coming in for age related reasons. So the question was really about, why is that? Is that because it's more difficult for people living with HIV to meet the disability requirements? And I think we don't 100% know. I want to point out that I think those answers are about proportion. We do know that the proportion of people aging with HIV is going up, and that's been well-documented in the HRSA. HIV/AIDS Bureau has been collecting lots of great data that documents that.

So there is certainly a very distinct trendline upward of the folks aging into Medicare. In terms of whether the people qualifying for Medicare based on disability is going up or down, I don't think we have the data in front of us to say that. I will just say as it relates to the listings, I don't think it's getting harder to qualify for disability based on the listings. I think the listings actually make it a little bit easier just by being a little bit more closely tethered to someone's reality. Whether folks living with HIV are just not as sick as they were and whether that's contributing to that overall number going down, I don't think we have the data, at least not in front of us right this second to say that. So I'll table that for another discussion, but it's a good question.

Molly Tasso: Great. Thanks so much, Amy. Christine, I have a couple questions I'm going to throw to you, both related to employer coverage in Medicare. So the first one I'll have you tackle, can a client apply for Medicare Part A if they have insurance through their employer?

Christine Luong: The answer is yes, but only if the person qualifies for premium-free Part A. Again, you qualify for premium-free if you have enough work credits. So if you do qualify for it, and you're working past age 65, and you still have employer-sponsored insurance, either your own or your spouse's employer, you can apply, you can enroll in Part A, and you can defer your Medicare Part B enrollment. And then when you lose your employer-sponsored insurance, then you'll qualify

for that eight month SEP that Liesl was talking about. And then you can enroll in the parts that you deferred before. But I always like to say that whenever you're dealing with employer-sponsored insurance and Medicare, it's always good practice to talk to your HR department as well as with the Social Security Administration, just to make sure on both ends that you can defer some coverage, you can enroll in some parts of coverage, that you can do so without incurring a late enrollment penalty. That could be a surprise later on.

Molly Tasso: Great. And so Christine, to that point, looking at the inverse, so if a person were to get a job, if a person were to become employed after enrolling in Medicare or after their Medicare starts, what should they do? Should they notify Medicare? It sounds like they should contact their HR as well.

Christine Luong: Yeah. So that's a good question. If you are currently on Medicare, then you decide to work again and then your employer offers employer-sponsored insurance, then you should definitely notify Medicare because you may be able to disenroll from your Medicare coverage, just so that financially, you're not on the hook for paying both Part B premiums as well as your employer health plan premium. Yes, always check with HR, always check with the Social Security Administration because the other factor in that is that the size of the employer may impact what type of Medicare coverage will work with it. And also, you definitely don't want to be surprised by late enrollment penalties later on. For Part A, specifically, if you qualify for premium-free Part A and you're currently receiving it and then you get a job, I don't believe you can defer that coverage again, because you're not paying anything for it. But to answer the question, definitely talk to Medicare.

Molly Tasso: Great. Thank you Christine. Okay, Dori, I have a couple questions for you. So first, someone asked, "If we could please talk about how a person with disability during the 24 month waiting period for Medicare might or maybe eligible for marketplace?"

Dori Molozanov: Sure. Hi, this is Dori. Sorry, my voice is a little bit scratchy. So I think this question is about marketplace financial assistance. So if the question is about eligibility for the marketplace in general, anyone eligible for the marketplace can buy a plan with or without tax credits. But if the question is about financial assistance, in this case, because the person doesn't have other coverage they're eligible for, they're not precluded from getting tax credits as long as they meet the other requirements for income, et cetera. But the promise of Medicare 24 months from now is not the same as being eligible for other coverage today. So

there is nothing preventing this person from getting financial assistance, assuming they meet all other requirements.

Molly Tasso: Great. Thanks, Dori. And while you're on, we've gotten a few questions related to the Medicaid unwinding process, which we now know will begin on April 1st. I'm wondering, Dori, if you could walk us through that timeline, share the dates, and maybe explain how the process over the next 12 to 14 months will play out in states.

Dori Molozanov: Yeah. Sure. So I'm going to chat out a link that has some visual timelines at the very end of this document, which I think will help maybe visualize what I'm saying here. And I think it's just a useful thing for folks to keep on hand. It's the most recent guidance we've gotten from CMS about this. So the terminations can now begin as early as April 1st, no earlier than that, even though states might start sending renewal letters to clients as early as February. But even if that were the case, terminations can still not start until April 1st or later. So no terminations before April 1st. And then the process is supposed to take a total of 14 months, so 12 months to begin all renewals, and then an additional two months on top of that to resolve all of the pending renewals and to complete them and close the books on the process.

So if your state decides to start sending renewals in February, then the process will be complete about 14 months after that, if your state starts to send renewals in April, 14 months after that. So that's what I just sent over the chat is helpful. But the most important dates to remember right now is that February clients could start getting renewal letters, and April 1st is the earliest that any involuntary terminations can occur.

Molly Tasso: Great. Thanks, Dori. And I'll just encourage everyone to make sure that you are subscribed to our email list serve as we, the ACE TA Center, is going to be pushing out some communication and information, and some steps that you all can be taking along with your clients to prepare for this process, and really to smooth any barriers and ensure that folks remain covered, whether that be through Medicaid or additional or different health coverage just as Medicare or marketplace insurance. So please do make sure that you are keeping an eye on. Thank you. Trisha just chatted out the center for a mailing list. Okay. Amy, I'm going to come over to you for a few questions. So this question was in the context of prescription drug coverage and thinking about utilization management restrictions, so things like step therapy, prior authorization, quantity limits, et cetera. So someone asked, or made the point that these types of restrictions might be a contributing factor in keeping folks from maintaining

coverage, and they were just wondering if there are any plans that remove these barriers?

Amy Killelea: Yeah. So it's a good question in utilization management, particularly in private market, it can certainly be a barrier. For Medicare, there's actually a couple of different protections at play that were mentioned in the presentation, one, and I just want to underscore this because it's super important and it's fairly unique, the ARV class, the antiretroviral class, so the drugs you use to treat HIV, they are one of only six protected classes of drugs in the Medicare Part D program. So that is a very powerful protection that basically requires every Part D plan to cover ARVs. So you're not going to see coverage exclusions that will be a barrier to care. And in addition to that, and this is a fairly recent policy change, the Centers for Medicare and Medicaid Services, CMS, has come out and said that Part D plans cannot use prior authorization or step therapy on the ARV class. So they also remove that barrier.

So that's important. I think what's also important to note are the things that still remain barriers in Part D plans, and that's really around tiering. So there are costs associated with Part D drugs, we talked about the Part D premium, but they're also Part D cost sharing, and ARVs, even though plans have to cover them, and even though there can't be utilization management, plans can and do put them on high cost sharing tiers or specialty tiers that can carry fairly hefty cost sharing for prescription pills. So that's the barrier that remains. But luckily, coverage, that has to happen, and then there can't be prior auth or step therapy placed on those drugs.

Molly Tasso: Thanks, Amy. And I will just tack on, someone just asked, can they exclude specific brands or injectables like CABENUVA?

Amy Killelea: Yeah. So that's a really good question. CABENUVA, now that's the brand name drug, within the past couple of years, approved long-acting injectable product for HIV treatment. Now, CABENUVA, unlike the Part D benefit, CABENUVA is mostly covered by Part B, as in boy, in Medicare because it's a physician administered or provider administered drug. It's not an oral medication that one picks up at the pharmacy. So because it's in the Part B space, that's not part of the six protected classes. Part B doesn't have a corollary to the six protected classes in Medicare Part D. Now, we haven't seen restrictions on CABENUVA in the Medicare space as of yet, but just to note, the Part B space is different and the protections are different than in part D.

Molly Tasso: Thanks so much, Amy. I'll also, if one of my colleagues can grab a link to, so the ACE TA Center, if you're interested in learning some more about the Ryan White cost and coverage considerations for long-acting injectable ARV treatment, we have a really great fact sheet that we worked, together with Amy, on actually, and we will chat that out as well. Some really interesting stuff going on in that space right now as well. Thanks, Amy. And while you're on, Amy, I will ask you, I see the response also prefacing, this is not legal advice, so I will let you also offer that disclaimer, but someone said that the SSDI had recently denied one of their patients, and this person is having serious physical problems and we're planning to cancel Medicare. Is there anything we can do to appeal?

Amy Killelea: Yeah. It is a good question. And first and foremost, legal services attorneys can and often do, often with Ryan White funding, help with these appeals because they can get fairly complex as you go up the chain. The short answer is, there is a very prescribed and fairly extensive appeals processes for SSDI disability determination denials. There are multiple steps. For every step of the way, there is an appeal process all the way up to a federal court reviewing the decision. Now, it can be a lengthy process, but there can be success at the end of it. Again, there are legal services attorneys who know the ins and outs of these processes and they're a good resource. We're also going to chat out a link to a good Social Security Administration resource that walks through the rights that folks have to appeal decisions made on their disability claims. So hope that's helpful.

Molly Tasso: Great. Thanks, Amy. Dori, question for you, so this question was asked in the context of the discussion around Medicare Advantage plans, and so couched in that or situated in that discussion, someone asked, "What would happen if a person needed home healthcare? Which plan would provide and provide coverage for that service?"

Dori Molozanov: Sure. So Medicare Advantage plans are required to provide the same level of home healthcare as original Medicare, but they might have some different rules, restrictions and costs, which is how we always talk about Medicare Advantage related to original Medicare. Even benefits are typically the same requirements, but there might be some changes when it comes to things like network limitations, prior authorization, you might need a referral, et cetera. I'm going to chat out a link also, which I think provides some more information about how to help clients navigate a situation where they're having trouble finding an in-network home health agency. And so instead of... everyone here go through all that now, I'll drop it into the chat and then you can take a look at that. If you have a client who's having trouble finding a home health agency, a network that

	will take them, there's some good information here. But any Medicare Advantage plan has to cover home health coverage, home healthcare, at least to the same level as original Medicare.
Molly Tasso:	Great. Thanks, Dori. While I have you, another question here related to sort of timeline and timing of coverage start, and SEPs, and enrollment. "So if a client's employer coverage ends the last day of the month, does the SEP start on the first of that month, or on the first of the next month? And if they can't sign up until the first of that next month, won't they always have a gap in coverage?" Dori, if you're speaking, you are muted. I also-
Dori Molozanov:	My apologies.
Molly Tasso:	No, no worries. Okay.
Dori Molozanov:	Medicare coverage begins the first month after you enroll. If that was not the case for the Part B... So you're referring here, I assume, to the Part B SEP, for people who have employer coverage and therefore delay enrolling in Medicare Part B specifically. I do not know if the rules were different before, but as of right from now on moving forward, Medicare coverage begins the first month after you enroll. I cannot remember now if this was one of the changes in the recent legislation that we talked about earlier. So that might have been different in the past, but now, Medicare coverage begins the first month after you enroll. So to avoid a gap, clients should enroll in Medicare the month before their employer-sponsored coverage ends. Recommend as early in the month as possible to give Medicare time to process all of that. But coverage should begin the month after you enroll.
Molly Tasso:	Great. Thanks, Dori. Christine, a couple questions heading your way. So first is, maybe an easy one, can you confirm that Medicare supplemental plans are the same as Medigap policies?
Christine Luong:	Yes, those are referring to the same thing. Medigap policies, when they're being marketed, they have to be clearly labeled as Medicare supplement insurance. To get into a little bit more detail, Medigap policies are lettered, so letters A through N, and so they're standardized in that way. But if you're looking for Medigap plan, definitely go to the Medigap plan finder on medicare.gov. That'll give you all the information about what types of Medicare plans there are, what those cover. And for anyone on the line now who lives in Massachusetts, Minnesota, or Wisconsin, just a heads up that Medigap plans are standardized in a slightly different way in those two states.

Molly Tasso: Great. Thanks, Christine. And then another question here, "Is there still a requirement to wait two years after SSDI enrollment to become eligible for Medicare through the disability pathway?

Christine Luong: Yes. So that two years, you may have heard it referred to as the two year waiting period. That refers to the fact that you have to have had received 24 months of social security disability insurance benefits before becoming eligible for Medicare. But I always want to remind folks that that term, two year waiting period, is a bit of a misnomer because those 24 months don't have to be consecutive. So for the purposes of Medicare eligibility, that starts in month 25 of receiving your SSDI payments.

Molly Tasso: Thanks, Christine. Okay. We have one more question for Amy and then we are going to start wrapping up actually. So this question was asked in the context of the case study around Keith, who, if you remember, was transitioning I believe from marketplace to Medicare. So the question is, "How long can a person stay on a marketplace plan with tax credit discounts after the age of 65 before going to Medicare?"

Amy Killelea: Yeah. So this is a good question and I think it makes a sense to unpack some of the rules that get a little bit sticky between the intersection between marketplace coverage and Medicare. And I know this question is about the premium tax credits in particular. The short answer is, it's not about a timeline necessarily. I think it's more about looking at the individual circumstance of the client. So to make this point, and everybody who's been on these webinars, there's no generalization that's going to apply in every circumstance. So I'll just say, in general, and for probably the majority of clients you all are seeing, it's going to be in a client's best interest to enroll in Medicare. There are going to be exceptions around the edges, but in general, barring some of those exceptions, Medicare is going to be the better deal.

Now, this question's about the premium tax credit. So let's talk about a case when it might be a better deal to stay on marketplace coverage. And that's really, the only way that you could remain on marketplace coverage with a premium tax credit is if you are not eligible for premium-free Part A. So you don't make the work requirements, for instance, you have to pay a premium for Part A. So there, you're not automatically enrolled in it, and so you could say... or your client could say, "I'm not going to enroll in premium Part A," and then they would also have to not enroll in Part B, and choose not to enroll. And so then you don't have a double coverage, you can't have Marketplace and

Medicare at the same time. So you don't have that issue. And because you aren't eligible for premium-free Part A, you can get tax credits.

So again, if you choose to decline Part B, you may be hit with a penalty down the road. This would be a pretty specific circumstance, and it may not be in the best interest to stay on for all that long. But again, maybe the message here, individualized assessment, it's not like a timeline where you're going to get kicked off your tax credits because you reach a certain age, it's really about both eligibility and then what cost burden are you putting, or is a client putting on themselves, both present time and then future, because of penalties.

Molly Tasso: Great. Thank you so much, Amy. That's super helpful. And thank you Dory and Christine as well for all of your very, very helpful insight and knowledge to all these questions. I will just say if there are any questions that I didn't get to or that pop up for you later, again, please always reach out to us through email or our website at any time, we're always happy to take in your questions and help you figure this stuff out. So to that end, we invite you to join us for the rest of our webinar series. So in two weeks, on January 31st, it's a Tuesday, we're going to be doing the part two of this Medicare series. So it's Medicare enrollment and coverage. Again, that's from two to 3:30. 2 weeks after that, on February 14th, we're going to be doing a webinar around Medicaid eligibility and enrollment.

And then on February 28th, also a Tuesday, it's Medicaid Medicare dual eligibility. So please continue on this journey with us. Again, if you have any questions, please feel free to reach out to us. Thank you so much for joining us today. Again, please visit our website to sign up for our mailing list, or download all of the tools and resources that we discussed today. And again, our email is acetacenterjsi.com. We strongly encourage you again to reach out to us. And also, please take a moment to complete the evaluation form that will pop up at the end of this webinar. So that, have a wonderful rest of your day, and we hope to see you soon. Thank you.