Webinar Transcript
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Medicare Enrollment and Coverage for Ryan White HIV/AIDS Program (RWHAP) Clients

Michelle Dawson: Good afternoon everyone and welcome to part two of the ACE TA Center's two part series on Medicare coverage. My name is Michelle Dawson from the ACE TA Center and I'm so happy that you've joined us today. Today's presentation will cover Medicare enrollment and coverage for the Ryan White HIV/AIDS program clients. The first part of this series, which covers the basics of Medicare eligibility for Ryan White HIV/AIDS program clients is also available online at targethiv.org/ace. Before we get started, here are some technical details for anyone who might be new to our webinars. First, attendees are in listen-only mode, but we encourage you to ask lots of questions during the webinar using the chat box. You can submit your question through the chat at any time during the presentation and we'll take as many of your questions as we can at the end of today's session. And if we don't get to your question or you think of another later, you can 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, make sure that your computer audio is turned on and the volume is turned up. And if you are still having issues, try closing out and rejoining the Zoom webinar session. Just in case none of that works or you prefer to dial in, we put the call i-n information in the chat box. At the ACE TA Center, we help build the capacity of the Ryan White HIV/AIDS program community to navigate the changing healthcare landscape and help people with HIV access and use their health coverage to ultimately improve health outcomes. Specifically, we support Ryan White HIV/AIDS program recipients and sub-recipients to engage in, enroll and retain clients in Medicare, Medicaid, and individual health insurance options, to build organizational health insurance literacy, thereby improving clients' capacity to use the healthcare system, and to communicate with clients about how to stay enrolled and use their health coverage. We do all this by developing and disseminating best practices and supporting resources and by providing technical assistance and training through national and localized activities.

Our audiences include the Ryan White HIV... Excuse me, Ryan White HIV/AIDS program, staff, clients, program managers and administrators, but also the people who enroll and help enroll Ryan White clients such as navigators and certified application counselors. Today's webinar will be archived on TargetHIV at targethiv.org/ace. All participants in today's webinar will receive an email when it's posted so that you can share it with your colleagues. Our website on TargetHIV also houses all the resources and tools that we're going to discuss and share with you today. We'll chat out the links to the resources we share as we go, but if you happen to forget or lose the direct link today, you can visit our website or search the topic library on TargetHIV.

In this presentation we'll discuss best practices for providing Medicare enrollment support, common Medicare enrollment challenges, sources of financial assistance for Medicare costs and ACE TA center resources to help enroll Ryan White HIV/AIDS program clients into Medicare coverage. Today I'm pleased to be joined by my colleagues Molly Tasso and Liesl Lu. Molly Tasso is the ACE TA Center Project Director and has been a part of the ACE TA Center team since 2016. Liesl Lu is the ACE TA Center Senior Technical Advisor and has been a part of the ACE leadership team since 2016. She's extensive experience providing technical assistance to build the capacity of the Ryan White HIV/AIDS program workforce to help their clients navigate the healthcare environment and stay engaged in care. And before we get into the webinar, we want to hear a bit from you to learn more about you and your organization.

So in a moment, once I pull it up, you should see the poll on your screen and when it pops up, you should see it now, tell us how ready is your organization to assist clients with Medicare enrollment. Would you say, we are experts and stay up to date on enrollment best practices? We have some experience and we partner with external enrollment specialists. We have some experience in our building, our in-house capacity, little experience and are looking to for ways to improve, or would you characterize it some other way and you can tell us more about that in the chat? I'm seeing results come in, give it just one or two more moments.

All right, I'll go ahead and share this with you. All right, so I'm seeing that we have a mix here. Many people are saying we have some experience and we partner with external enrollment specialists and then it's pretty close there between we have some experience and we have little experience. So we're hopeful that today will really get us on the right path and give you lots of resources to go from there. And one more poll for those of you who said that you are building your in-house capacity. Let's see. Tell us in this poll here, what areas do you need help with? You can go ahead and tell us in the chat. You can go ahead and tell us in the chat. I know that there's not... Okay, so I'm seeing folks say things like we want to be informed as possible and doesn't [inaudible] designated people how to get licensed to enroll people in Medicare. Great. All right, well we'll go through all of these and at this point I'm going to hand it over to Molly.

Molly Tasso: Great, thanks so much Michelle. Good afternoon everyone. So, before sort of launching into today's presentation, we are going to just provide a really quick recap of the Medicare basics, which is what was covered during the Medicare Part One webinar a couple weeks ago. So in part one we started with an overview of the changing demographics of the Ryan White population, including

more and more clients becoming older and aging into Medicare. We discuss the Medicare eligibility pathways for people with HIV as well as the different parts of Medicare. So that's Part A, hospital coverage, Part B, medical coverage and Part D, prescription drug coverage. And then finally we discuss the four major Medicare enrollment pathways. If you miss part one or you want a refresher on the content, please, we encourage you to visit the on-demand recording, which is on your website, targethiv.org/ace/webinars.

Or you can see the link that we're going to chat out to you all now. But to just provide some sort of reminder. So as a reminder to be eligible to enroll in Medicare, you must be a US citizen or a legal resident for at least five years with a few exceptions that do apply to that. If you meet the citizenship requirements, there are three potential eligibility pathways, you can age into Medicare when you turn 65. And this is really what comes to mind for most people when they hear or think about Medicare. If you are under 65, you can also become eligible for Medicare if you have a qualifying disability, though there is a 24-month waiting period. And then finally, you can become eligible at any age if you have end stage renal disease.

So someone had chatted earlier, one of their challenges is understanding the different parts of Medicare. So here's an overview of the coverage and costs of original Medicare and Medicare advantage. And this slide may look familiar to those of you who attended part one. So let's look at original Medicare first. That's on the left-hand side of this screen here. So for original Medicare, this includes Part A hospital coverage and Part B medical coverage. For Part A Hospital coverage, most people do not have to pay a premium as long as they have sufficient work credits to qualify for premium-free Part A. And this applies to anyone who qualifies for Medicare due to age or disability. People who don't qualify for premium-free Part A can pay a monthly premium depending on how many work credits they may have earned so far. For Part B, this is medical coverage, which is not tied to work credits.

So if someone doesn't sign up for Medicare Part B when they're first eligible, it's very important to note that they may have to pay a monthly late penalty, late enrollment penalty, for as long as they have Medicare... Sorry, as long as they have Part B coverage. And we will talk about this penalty again a little bit later in today's session. And then finally, you can add on a MediGap supplemental coverage and a Part D prescription drug coverage plan as well to original Medicare. So then let's look at Medicare Advantage plans, which is on the right. And these are also known as Part C. Medicare Advantage Plans include Parts A, B, and D, and these plans may or may not have a monthly premium and they have a yearly limit on out-of-pocket costs for Medicare Part A and B covered

services. You cannot buy or use supplemental MediGap policies if you have a Medicare Advantage plan, but some may have lower out-of-pocket costs than original Medicare.

So there are pros and cons to both options. We're not sort of promoting or highlighting one or the other. It's just important to compare plans in your area to really see which plan might be best for your client. You can shop and compare original Medicare and Medicare Advantage plans at medicare.gov and we'll chat out that link right now. It's important to note also that the Ryan White program, including ADAP, may pay in full or in part for Medicare premiums, deductibles, and co-payments. So it's very important to check with your local ADAP to determine how it may be able to help with costs. And to help you locate or contact your state's ADAP directory, we're going to chat out a link to a NASTAD resource that will help you find that person. Okay, so one final sort of overview slide before we dig into things. So this is related to the Medicare enrollment pathway. So there are four major Medicare enrollment pathways, Social Security, the initial enrollment period, the special enrollment period, and the general enrollment period.

So you'll see on the slide that the way that we are showing them here is sort of oriented along the lifespan to demonstrate when someone can enroll in Medicare based on their age and specific life circumstances. So we're going to start at the top left and move to the bottom right. So looking at the first couple boxes on the top left, a person who is under 65 who receives Social Security Disability Insurance, so that's SSDI, they will automatically qualify for Medicare after they have received SSDI payments for 24 months. So you will sometimes hear people refer to this as a two-year waiting period for their disability benefits, but that can be misleading because the 24 month actually do not have to be consecutive. The other way that this pathway works involves social security retirement benefits. So you can receive retirement benefits as early as age 62 and then you will be automatically enrolled into Medicare Parts A and B. When you turn 65, the Social Security Administration will take care of that auto enrollment and you'll receive your Medicare card in the mail about three months before your 65th birthday.

So moving on to the middle box, this is the initial enrollment period for people who are about to turn 65 but have not yet started to receive Social security retirement benefits. It's a seven-month period centered around the month that someone turns 65. So for example, if I'm turning 65 in July, I can sign it for Medicare between April, which is three months before July and October, which is three months after July... October, which is three months after July. And then the next eligibility or enrollment pathway is through a special enrollment

period, which is for people who continued working past age 65, so past their initial enrollment period and who are now transitioning from employer coverage to Medicare. So when your employer coverage ends, that triggers an eight-month special enrollment period that will allow you to enroll into Medicare.

And then finally, there is a general enrollment period from January one to March 31st annually, every year, for anyone who missed their initial enrollment period and who do not qualify for a special enrollment period. And then once they enroll, their coverage will begin on the first of the month after the individual enrolls. As a general rule, the longer a person waits to enroll once they become eligible, the more likely it is that they may have to pay a penalty. So we really want to stress, again, how important it is to enroll and to encourage your clients to enroll when they first become eligible.

So before we move on to best practices for Medicare enrollment, we just want to spend a few minutes discussing... If you could go to the next slide, thank you. A few minutes discussing the end of the Medicaid continuous coverage requirement, which is also known as the Medicaid Unwinding Process that will begin in some states next month. And so just as to provide some context, we're talking about this today because there may be situations where someone enrolls in Medicaid, who is redetermined and no longer Medicaid eligible might be eligible for Medicare. So all of the sort of enrollment best practices and strategies that we're going to discuss today really do tie into and will be applicable to the unwinding process. So sort of taking a step back, as a reminder, state Medicaid programs will begin conducting Medicaid eligibility reviews for all enrollees in February, March or April of this year.

And this review process will continue for the next 12 months until all enrollees eligibility has been reviewed. I've referred to it already, but this is called the Medicaid Unwinding and it's starting now because of legislation that was passed in December of last year, of 2022. So during this unwinding process, approximately 15 million people, including people with HIV, could lose coverage. And of that an estimated 6.8 million will lose coverage because of out-of-date paperwork or because they've waited too long to respond to Request for Information from the Medicaid office even though they might still be eligible. So people who are no longer eligible for Medicaid will need to explore alternative healthcare coverage options. So what can you do to make sure that your clients do not experience a gap in coverage? They're listed on the slide here, but first, make sure that clients are updating their contact information with their state Medicaid agency.

This will ensure that any correspondence, any letters, any renewal notifications, anything being sent out is getting to the right address, is getting to the right person. And then encourage clients to check their mail for letters from the state Medicaid agency and help clients fill out any paperwork including renewal forms or Request for Information that might be sent. And then if a client is ineligible for Medicaid, help them enroll into another form of coverage, which as Medicare or marketplace, whatever plan makes sense for them. So we're going to chat out a link to a blog that the ACE TA Center published last week that discusses what I've just presented in much more detail and we're keeping a very close eye on this unwinding process and plan to continue providing updates. So we really encourage you to stay tuned to make sure that you're on our lister so that you're receiving all of our notifications.

Okay, so moving on to Medicare enrollment best practices and enrollment support for clients who are transitioning to Medicare. So the four best practices that we're going to cover today are ensuring continuity of coverage, actively enrolling in Medicare coverage, avoiding penalties, and providing one-on-one enrollment support. So let's explore each of these in more in detail. So the first best practice is to ensure continuity of coverage for clients' existing providers and medications whenever possible. It's very important for case managers to confirm with their clients that their current providers accept Medicare. You can do this either by visiting the medicare.gov website in using the Care Compare tool, or you can help your clients call their providers letting them know that their insurance is going to be changing to Medicare and confirming whether or not that provider accepts original Medicare or Medicare Advantage.

If the provider states that their preferred plan is a Medicare Advantage plan, make sure to ask whether they are referring to an HMO or PPO plan. Case managers should also help their clients compare Medicare drug plans in their area and choose one that covers their HIV medications as well as their other non HIV related medications. And you can do this by visiting again, the medicare.gov website and using the Plan Compare tool. The Ryan White program, including the AIDS Drug Assistance Program, ADAP, may help pay for Medicare premium deductibles and copays. So again, we really strongly encourage you to reach out and learn more from your state's ADAP program.

All right, the second best practice is to help clients actively enroll in Medicare. Clients who opt for original Medicare, which again includes Medicare Part A, which is hospital insurance and Medicare Part B medical insurance, they should enroll through the Social Security Administration. Clients who choose Medicare Advantage or who want to add on Medicare Part D, which is prescription drug coverage or MediGap supplemental insurance to their original Medicare. Those

individuals should in enroll through medicare.gov. So most people who are eligible for Medicare must actively enroll in coverage, but there is a small subset of folks who will be automatically enrolled. And this includes people who are already receiving Social Security Retirement Benefits, which I had mentioned earlier. People under age 65 with a qualifying disability who have received 24 or more months of social security disability benefits. And then people with end stage renal disease or ALS, which is also known as Lou Gehrig's disease. And we're going to chat out a link to the Social Security Administration website with some more information.

The third best practice is to avoid penalties for late enrollment. So you can do this by creating automated reminders in your electronic health record or asking medical case managers to flag clients who are approaching their 65th birthday or clients who will soon be receiving their 25th month of Social Security disability benefits. This reminder is an opportunity to start the discussion with clients about their healthcare needs and preferences, whether original Medicare or Medicare Advantage makes more sense for them, and to start scheduling enrollment appointments. It's important to take these steps because if a client doesn't enroll in Medicare when they are first eligible, as I've sort of alluded to, they may face late enrollment penalties for Medicare Parts A, B, or D, and in some cases these are lifetime penalties. This is a common enrollment challenge that we will explore and talk through a little bit more in the next section. And then in addition to avoiding penalties, enrolling when the client is first eligible will help minimize gaps in coverage if the client may be transitioning from another type of health coverage.

And then finally, the fourth best practice is to provide one-on-one enrollment support. So we encourage Ryan White case managers to establish a relationship with their local State Health Insurance Assistance Program, or their SHIP program, which provides local one-on-one Medicare counseling and assistance. Your organization may refer clients to SHIP for external Medicare enrollment support, or you might want to consider supporting staff to become trained SHIP counselors in order to build in-house enrollment capacity. And over the next couple slides, we're going to discuss the benefits of SHIP in some more detail and also talk about how to become a trained SHIP counselor.

So SHIPs are state-based programs that again provide local, in-depth and objective insurance counseling and assistance to Medicare eligible individuals, their families and caregivers. They can help clients review their health and drug plan options and explore financial assistance options, answer questions about how Medicare works with other types of health coverage. They can help with more complex issues like dual eligibility for both Medicare and Medicaid,

navigating the appeals process and more. And you can find a SHIP program near you by visiting shiphelp.org. You can see it there on the screen and we'll also chat out a link and using the locator tool. There is a SHIP program in all 50 states was Washington DC, Puerto Rico, Guam, and the US Virgin Islands. But note that your local SHIP may have a different name or acronym. So for example, SHINE, HICAP or MAP are examples of local SHIP programs in states across the country.

I'll also note we have a SHIP counselor who's joining us for today's Q&A. So if you have any questions about this process or designation, please feel free to chat those in and we might have time to address those as well today. Ryan White and ADAP program staff are ideal SHIP counselors because they understand the eligibility requirements for both Medicare and also the Ryan White program. They understand the unique coverage needs of people with HIV as well as state specific programs that help and support Ryan White clients. The training and certification requirements may vary from state to state, but it typically includes a blend of self-paced online trainings, webinars, and virtual or in-person group sessions. There's no cost associated with the training or certification and it's considered voluntary. I will note, in order to become a SHIP counselor, your organization must be designated first as a SHIP site.

So if your organization is not already a SHIP site, your program director can reach out to your state Department of public health or your local SHIP program to find out more about the qualifications and process for becoming a SHIP site. So a couple polls here before I handed over to Liesl. So we're curious about what your programs are doing with or your interactions or engagements with SHIP counselors. So is your organization connected to a SHIP counselor? Options are, yes, we consult work with a SHIP counselor to enroll our clients. We refer our clients to a SHIP counselor. No, we are not connected but working to do so. Or no, we are not aware that there is a SHIP counselor in your area. Or please go ahead and chat in another response, anything you'd like to add. So we'll give folks a few more moments to respond here.

All right, I think we can go ahead and close. So it looks like, all right, it looks like many of you are not aware that there might be or that there is a shift counselor in your area. So we do hope that you'll take a few moments to use the find the SHIP help tool to hopefully find someone in your area, but it looks like many of you are also either working with or referring your clients to a SHIP console or are interested in getting connected to someone, which is great. All right. And then the next poll, we're curious, what are the top challenges that your organization related to Medicare enrollment and coverage? So is that... And please check all that applies. So determining whether clients are eligible for Medicare assisting clients with deciding when to enroll, assisting clients who are

eligible for both Medicare and Medicaid, so dual eligible clients. Helping clients transition to Medicare from another type of coverage, referring clients to external support, or again, something else that you were challenged with, please go ahead and chat it in. I'll just give folks a few more moments here.

Okay, I think we can go ahead and close it. So it looks like many of you indicated that both assisting clients who are eligible for both Medicare and Medicaid, so those are dually eligible clients. And also helping clients transition to Medicare from another type of coverage seems to be a challenge for many of you, along with referring clients to external support. And then also of course, and a couple folks in the chat also just mentioned helping clients understand when to enroll is a challenge. So I will note for those of you who find the dual eligible topic or population to be a challenge for your organization, please do join us for the next two installments of our webinar series.

In two weeks we'll be discussing Medicaid and then two weeks after that we'll be providing a webinar on specifically dual eligibility for the Ryan White community and clients. So we do hope that folks join us for those we'll chat out links for registration later. All right, so with that I'm going to hand it over to my colleague Liesl, who is going to talk with us about some enrollment challenges and ways to sort of navigate those challenges.

Liesl Lu: Great, thanks so much, Molly. So yeah, let's move on now to discuss some of the common Medicare enrollment challenges. So the first common enrollment challenge is avoiding late enrollment penalties when deferring Medicare enrollment. So you want to make sure that your Ryan White program clients enroll in Medicare Parts A, B, and or D when they're first eligible unless they have a legitimate reason to defer their enrollment to a later date. By first eligible, we mean the initial enrollment period or IEP, which is a seventh month period that's centered around the month of the client's 65th birthday. In some examples of legitimate reasons to defer include the client is still working and has employer-sponsored insurance which eliminates the Part A and B penalty. The client is eligible for a Medicare savings program which eliminates the Part B penalty. The client has other credible prescription drug coverage and this eliminates the Part D penalty or the client qualifies for the Extra Help program, which also eliminates the Part D penalty.

So keep in mind that this is not an exhaustive list whether a client will incur a penalty and how much that penalty will be really depends on each client's individual circumstance. And these are just a few of the most common reasons for deferring enrollment that would allow a client to be exempt from a late enrollment penalty. But it's still important to check with the Social Security

Administration office about deferring enrollment to make sure that there won't be any surprises later on. However, even if you are able to help your client avoid penalties when deferring enrollment, when they do decide to enroll at a later date, they may still experience a gap in coverage depending on when the coverage begins. If this happens, we encourage you to check with any state funded programs, clinic or hospital financial assistance programs, as well as ADAP for help in the interim with that gap in coverage.

So now let's go into a bit more detail on the penalties. So the Medicare Part A penalty only applies to people who don't qualify for premium-free Part A. Most people qualify for premium-free Part A by working and earning enough work credits over the years. Anyone who doesn't have enough work credits to qualify for premium-free Part A and who also did not enroll in Part A when they were first eligible may face a penalty of 10% on their monthly premium for twice the number of years they were eligible but chose not to enroll. So let's break this down. For example, if your client waited two years to enroll in Part A, they'll have to pay 10% more per month for four years. They can avoid this penalty if they're still working and have employer-sponsored coverage, of course, that's one option. The Medicare Part B penalty is similar. Anyone who did not enroll in Part B when they were first eligible may face a penalty of 10% on their monthly premium for each year they were eligible but chose not to enroll.

The difference here is that the Medicare Part B penalty is a lifetime penalty, whereas Part A was just twice the number of years that the person was eligible but chose not to. In the case of the Part B, it is a lifetime penalty. So for example, if your client waited three years to enroll in Part B, they'll have to pay 10% more per month for as long as they have Medicare Part B, and that can add up to be quite a lot. So clients can avoid this penalty if they're still working and have employer sponsored coverage or if they qualify for a Medicare savings program in your state. For clients who do incur a Part B penalty prior to age 65, meaning they became eligible for Medicare for reasons other than age, that penalty will reset when they hit their initial enrollment period again at age 65. And one additional thing to note about the Part B penalty is that if a client does not pay the penalty, their Part B coverage may be dropped.

And for this reason it's very important to check with Social security if your client is considering deferring enrollment. So we're going to chat out a link now with more information on these penalties at medicare.gov. The Medicare Part D penalty applies to people who don't have prescription drug coverage either through a Medicare Part D plan, a Medicare Advantage plan, or through other credible credit coverage. Creditable coverage includes coverage through a current or formal employer or union, TriCare, the Indian Health Service, the

Department of Veterans Affairs or Individual Health Coverage. Anyone who's eligible for prescription drug coverage through either of those routes but chose not to enroll may face a penalty of 1% of a specific benchmark amount for each full month that they did not have coverage.

So similar to the Part B penalty, the Part D penalty is a lifetime penalty. However, unlike Part A and Part B is generally much easier to defer enrollment in Part D. And Part D, penalties are also significantly smaller and usually much easier to resolve. So your client can avoid the penalty if they are still employed and have not retired or have qualifying insurance that provides creditable prescription drug coverage or if they qualify for the Federal Extra Help Program, also known as the Part D Low Income Subsidy. Most Ryan White clients qualify for this program which is income based. And I'll talk a bit more about this in a few moments. And in some cases if they qualify for Medicare under age 65, they may be able to have their penalties forgiven once they turn 65.

So let's do a quick knowledge check to go over what we just learned. Which of the following is a legitimate reason to defer enrollment in Medicare Part B? Is it having COBRA coverage, having employer sponsored coverage, having retiree insurance or D, all of the above. So just give everyone a few moments to respond to the knowledge check. Okay, I think we can close the poll and share the results. So the answer is B, having employer sponsored coverage. So for those of you who chose all of the above, it's important to keep in mind that COBRA coverage and retiree insurance are not considered employer sponsored coverage and therefore will not prevent your clients from incurring penalties for deferring their Part B enrollment. All right. The second common enrollment challenge is deciding whether and how to defer Medicare enrollment if your client has employer sponsored insurance or job based insurance.

If your client becomes eligible for Medicare but they're still working and plan to keep their employer sponsored insurance, they should first check with their employer's human resources department. The employer can tell the client if the plan they provide is considered qualifying insurance. And if it is qualifying insurance, then the next step is to talk with your client about which Medicare part or parts they want to defer. For Medicare Part A specifically, if your client or their spouse has at least 40 work credits, they will be eligible for premium-free Part A. If they don't have enough work credits, they can continue to work until they qualify for premium-free Part A. Your client can always call the Social Security office to ask how many credits they have to find out how many more they need, and clients can generally enroll in just Medicare Part A and also keep their employer sponsored plan.

For Medicare Part B, your client can defer Part B as long as their employer-sponsored insurance is considered qualifying insurance. So just as a reminder that we just talked about for the knowledge check, a retiree plan or COBRA coverage are not considered qualifying coverage and will not exempt an individual from the Part B penalty. For Medicare Part D, keep in mind that even if the employer sponsor an insurance is considered qualifying coverage, it may not necessarily provide creditable prescription drug coverage. So if your client does have creditable prescription drug coverage, they can defer Part D enrollment without a penalty. But if they do not have creditable prescription drug coverage through the employer-sponsored coverage, they will need to enroll in a Medicare Part D plan when they first become eligible in order to avoid the lifetime penalty.

So if and when your client chooses to quit or retire from their job, the employer will need to complete a Medicare enrollment form that the client has to return to the Social Security Administration with their enrollment form. And the reason for this is to ensure that when your client's employment ends that they will be eligible for a Medicare special enrollment period for a job based insurance that allows them to enroll in the parts of Medicare that they're missing and avoid penalties. There is an eight-month SEP for Medicare Part B coverage and a two-month SEP for Part D coverage. Once the client enrolls Medicare coverage begins the first month after they enroll. For example, if a client retires and signs up for Medicare in February, their coverage will begin March 1st. So to avoid a gap in coverage, we encourage you to make sure that your clients enroll in Medicare the month before their job based insurance or employer sponsored insurance will end.

So I just went over a number of many important points. Let's just pause for a moment and do another knowledge check of what we just learned. So what steps should Ryan White clients take if they're considering deferring Medicare enrollment in favor of employer-sponsored insurance? A, contact their employer's human resources department to identify any potential conflicts. B, contact the Social Security Administration to confirm whether deferring Medicare Part B coverage will incur a penalty. C time their Medicare Part D... Sorry, Part B deferment during their initial enrollment or D, all of the above. I'll just give everyone a moment. All right, so it looks like just over 50% of you that responded got the correct answer, which is D, all of the above. Clients should make sure to check in with their employer's human resources department and the Social Security Administration to identify any potential conflicts or penalties. They should also time their Part B deferment when they first become eligible during their IEP to avoid incurring any future penalties.

All right, let's move on to the third common enrollment challenge, which is transitioning from marketplace to Medicare coverage. So the first thing to keep in mind is timing. Clients who are enrolled in marketplace coverage should enroll in Medicare when they first become eligible during their initial enrollment. And the initial enrollment is the one that centers around when they turn 65. This will help avoid late enrollment penalties and coverage gaps. If they miss their IEP or initial enrollment period, they can enroll during the next Medicare general enrollment. There are also a number of new Medicare Part B SEPs available for those who have missed their IEP or GEP, including a new SEP for individuals who missed an enrollment opportunity because they're impacted by a federal, state, or local emergency. There's a new SEP for individuals who were released from incarceration on or after January 1st, and we'll be chatting out two links to resources on some of these Part B SEPs.

They can also apply for equitable relief, which allows an individual to request immediate or retroactive Medicare enrollment and eliminate any Part B penalties that they may have incurred, if they fail to enroll in Medicare as a result of inaction or receiving inaccurate or misrepresented information from a federal employee. Equitable relief has to be requested through the Social Security office because it's an administrative process rather than an enrollment process. The second thing to keep in mind is that coverage termination usually does not happen automatically. So once your client is enrolled in Medicare, they still need to go back and terminate their marketplace coverage. And furthermore, it is possible for clients to lose their marketplace APTCs or advanced premium tax credits, if they are either eligible for premium-free Medicare Part A and still enrolled in marketplace coverage or if they're enrolled in Medicare Part A with a premium. Clients can keep their APTCs only if they're eligible for, but not enrolled in Medicare Part A with a premium.

So deciding between marketplace and Medicare is complicated and it includes comparing current premium costs and potential costs of late enrollment penalties. And we're chatting out a few links with additional information right now. And so to that end, it's important that when you're helping your clients transition from marketplace to Medicare coverage to make sure to encourage them to check their mail frequently for any notices from the marketplace or Medicare. But also be aware of brochures and other marketing materials from insurance companies that may look like official notices but aren't actually from the government. And find out when their Part A, B and D coverage begins before terminating marketplace coverage so they can avoid any coverage gaps. And finally, encourage them to contact the Social Security office if they encounter any enrollment issues. And then I just want to note an additional new enrollment challenge due to the Medicaid Unwinding that Molly discussed

earlier. There will be people who are no longer eligible for Medicaid but who are eligible for Medicare and those people will qualify for a new SEP that allows individuals to enroll in Medicare after termination of Medicaid eligibility.

So they won't have to wait until the next Medicare enrollment. 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. So just wanted to make that note about the Medicaid Unwinding and the SEP available there. So let's do one last knowledge check. True or false. Clients who are currently enrolled in marketplace coverage will automatically be terminated from their plans once they enroll in Medicare coverage. So I'll just give everyone a few moments to answer this true or false question.

Great. So it looks about a third getting close to a half of everyone has responded. So false is the right answer that almost 80% of you got. So even if a client's no longer eligible for marketplace coverage because they've enrolled in Medicare, they still must actively cancel their marketplace coverage. So you can't assume that the coverage will automatically be terminated because there may be penalties associated with that. So great job everyone. All right, so now let's move on to financial help for Medicare. And keep in mind that the following is not an exhaustive list of the financial assistance options out there. So we do encourage you to check for any state specific or regional programs that may be available in your area as well. So first, let's start with the Ryan White program. The Ryan White program can help with premiums and cost sharing for Medicare Parts B, C, and D coverage, and this includes outpatient and ambulatory health service under Medicare Part B and prescription drug coverage under Medicare Part D, that includes at least one drug in each class or core antiretroviral therapeutics.

The Ryan White Program Medicaid and other payers may also provide additional services such as case management and transportation assistance that Medicare does not provide. Ryan White funds cannot be used to pay for Medicare Part A premiums, but as a reminder, most people don't have to pay Part A premiums anyway if they have sufficient work credits. So if you're not sure what the Ryan White Program covers in your area, we encourage you to check with your state ADAP and/or your local Part A program for details. And you can learn more about Ryan White program funds and how they can be used by reading the HRSA HAB Policy Clarification Notice 18-01, which we're chatting out the link to now.

Medicare Enrollment and Coverage for Ryan White HIV/AIDS Program (RWHAP) Clients

When clients use the Ryan White program to help pay the cost of Medicare, you should remind them that Medicare is the primary insurance and ADAP is always the payer-of-last-resort. And what this means is that if your client is going to the pharmacy to pick up their medications, they should pay the copay with their Medicare Part D or Medicare Advantage card first and ADAP second if needed. This helps to make sure that your client is paying towards the deductible for their Medicare plan if they have a deductible requirement. Another tip is to be aware that premium amounts can change throughout the year. So to avoid coverage, termination or accruing past due amounts, both clients and case managers to keep an eye out for any notices in the mail about changes to their premium amounts. And this will ensure that the Ryan White Program is helping clients pay their premiums in full and on time.

Another financial assistance option is the Medicare Savings Programs or MSPs. MSPs are federally funded, state administered programs for certain low income people that help pay for some or all of a Medicare enrollees' Medicare premiums and out-of-pocket expenses. They are available to most people who are dually eligible, meaning those individuals who qualify for both Medicaid and Medicare. There are four types of MSPs. First is the Qualified Medicare Beneficiary or QMB, which is the most comprehensive and pays for all Medicare costs. Then the other three are the Specified Low-Income Medicare Beneficiary, SLMB. Qualifying Individual, QI. And Qualified Disabled and Working Individuals, QDWI. These three MSPs only pay for some of the Medicare costs. All of these MSPs have slightly different eligibility criteria and not every state will have all four of these programs. They may also have different names depending on where you live.

So if you think your client might be eligible for a Medicare savings program, you can help your client apply through your state's Medicaid website, and we'll chat out a link to more information on MSPs. There is also the Extra Help program, also known as the Part D, low income subsidy or LIS, which I mentioned earlier in relation to the Medicare Part D penalties. So this is a federal program that helps individuals pay for some or most of the out-of-pocket costs associated with Medicare Part D prescription drug coverage. The program itself is not prescription drug coverage. The client must already be enrolled in a Part D plan in order to apply for Extra Help with those costs. Your client may qualify for either partial or full Extra Help depending on their income and assets. You can help them enroll either through the Social Security Administration online or with a paper application.

If your client is enrolled in a Medicare savings program, they usually will also qualify for Extra Help automatically. Clients can qualify for both MSPs and Extra

Help because MSPs are administered by the state, and Extra Help is a federally administered program. So since both the MSPs and Extra Help are income based, most Ryan White Program clients will qualify for both programs. And just as a reminder, enrolling in Extra Help will eliminate any Medicare Part D penalties that your client may have incurred. There are some other sources of financial help which may be specific to your state or local community, and these include state pharmacy assistance programs, which are offered in some states to help eligible clients pay for their prescription drugs based on their financial need, their age, or whether they have certain medical conditions such as HIV and AIDS.

There's also patients patient assistance programs which are offered by some major drug manufacturers to eligible people. So depending on the specific assistance program, the client may be able to get their medications for free or at a very low cost. Each program has different requirements including whether there's a copay and how to apply. And most of these programs have an online application through the drug manufacturer. Lastly, there are Programs of All-Inclusive Care for Elderly or PACE, which are state administered programs for people who require a nursing home level of care but are still able to live in the community. Most people who are eligible for the PACE program are dually eligible for Medicaid and Medicare and PACE will pay for some or all of the Medicare costs. If you believe your client may be eligible, you can check with your state's Medicaid program to see if it's offered and how to enroll. And we're going to chat out a few additional links for all of these.

Another financial assistance option is the Low-Income Newly Eligible Transition or LINET program, which provides temporary and sometimes retroactive Medicare Part D coverage for people who are transitioning off Medicaid and waiting for their Medicare coverage to begin. This is available for low-income seniors, age 65 and older. And finally, there may be other state or local resources near you such as a clinic or hospital's financial assistance program. If your client is a patient at a hospital or clinic, they can get in touch with the insurance department or financial assistance department to find out if they qualify, and we'll share a link now more on the LINET program.

So now let's do one final poll. We'd like to know what information would be most helpful for staff in your program to understand about dual eligibility for Medicaid and Medicare. Is it the basics including eligibility criteria, benefits and coverage, integrated care options, financial assistance programs, billing and payer requirements, role of the Ryan White program in ADAP, state level variations or other? You can chat in and let me just pull that up. I'm seeing that we just have a error here in our poll, so if you want to chat in what information

would be most helpful out of these or other options, please feel free and I'll just give you a few moments to chat in that information. So is it basics, integrated care options, financial assistance programs, billing and payers, role of Ryan White in ADAP or state level variations or something else? So I'm just looking over what you all are chatting in. It seems like a big vote for Basics.

Basics, all the above, role of Ryan White, the number of calls for more info on financial assistance programs. All right, this is really helpful for in terms of helping us determine what additional TA we can provide through webinars and tool development. And so as Molly mentioned, we do have an upcoming webinar on Medicare, Medicaid dual eligibility for Ryan White clients on February 28th. And we'll be sharing the link to register in just a little bit, but that is available at targethiv.org/ace. We also have a dual eligibility case manager tool, which you can access and I'll share the link in just a moment. And we're in the process of creating a new resource that is consumer facing about dual eligibility to assist you with your dual eligible clients in helping them to navigate the process. So we hope to release that new consumer facing tool in the spring or summer. So thanks for continuing to chat in what would be most helpful. Like I said, it's really, really, really helpful to hear from you all about what your needs are.

So now I'll just share some tools and resources that you can use when helping your clients enroll in Medicare coverage. And then we'll get into the Q&A portion of the webinar. So if you have questions, please feel free to chat the chat them in now and our panel will prepare to answer them. So the ACE TA Center has three tools that cover the nuts and bolts of Medicare coverage. The first is the basics of Medicare for Ryan White program clients, and this talks about the common eligibility pathways for people with HIV and the different parts of Medicare. This resource is also available in Haitian, Creole and Spanish, and that's the first one on the left here. The second tool in the middle is the Medicare prescription drug coverage for Ryan White Clients, which talks about how to get prescription drug coverage, the donut hole coverage for HIV medications and how ADAP can help with costs.

And the third tool here is how Medicare enrollment works, which goes into detail about, which goes into detail about the initial enrollment periods, special enrollment periods in general enrollment periods, as well as how to avoid penalty and make changes to your existing Medicare coverage. So these tools can all be found at targethiv.org/ace/medicare, and all of the remaining tools that I'm going to talk about can also be found at that link. So the next one is a tool about one-on-one Medicare enrollment assistance for Ryan White clients, which goes into detail about the benefits of partnering with your local SHIP

program as well as how to become a certified SHIP counselor. So this touches on some of what Molly presented early on, and I know a number of you said you weren't familiar with the SHIP program, so we encourage you to check out this resource. Then we have a tool on transitioning from marketplace to Medicare health coverage that includes a comprehensive FAQ and decision tree to help make this process a little easier and goes into more details than what I covered about making this transition. And that's also available at targethiv.org/ace/medicare.

And we also have a tool on financial help for Medicare, which goes into some of the most common sources of financial assistance that I talked about, including Medicare Savings Programs and the Extra Help program. And finally, we have a resource designed specifically for clients called the ABCDs of Medicare Coverage. And this is a brief plain language tool that describes different parts of Medicare and the difference between original Medicare and Medicare Advantage. So you can print this out and give it to your client clients to read on their own and also use it to discuss Medicare coverage during an appointment and give them a fact sheet to take home with them. So again, you can find all these tools at targethiv.org/ace/medicare, and we have included the direct links to these resources in the companion resource document for this webinar that has all the links in it. And this link's also where you can find our dual eligibility resources. So now I'll hand it back to Michelle to get us started with the Q&A.

Michelle Dawson: Thanks very much Liesl. Thank you. And at this time I'm happy to be joined by our fabulous panel of experts going to answer the questions that you've been chatting in throughout the presentation from the ACE TA Center. We have Liesl Lu who you were just hearing from. Molly Tasso, we heard from a little bit earlier today, and Christine Luong, we're also happy to be joined by Anne Callachan of Access Health Massachusetts. And I believe we also have Dori Molozanov from NASTAD as well. So let's get started with some of the questions that you've been asking throughout the presentation. Let's see. The first question that we have here is for Christine. The question is, do we have a number of people currently living with HIV over the age of 65 and those expected to be 65 in the next few years?

Christine Luong: Thanks, Michelle, and hello everyone. Yeah, so based on the most recent RSR, the Ryan White Services Report with 2021 data, about 10 and a half percent of all Ryan White clients are over the age of 65. So in actual numbers, that's about 57,000 clients. And about one fourth of all Ryan White clients are between the ages of 55 and 64, so that's about 145,000 people. So just looking at those numbers, there is a substantial number of clients who are expected to age into

Medicare in the next few years, which really highlights sort of the importance of the information that we're covering today.

Michelle Dawson: Thanks so much, Christine, for that great answer. Okay, our next question is for Anne, if you're ready. So if someone has been put on SSDI that's Social Security Disability Insurance and has Part A and B and is not 65 and did not sign up for Part D because they were not told about this and now they're being told that they have to wait until they're 65, is there anything that they can do to get Part D coverage?

Anne Callachan: Thank you so much for that question. So beneficiaries should be able to enroll in Medicare Part D or a Medicare Advantage plan that includes drug coverage during the annual Medicare open enrollment period that runs from October 15th to December 7th every year. Meaning depending upon the age of that client, if they're 63 years old, they shouldn't really have to wait until they turn 65 to enroll in Medicare drug coverage, though they might need to wait until the Medicare open enrollment period. Having said that, there are some special enrollment periods that might qualify somebody to enroll in Medicare drug coverage outside that open enrollment period. So I would encourage you if you're talking about a particular client, to maybe work with your local SHIP organization or a SHIP counselor to see if this client might qualify for a state program or some kind of SEP that would allow them to get Medicare or drug coverage before the next open enrollment.

Michelle Dawson: Thanks so much for that great answer. And Anne, if we could get you to stay on for just another moment, we have another question for you. So the question is, if a person is still employed and receiving employer insurance at their 65th birthday, should they still apply for Medicare?

Anne Callachan: So another great question. We did have a similar question that came in as well. So people should be able to avoid the Medicare late enrollment penalties for Part B and Part D if they are actively working and enrolled in employer sponsored insurance or they have a spouse who's actively working and they're enrolled in their spouse's employer sponsored insurance. Since most people qualify for premium-free Medicare Part A, it's never a bad idea to opt into the Part A when they become Medicare eligible during their initial enrollment period. And there are some circumstances where employer sponsored insurance doesn't pay first. So in those circumstances, people would want to take A and B. So it's always a good idea for employees to check with their employers' human resources department or benefits department to see if they are required to enroll in Medicare Parts A and/or B.

Michelle Dawson: Thanks so much and for that thoughtful response. Okay, our next question I think is for Christine. So what are the requirements to apply for the Federal Extra Help Program?

Christine Luong: Yeah, good question. So to qualify for Federal Extra Help program, first you have to be receiving Medicare coverage. And the other part is that you have to have limited resources and income. So in terms of income, these limits will change every year as of either 2022 or 2023, the income limit is about 16,000 for a single individual or about 33,000 for a married couple that's living together. So those numbers will change every year, you should always look online at ssa.gov or medicare.gov to get those updated numbers. Another requirement is that you have to be a resident of one of the 50 states or District of Columbia.

Another thing to keep in mind about Extra Help is that there's actually a way that you can automatically qualify for it instead of having to actively apply. So during this presentation, we talked about Medicare savings programs. There are four types for people who qualify for three of those Medicare savings programs. They will actually automatically qualify for the Extra Help program. But even if you don't automatically qualify, you can still apply for the program actively. So you could do that online by phone or via a paper application. So there's actually a number of ways that we could do that.

Michelle Dawson: Thanks very much, Christine. All right. Our next question is for Liesl. The question is, can a client defer Medicare enrollment and avoid penalties if they themselves are not working but they're covered by their spouse's insurance? Or a similar question that came in was, what happens if a spouse is working and providing coverage, not the client?

Liesl Lu: Sure, thanks. And this is similar to the last question that Anne answered, just taking a little bit further, if their spouse has active employer insurance and the spouse and the Ryan White client are enrolled in the employer or insurance, they may be able to defer Medicare enrollment, but we recommend checking with the employer to see if they should enroll in Part A or Part B if necessary. But like Anne mentioned, most times people will be able to enroll in Medicare Part A with no premium, and so that would probably be recommended even if they can defer their Medicare Part B enrollment.

Michelle Dawson: Thanks for that, Liesl.

Liesl Lu: Mm-hmm.

Michelle Dawson: Okay, I think let's have Anne come back, and Anne, a question posed for you. Can a client enroll in a Part D plan and defer a Part B plan if their employer sponsored insurance doesn't have sufficient prescription coverage?

Anne Callachan: Hi. So it's kind of a complicated question and one that leads me to think about the fact that this person might want to consider if their employer insurance doesn't have sufficient prescription drug coverage, whether or not it's really beneficial for them to stay enrolled in the employer-sponsored plan over opting into Medicare. Having said that, to avoid a Medicare Part D late enrollment penalty, their employer-sponsored insurance needs to offer drug coverage that's at least as good as Medicare's. So we would want to determine in these circumstances, does the fact that this insurance doesn't have sufficient prescription drug coverage, what does that mean related to that answer? So I would maybe encourage this person to reach out to Medicare, to their employer human resource department, to a SHIP counselor to really better understand whether the insurance they have through their employer is sufficient enough.

Michelle Dawson: Thanks so much. And we have another question about prescriptions or prescription coverage. So I've heard that Medicare has to cover all HIV antiretroviral medications. Is that the case? And if so, which Medicare parts are required to cover these medications?

Anne Callachan: So it is true that all Medicare drug plans must cover all antiretroviral medications. So that would include both Medicare Part D plans and Medicare Advantage plans that include drug coverage. Now that doesn't mean the Medicare plan isn't allowed to require prior authorization or have quantity limits, but they are required to cover all antiretroviral medications.

Michelle Dawson: Thanks. One more while we're on this track. So person asked a question. My patient has employee-based insurance, but it excludes all ARVs. So I'm assuming that's antiretrovirals. He was eligible for Medicaid... Or excuse me, Medicare last year, but declined because he felt like it was too much. Could he be penalized for not taking coverage?

Anne Callachan: So I think this goes back to that same question that I sort of answered before. Does the fact that this person's employer sponsored insurance drug coverage not cover antiretrovirals mean that it doesn't meet the credible coverage standard as it's set up by Medicare? So again, I would sort of encourage that a person in these circumstances is really looking into whether or not they are better served staying enrolled in the employer sponsored insurance or would be better off enrolling into Medicare drug coverage.

Michelle Dawson: Thanks so much for that answer. All right. Our next question is for Molly. So Molly, is ADAP considered creditable coverage given it is a subsidy and not insurance?

Molly Tasso: Great, thank you for this question. So no, ADAP would not be considered creditable coverage that would allow someone to avoid a Medicare late enrollment penalty. And really the important sort of point here is in the question, which is to say that ADAP is not health insurance, it is not health coverage. So even if someone is enrolled into ADAP, our hope is that they're also enrolled in a comprehensive health coverage plan, rather that be Medicare, Medicaid or a marketplace or employer sponsored plan.

Michelle Dawson: Thanks, Molly. Our next question is for Dori. Are there situations where the Ryan White HIV/AIDS program is permitted to reimburse clients for Part B premiums?

Dori Molozanov: Hi, this is Dori. Sure, I can take that one. So of course as folks probably know, HRSA policy does allow for payment of Part B premiums with Ryan White funds. However, there's a practical kind of issue that makes that impossible. Part B premiums for clients who receive social security monthly benefits, their Part B premiums are automatically deducted from those benefits, like their retirement disability. And that's automatic and clients are not allowed to opt out of that. Trust me, I have checked. It is legally not permissible for a client to opt out of doing that. So if they receive social security monthly benefits, their Part B premium is going to come out of it. Of course, Ryan White cannot reimburse clients directly and so therefore there is no way as of right now at least for programs to pay the Part B premiums even though they are allowed. They're technically allowed rather.

But there are some clients who don't receive Social security benefits and therefore would not have their Part B premiums deducted automatically. They'd be paying a monthly premium just like anybody else does for their insurance except they'd be paying it to the government. So clients who pay their own premiums directly each month, Ryan White can pay those premiums on behalf of the clients. An example of a client in this situation might be an older immigrant who lacks sufficient work history to receive retirement benefits, which that means they also likely lack sufficient work history to get Part A for free. So that's another expense for this person as well. But since they're ineligible for retirement benefits, their Part B premiums are not deducted from their retirement benefits.

Right. That is it. That is my answer unless someone has a follow-up question. Is there work to have this changed? I have personally been looking into this how to change this. I cannot really speak to any progress that's been made. Right now it's a little bit early, but just know, yes, this is something we care about. Don't want to officially talk too much about it, but this is on our radar. This is a personal issue that... An issue I personally care about a lot and have been trying to move forward and try to come up with some strategies for how this can be addressed. So we hear about this from programs all the time in NASTAD. This is a huge barrier. We are working on it and we hope that this will not be an issue for long. But for right now, this is unfortunately the way that it has to be.

Michelle Dawson: Thanks so much for that, Dori. Okay, our next question is why are people expected not to terminate marketplace coverage when they may not have the funds to pay for both marketplace and Medicare at the same time? Christine, can you take this?

Christine Luong: Yes, I can. Thanks, Michelle. So to clarify, clients are not expected to pay for multiple plans at once. What we suggest, what we strongly suggest actually, is that clients should find out the exact start date of their Medicare coverage before they make that phone call to the marketplace to request that their marketplace coverage be terminated. Because otherwise, if you cancel your marketplace before your Medicare coverage begins, that will obviously result in a coverage gap, which is not great. So for example, if your client's Medicare coverage doesn't start until July 1st, for example, don't call the marketplace in February to terminate coverage. You should do it when the timing is right to avoid those coverage gaps.

I will say that this is, I would say, less of an issue now that the new Medicare rules came into effect on January 1st of this year. So previously, individuals who enrolled during the general enrollment period would have to wait until July of that year for their coverage to begin. So now it's just a matter of getting all your ducks in a row, making sure when your coverage effective date is before planning those next steps.

Michelle Dawson: Thanks so much for that. All right, I have one question, a question that I love to see, that we love to see. I am interested in learning how to become a SHIP counselor. Please provide information on how to do this. Anne, can you provide that information?

Anne Callachan: Yes, I can provide that information. I mean, my best recommendation here, I am a SHIP counselor. So I got in touch with a local SHIP organization. I asked when they were doing their next SHIP training and I participated in the training and

since then two of my colleagues at the Massachusetts HIV Drug Assistance Program have also completed that SHIP certification. I am pretty sure that ACE has a map to find contact information for your local SHIP. You can also just Google it, get in touch with them, ask about the training. I have benefited so much from doing that SHIP certification training. I also learned a lot that I didn't necessarily think I would learn about Medicaid programs in my state, eligibility for those programs. And it has helped me so much working at the Massachusetts HDAP to help clients navigate this complicated issue.

Michelle Dawson: Thank you for that information. Okay, Anne, if you could pop back, I think this question's a good one for you. Sorry for that. How is the Extra Help application determination followed up on to find out if one is approved or denied?

Anne Callachan: So in my experience, the letters that people get telling them that they've been approved for Extra Help come from Social Security and it is sort of a whole process that happens. So people who qualify for Extra Help qualify for subsidized Medicare drug coverage with generally no or lower copays for meds and no or lower monthly premiums for the plan for somebody who is newly applying for Extra Help and gets approved. That letter they get from social security is typically followed by temporary drug coverage through what's known as the LINET, and then enrollment into a Part D plan.

For somebody who may be already had a Part D plan and has applied for the Extra Help and gets approved, they may want to look at other drug plans where they are premium drops to $0 because not all of them do. Most people when they're applying for their state Medicaid program, that includes that they get screened for Extra Help. So there are sort of a lot of ways to get those communications, but for clients who apply, didn't have it before, get approved, didn't have drug coverage before, the process kind of works automatically from there after the approval. That they get the temporary LINET coverage followed by enrollment into a Part D plan.

Michelle Dawson: Thanks so much, Anne. All right. Our next question is what are the qualifying circumstances for special enrollment? Liesl, do you want to start with this one?

Liesl Lu: Sure. So I'll just give a general overview of what we think that this person is interested in, what the new SEPs are. So their number of new SEPs that were issued at beginning of this month based on some new rules out of CMS that allow clients to enroll outside of the traditional enrollment pathways. So I mentioned earlier in my presentation the SEP for those who become ineligible for Medicaid. So there's a special enrollment period for those folks to enroll into Medicare. There's also an SEP for individuals impacted by an emergency or

disaster. So this is such as this would include the COVID PHE or for instance, there have been SEPs in the past for hurricanes, for people impacted by hurricanes. So it's a disaster emergency that's declared by a federal or state or local government, and it's a six-month SEP for that.

There's an SEP for a health plan or employer area... Employer error, sorry. That would provide relief in instances where an individual can demonstrate that their employer or their health plan materially misrepresented information to them relating to enrolling in Medicare in a timely manner. There's also an SEP for formally incarcerated individuals, which I had mentioned. And this is available for 12 months post-release and will allow individuals to choose between retroactive coverage back to their release date or coverage beginning of the month after they enroll. And then there's also an SEP for other exceptional conditions. That's a real case by case basis to be granted an enrollment period to an individual when circumstances beyond that individual's control prevented them from enrolling during the IEP, GEP or another SEP.

So with all of these, as far as we know right now, you have to contact the Social Security Administration to initiate any of these SEPs. So that would be calling the Social Security Administration in your state and stating the circumstances for the client's qualification for the SEP and then seeing from there, I think there was maybe just... Yeah. So just calling Social Security and seeing if the reason justifies for receiving an SEP. So hopefully that answers the question.

Michelle Dawson: Thanks so much. We have another question. Would you explain the new Medicare rule on Part B start dates? Christine, I think you might take that one.

Christine Luong: Yes, I can definitely take that one. Yes. So these new start dates, I'll talk specifically about the changes to the initial enrollment period start dates, and the general enrollment period start dates. So previously... Okay, let's talk about the IEP first. If you're not familiar, it's a seven-month period that's centered around your birthday month, so three months before your birthday month and then three months after. So let's say your birthday is in April, your IEP would be from January to July. Previously it used to be that if you enrolled during those last three months of your IEP, your coverage would start either two or three months after you enrolled. So there was a little bit of a coverage gap there. Now with this new ruling, if you enroll during those last three months of your IEP, your coverage will begin on the first of the month following enrollment, so that's the major change there.

For the GEP, which is from January 1st to March 31st every year, it used to be that if you applied at any point during that GEP, your coverage would not start

until July 1st of that year. So that's anywhere from four to six months after you were enrolled, and that would be a pretty significant coverage gap. With the new rule, your coverage will, again, it will start on the first of the month after you enroll. So if you enrolled in Medicare on January 15th, your coverage would start February 1st and it would kind of stagger that way. So that is really the major change that we're talking about with this new Medicare ruling.

Michelle Dawson: Thanks, Christine. Okay, our next question is, what if a client is over 65 still working without insurance and wanting to enroll in Medicare? I'll pose that to Anne.

Anne Callachan: So we have somebody who's still working, is now 65, is still working, they have no insurance, and they want to enroll in Medicare. So this is a perfect person to access that Medicare general enrollment period that is going on right now, runs from January 1st through March 31st. They should be able to enroll in Medicare Part B that will become effective the date after they enroll. Should be able to enroll in Medicare Part A that is likely backdated for a while. I can never totally determine how Medicare makes that decision. And once they have the A and the B, they should be able to enroll in a Medicare Part D or Medicare Advantage plan. I would also look to see does this client qualify for anything through their state Medicaid, maybe a buy-in program or something else that would facilitate that enrollment if we were outside of the Medicare general enrollment period, which again runs from January 1st till March 31st.

Michelle Dawson: Thanks so much for that. We have just a few moments left. I think that will have been our last question. But I thank all of our wonderful Q&A panelists for their time, their expertise there. And we just have a few more things that we want to say before we close out for the day. We want to remind you that at the top of this presentation today, we mentioned that today is the second part in our four part series. You can access all of these webinars on demand at targethiv.org/ace/webinars. And we'll also chat out a link to register for next week's webinar now, or the next webinar now, which will take place on February 14th. It's Medicaid 101 for the Ryan White HIV/AIDS Program Recipients and Providers. You can also sign up for our upcoming webinars on our webinar page.

So we've reached the end of our presentation on Medicare Enrollment for Ryan White HIV/AIDS program clients. Thank you again for joining us today. Be sure to complete the evaluation that'll pop up once we close. Please also be sure to sign up for our mailing list to download tools and resources and more by visiting us at targethiv.org/ace. And if you have questions after the webinar, you can always contact us at acetacenter@jsi.com. Thank you, have a great day.

Webinar Resource Links
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Medicare Enrollment and Coverage for Ryan White HIV/AIDS Program (RWHAP) Clients