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

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Jared Brumbeloe:

Minutes after the hour. We certainly want to be respectful of everyone's time. We're excited to get started today. My name is Jared Brumbeloe. I'm a senior associate here at JSI and a materials specialist on the ACE TA Center. I'm very excited to have all of you joining us today. But to get us started, I do want to share a few logistical updates and tech details, and then hand it over to our amazing presenters.

So for today's session, for today's webinar, attendees are in listen-only mode, but we'd certainly encourage you to ask plenty of questions using the chat box, the chat feature. You can submit your questions at any time during the presentation, and we'll take as many as we can at the end of today's session. And you also can certainly email questions to us at acetacenter@jsi.com. Wanting to make sure you all can hear us, the audio is being shared via your computer speakers and headset. However, if you do have problems hearing us at any point during today's webinar and presentation, or if you experience a sound delay, please try exiting and re-entering the webinar, or you can simply mute your computer audio and then call in using your telephone or landline to the information below, the information that was sent in the chat. You will be able to hear us that way as well.

So here at the ACE TA Center, we certainly have many ways that we want to ensure information is spread out and that we can help all who come to our website. But some of you may know this, and some of you may not. So for those of you who are new, welcome. We are a HRSA-funded technical assistance center that helps build the capacity of the Ryan White community to navigate the changing healthcare landscape and people with HIV access and use their health coverage to ultimately improve their health outcomes. We support Ryan White recipients and sub-recipients to engage, enroll, and retain clients in Medicare, Medicaid, and individual health insurance options. We help build organizational health insurance literacy, and we communicate with clients about how to stay enrolled and use health coverage. We do this by disseminating and developing best practices to support resources in providing TA and training through national and localized activities. We certainly hope you will join and see our target HIV website, the ACE TA Center, and be able to see more of our information there.

So a little bit more about the ACE TA Center and who our audiences are. They include Ryan White program staff, clients, program managers, case managers, administrators, but also people who help enroll Ryan White clients, such as navigators and other application counselors as well. Again, as I mentioned before, all of our TA resources can be found, including today's webinar, on our targethiv.org/ace website. In addition to the webinar recording, our website houses all the resources and tools that we'll be showing and displaying today, and anything that we discuss and share today will be there as well.

So now a little bit about our roadmap for our webinar today. In this presentation, we'll discuss the aging demographic of Ryan White clients, Medicare eligibility for people with HIV, the different parts of Medicare, including Medicare prescription drug coverage with people with HIV, and the common Medicare enrollment pathways. Today, I'm pleased to be joined by some of my colleagues that are going to present Christine Luong and Molly Tasso. Christine is the research and policy associate for the ACE

TA Center. She specializes in mixed methods research, health policy analysts, GIS and data visualization, and materials development for our Ryan White grantees, clients, and a variety of other audiences. Molly is a senior associate here at JSI and the project director for our ACE TA Center. She specializes in health policy and health insurance reform and its implications for people living with HIV in the Ryan White program. We're also joined by our principal investigator, Liesl Lu, who will be able to help us behind the scenes today. Very excited.

So to kick us off, we want to start with kind of our first poll that helps you identify what are the top challenges that your organization faces related to Medicare enrollment and coverage. When the poll pops up, please be sure to select all that apply.

We'll give a couple more seconds for everyone to select and vote.

All right. If we can go ahead and close the poll, and see what our top answers are. All right. So it looks like some of our high points here with our most percentage is understanding the differences between Medicare plans, understanding the basics of what Medicare covers, and determining client eligibility. We certainly hope that by the end of today's presentation, you will have more information regarding these and all the areas on here, and that you will feel that you have the information needed. But as always, please reach out to us as well to ensure that we can help answer your questions. At this point, I would like to pass it over to my colleague, Christine Luong, to kick us off on the aging demographics of Ryan White clients. Christine?

Christine Luong:

Hi, everyone. Thanks so much, Jared. I'm so happy to be here. So like Jared said, I am going to get us started today with some data about the aging demographics of Ryan White clients. All righty. So first and foremost, more Ryan White clients are aging into the Medicare program than ever before. Medicare is the second largest source of federal funding for HIV/AIDS care in the US after Medicaid. Over one quarter of all people with HIV, so about 28%, get their health coverage primarily through the Medicare program. And based on the most recent data that's available, about half of all Ryan White clients, 47.7%, are age 50 and over. And it is expected that in just a few years, in 2030, two-thirds of the entire Ryan White population will be aged 50 and older.

This slide shows how the age distribution of the Ryan White population has been changing over time. So this chart on the left shows the age distribution in 2010, and the chart on the right shows the age distribution in 2023, which is the most recent data that's available. So I want to draw your attention to the orange and yellow bars on the right-hand side of both of these charts. The orange bars represent the proportion of Ryan White clients who are age 55 to 64. So you can see that in 2010, that percentage was 13.7%. And it has almost doubled now to 24.5% in 2023. The yellow bars represent the proportion of Ryan White clients who are aged 65 and older. It went from just under 3% in 2010, and now it has quadrupled to 12.4% in 2023. So, if you combine the orange and yellow bars in the chart on the right, you can see that about 37% of all Ryan White clients in 2023 are aged 55 or older. And this is an upward trend that we are going to continue to see in the next few years. Next slide. Thank you.

So let's take a closer look now at Medicare beneficiaries with HIV. Among all people with HIV who have Medicare coverage, 39% are age 65 and older. So if we're looking at the donut chart at the top of this slide, that's that orange slice. And the other 61% are under the age of 65 and qualified for Medicare based on having a disability. So that's that teal or green-colored chunk of the donut chart on the top. And it's very interesting to note that this proportion is very different from the general population, where only 13% of all Medicare beneficiaries qualified for Medicare based on a disability. And then among all people with HIV who have Medicare coverage, 61% are dually eligible for both Medicare and Medicaid. And again, this number is much higher compared to the general Medicare population where only 18% of all Medicare beneficiaries are dually eligible.

So moving on to Medicare eligibility for people with HIV. Next slide. Great. So in order to be eligible for Medicare, you must be a US citizen or a legal resident for at least five years. There are three potential pathways towards Medicare eligibility. The first pathway, and this is probably the one that you all have heard the most about, is the aging pathway. So that is when you turn 65 and you age into the Medicare program. The second is the disability pathway, where you are under the age of 65, but you qualify for Medicare by having a qualifying disability, and I'll talk about that in just a second. And the third pathway is for folks who have end-stage renal disease or ALS, also known as Lou Gehrig's disease, at any age. And this webinar, we are going to focus more on the first two pathways.

So a couple of notes about the disability pathway in particular. So in order to qualify for Medicare under the age of 65, due to a disability, you have to qualify for Social Security Disability Insurance, or SSDI, benefits for at least 24 months. Those 24 months do not have to be consecutive. So, as long as you have received 24 months of SSDI benefits within your lifetime before the age of 65, you'll be automatically enrolled in Medicare when you are receiving the 25th month of SSDI benefits. For people with HIV in particular, the Social Security Administration does not acknowledge HIV status by itself to be a disability. However, you can still qualify for SSDI benefits if you meet the medical requirements for another physical or mental health condition. There are a few HIV-related conditions that will allow you to qualify for SSDI. And we've just chatted out a link to a resource that describes those listings in more detail. Next slide.

So let's do a quick poll. If we could pull up the poll. Please answer the question that pops up on your screen. The question is, what is the most common reason why clients at your organization are becoming eligible for Medicare? And you can select one of those, whether that's turning 65 and aging into Medicare, having a qualifying disability under 65, or having ESRD or ALS. So let's give it another few seconds. And let's go ahead and end the poll and share the results. Let's see what we have here. Okay. So just, yeah, exactly two-thirds of you said that your clients are turning 65 and aging into Medicare, and the other third are seeing clients with a qualifying disability under the age of 65. And interestingly enough, no one has said that their clients have ESRD or ALS. Okay. Thank you so much. We can stop sharing that.

And now we can move on and get into the nitty-gritty of Medicare coverage. So there are three parts to Medicare Part A, Part B, and Part D. So we're going to start with Part A. Next slide. So Medicare Part A is hospital coverage. It covers inpatient hospital care, skilled nursing facility care, hospice care, and some home healthcare and other things of that nature. Most people will actually qualify for what's called premium-free Part A. So, like it says in the name, it means that you don't have to pay a monthly premium for Medicare Part A coverage. If you have been working at a job that pays towards Social Security taxes, and you've accumulated 40 work credits, which is approximately 10 years of work history. So again, most people are going to fall into this category, so that by the time they turn 65 and enroll in Medicare, they won't have to pay a premium for it. But don't worry, if you don't have enough work credits by the time you turn 65, you'll have to pay a premium if you want that coverage, but you can also continue accruing work credits until you qualify for that premium-free Part A. So we've chatted out a link with more information about that as well.

Medicare Part B. This covers medical services from doctors and other healthcare providers. It covers preventive services. It covers medications that are administered by a physician. So that includes things like the flu shot or the COVID-19 shot that you get at the doctor's office. It includes some home healthcare, chronic pain management and treatment services, outpatient mental healthcare, and durable medical equipment. And new, beginning this year in 2025, Medicare Part B also covers caregiver training resources as well as a social determinants of health risk assessment every six months. So we've chatted out a link to tell you what else Medicare Part B covers.

And then finally, we have Medicare Part D, D for drug. It covers prescription drug coverage. Specifically, it covers outpatient prescription drugs, which includes all HIV antiretroviral medications. Under Medicare Part D, insulin is available without a deductible, and the cost is capped at $35 a month. Medicare Part D also covers vaccines that are recommended by the Advisory Committee on Immunization Practices

without any cost-sharing. So some examples would be the RSV vaccine or the shingles vaccine. And as of January 1st of this year, Medicare Part D cost sharing is capped at $2,000 a year. What this means is that the most that any Medicare Part D beneficiary has to pay out-of-pocket towards their deductible, their co-payments, or their co-insurance is $2,000. And also, as of January 1st of this year, there is a new optional program called the Medicare Prescription Payment Plan, or MPPP, MP3, however you want to call it. This is a program where Medicare Part D beneficiaries can choose to spread out their cost sharing over the course of the planned year instead of paying it all upfront when they receive the bill. So we'll chat out some links to that as well.

And this slide has just a little bit more information about those changes to the Medicare Part D cost-sharing model. So, like I just said, as of January 1st of this year, there is a $2,000 cap on out-of-pocket costs. If you have Medicare Part D coverage, you still start off in the deductible phase in the beginning of the plan year. So that part hasn't changed. The deductible amount changes a little bit year to year. In 2025, the Part D deductible is $590. Once you have paid that $590 towards your deductible, you move into what's called the initial coverage phase. In that phase, you pay a 25% co-insurance for each drug that you are purchasing. And after you reach $2,000, then you pay $0 in cost sharing for the rest of the year. So that's when we reach the catastrophic coverage phase.

So basically, what's new this year is basically it eliminates the Part D donut hole. So in the past, Part D beneficiaries had to pay an exorbitant amount out of pocket after the initial coverage phase and before they could reach the catastrophic coverage phase. So this has been a great development, obviously. And as a reminder, ADAPs can help with the Medicare Part D deductible and cost-sharing. And because HIV medications are pricey, most Ryan White clients are going to reach that $2,000 cap pretty early in the calendar year as well. Okay. Next slide. Great.

So we've talked about what Medicare Part A, Part B, and Part D covers. So now I'm going to talk about what that coverage means in the context of original Medicare versus Medicare Advantage. So we'll start with original Medicare here. Original Medicare is also known as traditional Medicare. So those terms are interchangeable. Original Medicare is administered by the federal government, and it includes Medicare Part A, hospital coverage, and Medicare Part B, medical coverage. It does not include Medicare Part D, which you do have to purchase separately if you need it, which I will talk about in just a minute. Next slide.

So, as with any health coverage option, original Medicare has its pros and cons. And we'll start with the pros. Original Medicare has an extensive nationwide network that allows beneficiaries to receive care from any doctor, provider, hospital, or healthcare facility across the US who accepts Medicare. If you have original Medicare, you do not need to choose a primary care doctor. You generally do not need a referral from a primary care doctor in order to see a specialist. And so for these reasons, original Medicare might be a more attractive option for clients who value having that greater choice of providers. Next slide.

And then on the flip side, there are some downsides to original Medicare, and it's mostly related to the cost of that coverage. So I'll talk about Part A coverage first. If you have Medicare Part A, one of the disadvantages is that the Part A deductible is based on a 90-day benefit period rather than an annual benefit period, which is how most other health plans do it. What this means is that if you have a client that has high healthcare utilization and has inpatient care needs throughout the year, they're going to have to meet their deductible up to four times a year. And remember, even after you meet that deductible, you could still face additional charges out of pocket for things like hospitalizations, for skilled nursing care, and for blood products.

And then if you have Medicare Part B, that deductible is based on an annual benefit period. But keep in mind that even after you've met your deductible, Medicare only pays for 80% of all approved charges. And that means you're responsible for the remaining 20%, which is your co-insurance. That means you pay 20% of the total cost of any Part B service you receive. And depending on the cost of that individual service, those costs are really going to add up. Next slide.

Okay. So, like I said before, original Medicare only includes Part A or Part B. If you need prescription drug coverage, you have the option to add it on and pay for it separately. So Medicare Part D plans are sold by private insurance companies. For people with HIV, you should know that all Medicare prescription drug plans are required to cover all or nearly all drugs in six protective drug classes, which includes HIV antiretroviral treatments. And they are required to be covered without any utilization management requirements like prior authorizations or step therapy. However, coverage isn't guaranteed for non-HIV medications. So every Part D plan has a different formulary. So you should keep in mind that it's possible that there may be some coverage restrictions for your non-HIV medications. For example, it may not be covered by the formulary at all, or there may be some quantity limit restrictions.

And for Ryan White clients in particular, there are some considerations that you should keep in mind if you have original Medicare and you want to add on that Part D coverage. So while technically, you only need either Medicare Part A or Medicare Part B in order to purchase a standalone Part D plan. We do recommend that you encourage clients to enroll in both Medicare Part A and Part B if they're eligible for it so that they have comprehensive coverage for both their inpatient and outpatient care needs.

And the second thing to keep in mind is that Medicare Part D coverage can be expensive, so you should work with your clients to see if they're eligible for the federal Extra Help program. This is a program that provides financial assistance for certain low-income individuals with Part D. If you do qualify for Extra Help, you pay $0 for your Part D premium and $0 for your deductible. And the amount that you have to pay out of pocket for generic and brand-name drugs is capped at a specific dollar amount. And even if your client's income is too high to qualify for the Extra Help program, ADAPs can help pay for Part D premiums, but that decision is actually-- it's up to the individual state or territories' ADAP program. Next slide. Great.

And if you have original Medicare, you can also choose to add on Medigap supplemental insurance and pay for it separately. Medigap plans, these are also sold by private insurance companies, but they are standardized by law. They have letters in their name to help make it easier to compare Medigap plan types. So if you're looking at multiple Medigap Plan K's, they're all going to cover the same thing. If you're looking at two different Medicare Plan M's, those are going to cover the same thing. So that's the purpose of that standardization. And like it says in the name, Medigap plans supplement the remaining costs of Medicare Part A and Part B coverage, like co-pays and deductibles, but it doesn't help with the cost of Part D, prescription drug coverage. And lastly, you do have to have original Medicare in order to purchase a Medigap plan. Medigap is not compatible with Medicare Advantage.

So, Medigap plans do have a monthly premium. That premium amount is going to vary, and it's going to determine exactly what your out-of-pocket cost will be, if any. ADAPs may be able to help pay for Medigap premiums. And as a rule of thumb, as with most things, usually, the more expensive the Medigap plan is, the greater the benefits. But keep in mind that Medigap still doesn't cover things like long-term care, vision, or dental, but it can still be a good add-on for clients who have original Medicare if they have more complex medical needs.

All right. So let's turn to Medicare Advantage. So everything that I've just presented was about original Medicare. The other option is Medicare Advantage. It's also known as Medicare Part C. So, Medicare Advantage and Medicare Part C, those terms are interchangeable. Medicare Advantage plans are administered by private insurance companies that contract with the federal government to provide coverage to Medicare beneficiaries. Medicare Advantage is a single plan that bundles Medicare Part A, Part B, and very often also Medicare Part D coverage all into one product. More than half of all Medicare beneficiaries in the US have a Medicare Advantage plan, so it's a very popular option. Next slide.

So there are some pros of Medicare Advantage. In terms of cost, there is usually a very low premium or no premium at all for this type of plan. But you do still have to pay whatever your Medicare Part B premium is. The Ryan White program and ADAP can help with Medicare Advantage premiums. Advantage plans usually provide extra services like vision or dental. And this is one of the draws of this type of coverage. Some Advantage plans have lower out-of-pocket costs for some services as compared to original Medicare. So if you are someone that has less complex medical needs and you

want those extra benefits like the vision and dental, Medicare Advantage could be a more attractive option for you. Next slide.

But again, on the other hand, there are some cons, right? So, Medicare Advantage plans are more limited when it comes to provider networks. Advantage plans are usually an HMO plan or a PPO plan. What that means is it has a very specific provider network depending on where you live. And obviously, that is going to vary widely from state to state. And having this limited provider network can be a little troublesome for people with HIV who have long-standing relationships with their HIV providers and their non-HIV providers. So it's possible that you might not be able to find a Medicare Advantage plan in your area that's accepted by all of the providers that you're currently seeing. And if you choose to see a doctor that's out of network, it's going to cost you more, especially for inpatient services. And with Medicare Advantage, you also have to choose a primary care provider. You might need to get some services approved ahead of time, and you might also need to get a referral before you can see a specialist. Next slide.

Okay. So I've laid out the two Medicare coverage options and the pros and cons of each. This is just a summary slide. So, while we can't tell you which plan to pick for your clients, what I can offer is an analogy that can hopefully help with the comparison between original Medicare and Medicare Advantage. So the way I think about it is original Medicare is kind of like going out to eat and ordering a la carte. So you have a lot of flexibility to pick and choose the specific items that you want, and you only pay for each specific item that you want. And then on the other hand, Medicare Advantage is kind of like ordering off a pre-fixed menu or a set menu. So it comes with a bunch of stuff for one price. You might like everything that's offered, or you might not, but there's really no flexibility to change the menu, right, and you can't substitute any items. So as you're working with clients to figure out which option is right for them, you can shop and compare plans on medicare.gov, and we'll chat out some links to help with that. And just remember that the Ryan White program, including ADAP, can help pay for Medicare and Medigap premiums and out-of-pocket costs. So hopefully, that analogy is helpful with making that comparison.

And before we move on, I would like for us to do a quick knowledge check because I've just said a lot. So, please answer the question as it pops up on your screen. The question is, which of the following is true about Medicare Part D prescription drug coverage? So you can select more than one answer if you'd like. It can be purchased separately to add on to original Medicare. It can be part of a bundled Medicare Advantage plan. Cost-sharing is capped at $2,000 a year. All of the above, or none of the above. So let's give folks maybe another 10 seconds or so. Which of the following is true about Medicare Part D prescription drug coverage? Let's see.

Okay. Let's go ahead and end the poll and share the results. Okay. So 75% of you said all of the above. 22% of you answered A, could be purchased separately. 17% said it can be bundled. 13% said cost sharing was capped, and 1% of you said none of the above. So let's go to the next slide and see what the answer is. The answer is D. So most of you did get it right. All of the above are true. All right. Thank you so much. And I am going to pass it now to Molly to talk about Medicare enrollment pathways.

Molly Tasso:

Great. Thanks so much, Christine. Good afternoon, everyone, or good morning from wherever you're joining us. So we've talked about what Medicare covers. You've gone through the different parts and sort of types of Medicare. So now we're going to talk about the Medicare enrollment pathways. There are four primary ways that a person can enroll in original Medicare or a Medicare Advantage plan based on their age and specific life circumstances. So first, if they receive Social Security Disability Insurance, SSDI, or Social Security retirement benefits before the age of 65, they will be automatically enrolled in Medicare Parts A and B when they become eligible for Medicare at age 65. That person's 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 the IEP. So the client is about to turn 65 and they've not yet started to receive Social Security retirement benefits, they can enroll in Medicare during their IEP, their initial enrollment period. And then there are also a number of SEPs, or special enrollment periods, including new SEPs that have shortened the waiting periods to gain coverage after enrollment and that have expanded SEPs. So we are going to talk a little bit more about some of these later on in this section. And then finally, there's the general enrollment period, or the GEP. And that's if a client has missed the initial enrollment period and they don't qualify for the special enrollment period.

So let's dig into these in a little more detail. So the Medicare initial enrollment period, again, or the IEP, is a seven-month period centered around the month of a person's 61st-- 65th, excuse me, birthday. So some people call this the IEP the 3-1-3 period. It starts three months before the 61st-- 65th. I don't know why I'm stuck on 61. 65th birthday. It includes the month that the person turns 65, and then it ends three months after they turn 65. And then also with the recent CMS rule change, the coverage gap has been shortened in the last three months of the IEP. So let's talk through that.

So an individual signs up for Medicare during the first three months of their IEP. Their Medicare coverage will begin on the first day of their birthday month, which is the fourth month of the IEP, that middle month. And then this portion of the IEP is the same as it has always been. 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. The coverage gap here has been shortened. So one thing to note here is that if a person's birthday falls on the first day of the month, their IEP, their initial enrollment period, is shifted one month earlier to include the four months prior to that birthday month. It includes the month that the person turns 65 and then two months after the birthday month. So it's still a seven-month sort of timeline, but instead of 3-1-3, 4-1-2.

All right. So then let's talk about Medicare special enrollment periods for folks transferring from employer coverage after they turn 65. So this enrollment option applies if a client is still working past the age of 65 and have employer-sponsored insurance or if they have employer coverage through a spouse who is still working. So when this person quits, retires, or otherwise is no longer enrolled in that employer-sponsored insurance, they will begin an eight-- they will qualify, rather, for an eight-month SEP to help them transition into Medicare. The SEP begins when the employer coverage ends. And then if they enroll during that eight-month period, their coverage will begin the first day of the month after they sign up.

One thing to note here, just keep in mind that COBRA health plans are not considered employer-sponsored coverage. And so if a client is currently enrolled or covered by a COBRA plan, they won't be eligible for an SEP when their COBRA coverage ends. One final thing to note about this sort of scenario is that even if a client is keeping their employer coverage, they could actually enroll in just Medicare Part A if they qualify for premium-free Part A. And again, remember that this is possible-- the situation is possible if this person has 40 work credits or approximately 10 years of work history.

So next up is an SEP for folks whose Medicaid eligibility is terminated. And this particular SEP allows for these individuals to enroll into Medicare and not have to wait until the next Medicare enrollment period. So individuals can choose between retroactive coverage back to the date of termination for Medicaid, or they can opt for coverage beginning the month after the individual enrolls. One thing to note is that if a person selects retroactive coverage, they will be-- they need to pay the premiums for that retroactive cover time period. So that's something to consider when thinking about the sort of financial piece of that.

And there's also a number of additional SEPs now available that allow clients to enroll outside of the enrollment pathways that I just discussed. So on the slide here, you see there's an SEP for individuals impacted by an emergency or disaster, which would be declared by a federal, state, or local government entity. And this SEP is available six months after the end of the emergency declaration. There's an SEP for health plan or employer error, and this would provide relief in situations where an individual can demonstrate that their employer or a health plan materially misrepresented information related to enrolling in Medicare in a timely manner. There's an SEP for individuals who believe that they were

misled by a plan's marketing materials and maybe made the wrong plan choice. So misleading marketing includes inaccurate information, maybe promises of benefits that are not available, or any marketing that violates Medicare's rules related to marketing.

There's an SEP for formerly incarcerated individuals that would allow folks to enroll following their release from a correctional facility. This SEP is available up to 12 months post-release and will allow individuals to choose, again, between retroactive coverage back to their release dates or coverage beginning the month after the month of enrollment. Again, looking at retroactive coverage, again, that person would be required to pay the premiums for those retroactive months that they've opted to cover. And then there's an SEP for other exceptional conditions. And this will, sort of on a case-by-case basis, grant an enrollment period to someone when circumstances beyond the individual's control prevented them from enrolling during the IEP, GEP, or another SEP. And this is available for a minimum six-month duration. This SEP is not intended to replace equitable relief, which offers additional flexibilities that go beyond the parameters of this SEP. But it's an important sort of muscle to flex if someone needs to, again, on a case-by-case basis, take a look at some enrollment needs that they might need outside of the sort of traditional pathways. So we're going to chat out some helpful links with more information about these SEPs, and also how to access these SEPs.

And then finally, if a client misses their initial enrollment period, their IEP, and they also don't qualify for a special enrollment period, they can enroll during the general enrollment period, the GEP. And this runs every year from January 1st to March 31st, and then their coverage begins on the first of the month after the individual enrolls. During the GEP, a person can enroll in Medicare Part A and B for the first time. And then once that coverage starts on the first of the following month after that enrollment, then they can also enroll into Medicare Part D.

So we're going to check our knowledge here. Again, as Christine said, I've just shared a lot with you all. So we're going to think about Keith here on the slide. So Keith is turning 65 in July. He's currently enrolled in Marketplace coverage. What should Keith do? Should Keith keep his Marketplace coverage through the end of the year and enroll in Medicare through the general enrollment period next year? Should Keith enroll in Medicare during his IEP and then cancel his Marketplace plan? Or should Keith enroll through a special enrollment period at any point after he turns 65? We will give folks a few minutes to respond. All right. I think we can-- people are still responding. We'll give folks a few more minutes.

All right. Let's go ahead and share the results. So the correct answer is B, which about 65% of you got correct. So that is right. So to avoid a late penalty, a late enrollment penalty, Keith should be enrolling during his IEP. And that's happening April to October, which is around his birthday there, and then cancel his Marketplace plan after his Medicare coverage begins.

All right. So let's look at Sandra here. So Sandra, unfortunately, missed her IEP. She missed her initial enrollment period, and she doesn't qualify for any special enrollment periods. She enrolled during the GEP, the general enrollment period, in February of this year. When does her coverage start? On her 65th birthday last year, March of this year, or January of next year? I'll give folks a few moments to respond.

Okay. I think we can share the results. So Sandra's coverage - and you'll see on the next slide - will begin March of this year. So Sandra enrolled in February, and then coverage will begin on the 1st of the next month, the month after she enrolled. So she enrolled in February. Next month, March, March 1st, her coverage will begin.

All right. So to sort of wrap this up before we move into sharing some resources and then our Q&A, just want to provide sort of a high-level view of the enrollment pathways we've just described that are oriented, as you'll see, along the lifespan, to show when someone can enroll in Medicare based on their age and specific life circumstances. So I'm going to move from top left to bottom right. So, the earliest that someone can enroll in Medicare is through the Social Security pathway. So that's happening either by claiming Social Security disability benefits at any age or receiving retirement benefits as early as age

62 and then automatically becoming enrolled at 65. There's then the initial enrollment period, the IEP. This is the seven-month period centered around the month that a person turns 65. So that's the 3-1-3 or the 4-1-2. Making sure I'm doing my math there. And then the general enrollment period, the GEP takes place at the beginning of each calendar year for anyone who was otherwise ineligible or unable to enroll through the other pathways.

And then finally, as we talked about, there's the various SEPs that are available for folks who experience certain life events after 65. So on this graphic, just as a couple of examples, we're showing an eight-month SEP for someone who loses their employer-sponsored coverage after age 65, and then also showing a three-month SEP for a person who loses Medicaid coverage and then transitioning to Medicare. And again, as a quick reminder, the longer that a person waits, really, the more likely it is that they're going to have to pay a penalty. So we just want to stress again how important it is to enroll and to encourage your clients to enroll when they first become eligible for Medicare.

So we're going to pause. I'm going to share some great Medicare resources that we've put together and that we have available. I also want to encourage folks to chat in any questions that you all have. We just have a few more slides of resources, and then we're going to transition to a sort of Q&A panel. So we'd love to take this time to make sure that we get all your questions and that we're able and ready to answer them in a few moments. So before we do that, though, I just want to share, again, some tools and resources we have that support your work with clients and in your programs.

So what you're seeing here on the slide is a tool, the basics of Medicare for Ryan White clients. And this is, again, really going over sort of the high-level sort of topics that we discussed today. And it is also available in Haitian Creole and Spanish. So it is hopefully easily accessible for some of your clients. On the next slide, you'll see a tool that is Medicare prescription drug coverage for Ryan White program clients. And so this is specifically looking at the drug coverage as it relates to Medicare enrollees, and also how that interplays and interacts with the Ryan White program. This tool is focusing on how Medicare enrollment works. And this one, again, is a great tool that provides information, again, how the Ryan White program sort of ties in and can support enrollment as well as premium payments and other cost sharing. And so this is a great tool as you're thinking about supporting, again, your clients transitioning from other types of coverage into Medicare.

And then we've got a resource here specifically designed for clients. This is called the ABCDs of Medicare coverage. It's a brief, very high-level sort of plain language tool that describes the different parts of Medicare and the differences between original Medicare and Medicare Advantage. And this is ideal to have, of course, available online, but also something to have printed out and available to your clients sort of in paper form, in clinics or other programs, sort of brick and mortar operations. So again, we'll chat out a link to this, and you can also find this on our website.

And then finally, this is one of our newer FAQs related to the Medicare Prescription Payment Plan. As Christine mentioned, there were some significant Medicare changes over the last couple of years, including the $2,000 out-of-pocket cap, and also then the introduction of the Medicare prescription payment plan that allows someone to smooth or sort of spread out their out-of-pocket costs over the course of a year instead of paying everything right upfront. And so there are definitely some pros and cons of enrollment into the MPPP for Ryan White clients. So we strongly suggest that you all check this out to sort of better wrap your head around the program. And again, if you have any questions about that, would love to answer that during the Q&A. So with that, I'm going to pause and hand it over to Jared to get us going with.