The Basics of Medicare for Ryan White HIV/AIDS Program (RWHAP) Clients Webinar Medicare Part 1 Transcript

June 2, 2026

Jared Brumbeloe:

Momentarily… Excited for all of you to be here today, I appreciate you joining us. Again, thank you to those who are joining. I see our number is increasing over almost 400, so just want to say again, thank you for all joining us. We're gonna give it just another minute or two to let folks join from their previous meeting, and we will get started momentarily. Alright, we'll give it about 30… 15, 20 more seconds. Thank you all again for joining. We will begin the presentation very shortly. Alright, for the sake of time, we are going to go ahead and jump in and get started. We do appreciate you all joining us today.

Today is our part one of our three-part series of the basics of Medicare for Ryan White HIV/AIDS Program clients. We are the ACE TA Center, we are thrilled you all could join us today, and we're gonna go ahead and kick off with a couple admin, next steps, and then we will move to our content. So before we get started, just a couple technical details for anyone that might be new to our webinars. First of all, all of our attendees are in listen-only mode, but we do encourage you to please ask lots of questions using the chat box. You can submit your questions at any time during the chat, during the call, during the webinar via the chat, and we will take as many of your questions as we can at the end of today's session. And you can always email us any questions you have at acetacenter@jsi.org after the webinar as well. Wanting to make sure you can hear us, the easiest way is to listen to our webinar through your computer, but if you do have trouble hearing, check to make sure your computer audio is turned on and the volume is turned up. If you're still having issues, please try closing out and rejoining the Zoom webinar session. But we will also put the call-in information in the chat box as well, if your computer audio is not working today.

Wanting to highlight us here and the ACE TA Center overall, here at the ACE TA Center, we help build the capacity of the Ryan White community to navigate the challenging healthcare landscape and to help people with HIV to access and use their health coverage to improve health outcomes. Specifically, we support Ryan White recipients and subrecipients to assist and engage, enroll, and retain clients in Medicare, Medicaid, and individual healthcare coverage plans and health insurance options. We assist in building organizational health insurance literacy, thereby improving clients' capacity to use the healthcare system. And we help with communicating with clients about how to stay enrolled and use their healthcare coverage. We do this by developing and disseminating best practices, and supporting resources, and by providing technical assistance and training through national and localized activities, such as this webinar today.

So just highlighting our audiences, the ACE TA Center has a number of key audiences, including program staff, clinic clients, program managers and administrators, and also people who help enroll Ryan White clients, such as navigators, certified application counselors as well. Today, we'll focus primarily on resources for case managers and other staff that do work directly with clients.

Please visit us at TAforHIV for our ACE TA resources. That's taforhiv.org. We are working diligently to upload these important resources once they are all approved, and all participants in today's webinar will receive an email when the resources are posted, so you can share with your colleagues. I do want to note that the majority of us are familiar with the targethiv.org. However, while Target HIV is on pause, this website, TA4HIV.org, is a JSI-driven website specifically for the ACE TA Center and other HIV-

related projects housed within the JSI portfolio. Again, as soon as these resources are cleared and uploaded, we will send out a notification.

Wanting to highlight the roadmap for today's webinar, we will kick off with the aging demographics of Ryan White HIV/AIDS Program clients, moving to Medicare eligibility for people with HIV, making sure we discuss the different parts of Medicare, and then comparing Medicare coverage options, and then lastly, Medicare enrollment pathways for the clients.

Wanting to quickly introduce today's presenters. Good afternoon, everyone. I am Jared Brumbeloe, an Evaluation Specialist here with the ACE TA Center. Another presenter of ours today will be Molly Tasso, our project director. Molly specializes in health reform and its implications for people with HIV. Previous to her work here at JSI, Molly was the Policy Manager and Director of Healthcare Navigation Program at a Chicago-based HIV-AIDS nonprofit organization. And last but certainly not least, we have Christine Luong. Christine is a research and policy associate for the ACE TA Center, with a focus on Medicare and Medicare-Medicaid dual eligibility. She has over 6 years of experience in mixed research methods, health policy analysis, GIS and data visualization, and materials development for Ryan White grantees, subrecipients and recipients, clients, and a variety of other audiences as well.

At this point, I would love to pass it over to Christine to get us started. Christine?

Christine Luong:

Thank you so much, Jared. Good morning and good afternoon, everyone. So glad you are here with us today. So I am going to start us off with a bit of data to provide some context about why Medicare and aging is relevant for Ryan White clients and for people with HIV. So, as you all may know, a large proportion of Ryan White clients are aging, and they are becoming eligible for Medicare for the very first time when they turn 65. This is because people with HIV are living longer and healthier lives due to advances in HIV antiretroviral therapy, or ART. In terms of health coverage, Medicare is the second largest source of federal funding for HIV care in this country, after Medicaid. More than a quarter of all people with HIV in the U.S, about 28%, get their healthcare coverage primarily through the Medicare program. And if we're looking within the Ryan White program specifically, 17.6% of clients had Medicare coverage or were dually eligible for both Medicare and Medicaid.

Based on the most recent RSR data, which is from 2024, almost half of all Ryan White clients were aged 50 and older. And researchers project that, by 2030, which is in just a few years, almost two-thirds of all Ryan White clients will be aged 50 and older. And this trend has, you know, broad implications for the healthcare system as a whole, because as people with HIV are getting older, they can experience accelerated biological aging, they're at an increased risk of developing chronic conditions, and in general, their healthcare needs can start to become more complex.

And on this slide, we have a side-by-side comparison of the age distribution of the Ryan White population. So, on the left side, we have 2010 data, and on the right side, we have 2024 data, which is the most recent that's available. So, if you look at the last two categories on the right-hand side of both of these charts, you can see a large increase in the proportion of folks who are aging. So looking specifically at the age 55 to 64 group, that's the orange bars, that group made up 13.7% of the Ryan White population in 2010. And now makes up almost 24%, almost one-fourth of the entire Ryan White population, as of 2024. And if you look at the age 65 and up group, which is those yellow bars at the end, this group made up less than 3% of the Ryan White population in 2010. But now makes up 13.4% of the Ryan White population in 2024, so we are seeing explosive growth within this aging population. Among all people with HIV who have Medicare coverage, 39% are age 65 and older, so if we're looking at the donut chart on the top, that's going to be the orange part. And then the other 61% of people with HIV who

have Medicare, are under the age of 65, and they qualify for the Medicare program based on having a disability. So, that's going to be the green or teal part of that donut chart on the top. And it's interesting to note that these proportions look very different, compared to the general population, where only 13% of all Medicare beneficiaries overall qualified for the program based on a disability.

And then looking at this donut chart on the bottom, among all people with HIV who have Medicare coverage, 61% are dually eligible for both Medicare and Medicaid, and again, this looks very different, compared to the population of all Medicare beneficiaries, where only 18% are dually eligible. So hopefully that provides a bit of context about why we're talking about aging and Medicare today. So in this next section, we're going to go over the Medicare eligibility criteria and talk a little bit about what that looks like for people with HIV.

Next, thanks. So, in order to be eligible for the Medicare program, you have to be a U.S. citizen or a legal resident for at least 5 years, with some exceptions. And assuming that you meet that first criteria, there are 3 potential eligibility pathways to Medicare. The first pathway is probably the one that most people have heard of, so that's the aging pathway. So that's where you turn 65 and you age into the Medicare program for the first time. The second is the disability pathway, where you have a qualifying disability, under the age of 65. And then the third pathway is for folks who have end-stage renal disease, or ESRD, or who have ALS, also known as Lou Gehrig's disease, at any age. And our presentation today is going to focus more on those first two pathways, the aging and the disability pathways.

And so, a couple of notes here about the disability pathway for Medicare. So, in order for the disability to count for Medicare eligibility, you would have to qualify for Social Security Disability Insurance Benefits, or SSDI benefits for at least 24 months. So, if you've ever heard of the 2-year waiting period for Medicare, that's a reference to that 24 months of SSDI benefits. But one thing to keep in mind is that those 24 months do not actually have to be consecutive. So, as long as you have accrued 24 months of SSDI benefits during your lifetime before you've turned 65, you'll be eligible for Medicare when you hit month 25 of those benefits. And for people with HIV in particular, it's important to know that the Social Security Administration does not acknowledge HIV status by itself to be a qualifying disability for the purposes of Medicare eligibility. However, you can still become eligible for Medicare through the disability pathway if you meet the medical requirements for another physical or mental health condition. So, there are a few HIV-related conditions that will count as a qualifying disability, like having a chronically low CD4 count, but the main takeaway here is that just having an HIV diagnosis alone is not enough to qualify for SSDI benefits, and therefore will not allow you to qualify for Medicare through that disability pathway.

Okay, and so now, we'll cover some of the nuts and bolts of Medicare. So we're going to talk about the Medicare parts, what are they, and what they cover. So, Medicare coverage is divided into various components that are called parts. Each of these parts will cover different types of services, and each of those parts has its own premium amount and cost sharing that's associated with it. So you may be familiar with Medicare Parts A, B, and D, so they're lettered. Part C is something slightly different, and I'll cover that in a moment. But there's three parts, and we'll start with Medicare Part A, so this is the component that covers inpatient hospital care, skilled nursing facility care, hospice care, some home health care services, and things of that nature. Most people actually will qualify for Premium Free Part A, which basically means that they don't have to pay a premium for Medicare Part A coverage. And you can get Premium Free Part A if you've worked in a job that has been paying towards Social Security, and if you've accumulated 40 work credits by age 65. And 40 work credits is equivalent to about 10 years of work history.

Okay, and then the next part is Medicare Part B. This part provides coverage for medical services from doctors and other healthcare providers. It covers preventive services, it covers outpatient care, medications that are administered by a physician, so like think flu shots, COVID shots, things like that. It

covers some home healthcare services, chronic pain management, and treatment services, outpatient mental health care, at-home telehealth, etc. And as of this year, Medicare Part B also covers a new type of service called Advanced Primary Care Management Services. This is basically where your doctor or your other healthcare provider coordinates and tailors care to your needs. They'll give you 24-7 access to your care team or your provider. They'll provide comprehensive care management, help you manage care transitions, and more.

And the next part is Medicare Part D. And this part provides coverage for outpatient prescription drugs, including all HIV antiretroviral medications. It also covers insulin without a deductible for no more than $35 per month. It also covers vaccines that are recommended by the Advisory Committee on Immunization Practices without any cost sharing to the beneficiary. So some examples would be like the shingles vaccine or the RSV vaccine. As a reminder for Medicare Part D, there is now an out-of-pocket cost cap. This cap was first introduced in January 2025, and for this year, the current cap amount is $2,100. Contributions from Ryan White and ADAP, and Extra Help do count towards this cap. So, once that cap has been reached, the beneficiary does not have to pay any out-of-pocket costs, or the co-pays or coinsurance for Medicare Part D for the rest of the year.

And on this next slide, we have a visual to sort of explain what Medicare Part D cost sharing looks like, and where that out-of-pocket cap fits in. So, from left to right, everybody starts in the deductible phase at the beginning of the plan year. You pay for your medications like you normally would until you reach your deductible amount, which is $615, in 2026. After you reach that deductible amount, you then enter the initial coverage phase. In this phase, you pay a 25% coinsurance, until you, your plan, or a third-party payer, like Ryan White and ADAP reach that $2,100 cap. After you reach 2,100, you enter the catastrophic coverage phase, where you don't have to pay anything at all in out-of-pocket costs for the rest of the plan year. And for most people with HIV, they will reach this cap very early on in the plan year, because, as we all know, HIV medications are expensive, so can reach $2,100 pretty quickly.

Okay, so we've got these three parts, A, B, and D, and they cover different things, right? But there's two ways that you can actually get your Medicare coverage, and that's either Original Medicare or Medicare Advantage. So, first, I'm going to go over some of the basics and the pros and cons of Original Medicare, and then we'll do the same for the Medicare Advantage option.

So, starting with the Original Medicare, this is also known as Traditional Medicare. Those terms are interchangeable. It includes Medicare Part A, hospital coverage, and Medicare Part B medical coverage. It's administered by the federal government. It does not include Medicare Part D prescription drug coverage, which, if you decide you need it, you'll have to purchase separately. Okay, so starting with some of the pros of the Original Medicare option. Original Medicare has an extensive nationwide network that allows beneficiaries to receive care from any doctor, provider, hospital, or healthcare facility across the country that accepts Medicare. You do not need to choose a primary care doctor. You generally do not need a referral to see a specialist, assuming that they accept Medicare. So, for those reasons, Original Medicare might be considered a better option for clients who value having a greater choice of providers. But on the flip side, Original Medicare comes with some important cost considerations, so those are some of the cons. So, for Medicare Part A, there's this deductible that is based on a 90-day benefit period, not an annual benefit period, but 90 days. So, what this means is that, if a client has high healthcare utilization, and inpatient care needs throughout the year, it is possible that they'll have to meet that deductible amount up to 4 times a year, so that can really add up. And then, after that deductible is met, they could still face additional charges for hospitalization, skilled nursing care, and blood products. And for Part B in particular, although the deductible is based on an annual benefit period, after the deductible is met, there's still a 20% coinsurance that you are responsible for. So, basically, that's 20% of the cost of any service you receive. So, if the service costs $1,000, you are responsible for paying $200 of that. So as you can imagine, those costs can really add up.

Next slide. Thanks. So as I mentioned before, there is an option to add on prescription drug coverage if you have Original Medicare. You can pay for it separately. These are plans that are sold by private insurance companies, so think of like Blue Cross, Aetna, UnitedHealthcare. For people with HIV, it's important to know that all Medicare prescription drug plans are required to cover all or nearly all drugs in 6 protected drug classes, and that includes HIV antiretroviral medications without any utilization management requirements, like prior authorizations or step therapy. But for folks who have non-HIV medications, that coverage is not necessarily guaranteed by a Medicare prescription drug plan. Each Part D plan has a different formulary, so that's something to keep in mind as well. So overall, if you are working with a client, who wants to enroll in Original Medicare and also wants to add on a Part D plan, there's a few considerations. So if at all feasible, try to encourage your clients to enroll in both Part A and Part B, if they're eligible for it. You don't necessarily need both Part A and Part B in order to purchase that Part D drug plan, but having the coverage from all of those three parts ensures comprehensive coverage. Another thing to keep in mind is that the Part D premiums can be expensive, so if possible, see if your client is eligible for the Federal Extra Help Program. Depending on your individual Ryan White ADAP program, they may be able to help pay for Part D premiums as well, so definitely check with your ADAP program. And then the other thing to be aware of is if you have an Original Medicare, you can add on something called a Medigap Supplemental Insurance Plan. So these are plans that are sold by private insurance companies. Again, so think of your Blue Cross, your Aetna, your UnitedHealthcare types of plans. But Medigap coverage is standardized by law, so Medigap plans have letters, so, for example, all Medigap Plan Ks will cover the same thing, all Medigap Plan Ms cover the same thing, and so on and so forth. So there is a level of standardization across these. So like it says in the name, Medigap Supplemental Plans will supplement the remaining costs of Medicare Part A and Part B coverage, like co-pays and deductibles, but it will not help with the costs of Part D prescription drug coverage.

So this next slide, so a little bit more info about Medigap plans. They require a monthly premium, that determines exactly what your out-of-pocket costs will be, if any. Some Ryan White and ADAP programs can pay for Medigap premiums, so again, check with your individual ADAP to see what their policy is. Usually, the more expensive the Medigap plan is, the greater the benefits. But they don't cover things like long-term care, vision, or dental. That could still be a good option, could be a good add-on for clients who have more complex medical needs, and therefore would have higher out-of-pocket costs. So it can be an option for them.

All right and now let's turn to the Medicare Advantage option. Medicare Advantage is also known as Medicare Part C, so those two terms are interchangeable. Medicare Advantage plans are administered by private insurance companies that contract with the federal government to provide coverage to Medicare beneficiaries. So, a Medicare Advantage plan is basically one single plan that bundles Part A coverage, Part B coverage, and usually Part D coverage as well, all into one product. More than half of all Medicare beneficiaries in the U.S. have a Medicare Advantage plan, so it's definitely a popular option nowadays. In terms of cost, there's usually either a very low premium or no premium at all for a Medicare Advantage plan, but you do still have to pay whatever your Medicare Part B premium is. Ryan White and ADAP may be able to help clients pay their Medicare Advantage plan premium, but again, that's up to the individual ADAP program. Medicare Advantage plans often will offer extra benefits, like dental, vision, and nutrition services, and can have lower out-of-pocket costs for some services compared to the original Medicare. So, if you have less complex medical needs, and you want those extra benefits, those extra bells and whistles, Medicare Advantage might be a more attractive option for you.

But on the flip side, right, there's pros and cons. There are some downsides. Medicare Advantage plans are usually an HMO plan or a PPO plan, and what that means is it has a very specific provider network that depends on where you live. So, thinking specifically about people with HIV who may have some long-standing relationships with their HIV providers or even non-HIV providers, they may not be able to find a Medicare Advantage plan where they live that's accepted by all of the providers that they currently see. You can also, you know, you can choose to see a doctor that's outside of that network, but it will

cost more, so that's something to be aware of. And generally, with a Medicare Advantage plan, you also have to choose a primary care provider. You'll have to get some services approved ahead of time, and you'll generally have to secure a referral in order to see a specialist. So those are some of the downsides to Medicare Advantage. So, in summary, when you are comparing coverage and cost between Original Medicare and Medicare Advantage: overall, Original Medicare is going to offer some more flexibility for folks who want to pick and choose the specific coverages that they want, but the downside is that the costs can add up with that option. For Medicare Advantage, it offers a package deal, which can be convenient for folks, but the downside is that the plan network and the provider choice might be limited. But there is no right or wrong option. It really comes down to each client's specific healthcare needs. We'll also chat out some links where you can compare Original Medicare and Medicare Advantage plans in your area. And finally, just one last reminder that Ryan White and ADAP may help pay for Medicare and Medigap premiums, deductibles, and cost sharing, but that decision is up to the individual program, so we strongly encourage you to check with your local ADAP to see what they do and don't cover.

Alrighty, so let's… I feel like I talked a lot, so, let's do a quick knowledge check. I think a poll should pop up on your screen. So, the question is: Which of the following is true about Medicare Part D prescription drug coverage? A, it can be purchased separately to add on to the original Medicare. B, it could be part of a bundled Medicare Advantage plan. C, cost sharing is capped at $2,100 a year. D, all of the above, or E, none of the above?

So, take a few moments to answer that poll. Okay, and so you reach 50%, so let's give another few more seconds. Alrighty, so let's end the poll and share the results. Let's see what you all said. Alright, so, 79% of you who responded selected D, all of the above. Which is the correct answer, congratulations. So yes, Part D, if you choose Original Medicare, you can add on Part D. If you choose Medicare Advantage, it can be, it usually is part of that bundled plan, and there is a cap on out-of-pocket costs for cost sharing. So, great job, everyone. And now, I will pass it over to Molly to talk about Medicare enrollment pathways. Thank you.

Molly Tasso:

Great, thank you so much, Christine. Hi, everyone. Thank you so much for joining us today. So, as Christine mentioned, we've talked a lot about what Medicare covers, so now I'm going to talk a bit about the Medicare enrollment pathways. So, there are 4 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 a person receives Social Security Disability Insurance, SSDI, or they receive Social Security retirement benefits before the age of 65, they will be automatically enrolled into Medicare Parts A and B when they become eligible for Medicare at age 65. Their Medicare card will come in the mail 3 months before their 65th birthday. And the earliest that a person 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, if a client is about to turn 65, but have not yet started to receive Social Security retirement benefits, they can enroll in Medicare before their initial enrollment period. There are a number of SEPs, which are called special enrollment periods, which include newer SEPs that have been released by CMS, or the Centers for Medicare and Medicaid Services, that have shortened the waiting periods to gain coverage after enrollment, and expand special enrollment periods. We're not going to go into all of those, into all of them today. But we will, in a few slides, call your attention to a few SEPs and some of the changes. And then finally, there is a general enrollment period, or the GEP, if a client has missed their initial enrollment period, and they don't qualify for a special enrollment period.

So, let's get into each of these pathways in a little bit more detail. So, the Medicare initial enrollment period, again, or the IEP, is a 7 month period, centered around the month of a person's 65th birthday. So,

some people call the IEP the 3-1-3 period. It starts 3 months before the 65th birthday, so you're looking at that teal sort of section on the left-hand side on the slide. And that also includes the month that a person turns 65, and then it ends 3 months after they turn 65, so that's then the sort of orange on the right. And then with the recent CMS ruling, the coverage gap has been shortened in the last 3 months of the IEP, so let's talk about that. So, if an individual signs up for Medicare during the first 3 months of their IEP, so that's that, again, that teal on the left-hand side, their Medicare coverage will begin on the first day of their birthday month, which is the fourth month of that IEP, that red box right in the middle. This portion of the IEP is the same. Nothing has changed there. If a person signs up during their birthday month, or during the last 3 months of their IEP, their Medicare coverage will begin on the first day of the month after they enroll. And that's where the coverage gap has been shortened. It has been… it is important to note that if a person's birthday falls on the first of the month, their IEP is shifted one month earlier to include the 4 months prior to the birthday month, the month that the person turns 65, and so then it's gonna be… it'll be… it would be a 4-1-2 arrangement there, and that's only for folks who have birthdays on the first of the month.

So, looking at Medicare special enrollment periods, this enrollment option applies if a person, if a client is still working past 65, and they have employer-sponsored insurance, or have employer coverage through a spouse who is still working. So when a client quits, retires, or otherwise loses that employer-sponsored insurance, they will then qualify for an 8-month SEP to help them transition to Medicare. The SEP begins when the employer coverage ends, so not necessarily when the person stops working, but when the coverage ends. And if they enroll during that 8-month period, their coverage will begin on the first day of the month after they sign up. It is important to note that COBRA plans are not considered employer-sponsored coverage. So, if a client is currently covered by a COBRA plan, they're not going to be eligible for an SEP when that COBRA coverage ends. Another thing to note about Medicare and employer-sponsored insurance is that even if a client is keeping their employer coverage, they can actually enroll in just Medicare Part A if they qualify for the premium-free Part A. So again, remember that this is possible if they have 40 work credits or approximately 10 years of work history. So that is an option for folks who are still working or have insurance, but again, if they do qualify for that premium-free Part A.

One of the SEPs that we wanted to provide a little more detail on today is the SEP to coordinate with the termination of Medicaid coverage. So, if a beneficiary is determined to no longer be eligible for Medicaid, but is newly eligible for Medicare, they would qualify for this SEP. So this SEP allows folks to enroll in Medicare after Medicaid coverage is terminated, and that's so they don't have to wait until the next Medicare enrollment period. If someone is enrolling through this SEP, they can choose between retroactive coverage back to the date of their Medicaid termination, or coverage beginning the month after the individual enrolls into Medicare. Just note that if a person does choose or opt into the retro coverage, the retroactive coverage, they would be required to pay the premiums on the retroactive coverage during that time period. It's very important that Ryan White case managers and program staff really take steps to ensure that clients aren't losing Medicaid coverage by making sure paperwork, and other sort of eligibility requirements are up to date, but it's important to know that if a person is no longer eligible for Medicaid or their coverage is terminated for some reason, there is a Medicare SEP that is available to them.

And then there are a number of additional SEPs that we're going to talk about today. So there's an SEP for individuals impacted by an emergency or disaster, so this is for folks who missed an enrollment opportunity because they were impacted by a disaster or a situation that's declared by a federal, state, or local government entity as an emergency. This SEP is available 6 months after the end of the emergency declaration. There's an SEP for health plan or employer error that would provide relief in situations where an individual can demonstrate that their employer or their health plan materially misrepresented information related to the process of Medicare enrollment and the importance of enrolling in a timely manner. There is an SEP for individuals who believe that they were misled by a plan's marketing materials and made the wrong plan choice. Misleading marketing can include inaccurate information,

promises of benefits that are not available, or any other marketing that violates Medicare rules. There's an SEP for formerly incarcerated individuals. And this allows folks to enroll following their release from a correctional facility. This SEP is available up to 12 months post-release, and would allow individuals to choose, again, between retroactive coverage back to their release date, or coverage beginning the month after the month of enrollment. Similar to the Medicaid or employer-sponsored, rather, transition, if a person does select retroactive coverage, again, they must pay the premiums for that time period that they're opting into. And then there's an SEP for other exceptional conditions. In this, in this situation, really on a case-by-case basis. A person will be granted an enrollment period when circumstances beyond the individual's control prevented them from enrolling during the IEP, GEP, or another SEP. This is available for a minimum of a 6-month duration if this SEP is granted. I will note this SEP is not intended to replace equitable relief, which offers additional flexibility that go beyond the parameters of this… of this SEP.

And then finally, if a client misses their initial enrollment period, and they also don't qualify for any of the special enrollment periods that I just talked about, they can enroll during the GEP, or the general enrollment period. This runs every year from January 1st to March 31st. And then coverage begins on the first of the month after the individual enrolls. Previously, clients did have to wait until July 1st for their coverage to begin, but CMS has eliminated that wait, that 4-6 month coverage gap, and coverage now begins the first of the month after they enroll. During this GEP, they can, a person can enroll in Medicare Part A and Part B for the first time. And CMS also reduced the gap for when clients can enroll in Medicare Part D. Once a client's coverage starts on the first of the following month, after enrollment into Medicare Part A or B, they can then enroll into Medicare Part D.

So, we're gonna take a pause, and I'm going to, go through a couple kinds of case studies, and we're gonna do a couple knowledge checks, fully recognizing we've introduced a lot of information today. So, let's take a look at Keith here. So, Keith is turning 65 in July. He's currently enrolled in a marketplace plan. He has marketplace coverage. What should Keith do? A, Keith can keep his marketplace coverage through the end of the year and enroll in Medicare through the GEP, which would be the next year. Keith can enroll in Medicare during his initial enrollment period, so that 3-1-3 in April through October, and then cancel his Marketplace plan, or enroll in a special enrollment period at any time after Keith turns 65. Okay, we're gonna give folks… we've got a lot of people who have… are responding. Alright. Let's… You can go ahead. And close it. And… Looks like about 75% of you responded correctly, that Keith should enroll in Medicare during his initial enrollment period, so April through October, and then cancel his Marketplace plan. So enroll, and then cancel the Marketplace plan, doing it during his initial enrollment period.

Okay, let's take a look… at Sandra. Sandra unfortunately missed her initial enrollment period. On the next slide… Awesome, thank you. Okay, Sandra missed her initial enrollment period, and she doesn't qualify for any special enrollment periods. She enrolled during the general enrollment period, the GEP, in February this year. When did her coverage start? Did it start on her 61st… 65th birthday… birthday last year? Did it start March of this year, or will it start January of next year? We'll let folks…Respond…Okay. A few more folks are answering. Okay, I think we can go ahead and close it. So again, about 70, a little over, a little over 75% of you answered correctly that her coverage will begin, or did begin, in March of this year. So, if she enrolled, let's say, February 15th, it began on the 1st of the next month, so that would be March of that year.

Alright. So I'm just gonna go over, kind of a quick recap of what I just introduced around the sort of enrollment pathways. So this graphic here you see on the chart is what I've really just discussed, but also oriented sort of along the lifespan to show when someone can enroll in Medicare based on age, and then specific life circumstances. So going from top left to bottom right, the earliest that someone can enroll in Medicare is through the Social Security pathway. 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 is then the initial enrollment period. Again, this is the 7-month, the 3-1-3 time period, centered around the person's, the month in which that person turns 65. Next, we have the general enrollment period. This is taking place at the beginning of every calendar year for anyone who was otherwise ineligible or unable to enroll, through another pathway. And then, finally, there are various SEPs for folks who experience certain life situations or events after the age 65. On this graphic, there are two examples. An 8-month SEP for someone who lost their employer-sponsored coverage after age 65. And then a 3-month SEP for someone who loses Medicaid coverage and is transitioning to Medicare. Those are just, of course, not the only two SEPs available, but up here for illustrative purposes. So, again, it's been mentioned, and I think we all know this, but just a quick reminder that the longer a person waits, the more likely it is that they're going to have to pay a penalty if they don't enroll in time. And so we just really want to stress, again, how important it is to enroll, and encouraging clients to enroll when they first become eligible for Medicare.

Okay, so I'm going to go over a few resources that the ACE TA Center has to support your understanding of Medicare and your work with clients, and then we are going to get into Q&A. I've been seeing a ton of great questions come in. And we are very excited to dig into those. So, on the next slide here are just, here's a snapshot of a few resources that we have available that I'm going to walk through today, and they're all going to be available on our interim Target or HIV Resource Hub website, ta4hiv.org, which my colleague Julia just chatted out. So, taking a look at the first resource, we have 3 tools that cover the nuts and bolts of Medicare coverage and enrollment, and not just Medicare coverage and enrollment, but also in the context of the Ryan White program, and,you know, enrollment considerations for people living with HIV. So the first one you're seeing here on the screen is the basics of Medicare for Ryan White clients, and this is also available in Haitian Creole and Spanish. The next tool we have is the prescription… Medicare prescription drug coverage for Ryan White clients. So this is covering how clients get Medicare prescription drug coverage, the requirements for Medicare prescription drug coverage, coverage for HIV medications, and then also how the Ryan White program, including the ADAP program, can help clients pay for Medicare prescription drug coverage. The third one in our, sort of, initial Medicare series is, how Medicare enrollment works. And so, this tool describes, really what I just walked through, the difference between the IEP, SEPs, GEP for Medicare. It talks about when clients need to enroll in Medicare to avoid late enrollment penalties, what clients enrolled in a marketplace plan should do when they enroll in Medicare, and then how you can go about making changes to their Medicare coverage. And then we have a couple… we have a handful of resources designed specifically for clients. The one you're seeing is called the ABCDs of Medicare Coverage. This is really just a brief, plain language tool that describes the different parts of Medicare, the differences between Original Medicare and Medicare Advantage.

And it's intended to be, you can print it out, you can give it to a client, to read on their own, or it can be brought up as a PDF, and discussed or walked through, during an appointment or a meeting. And then, finally, we have our FAQ on the Medicare Prescription Payment Plan, or the MPPP. The MPPP is relatively new, it was rolled out a couple years ago by CMS, and it's an optional program for Medicare beneficiaries to help pay for Medicare Part D out-of-pocket costs in a monthly amount over a course of a plan year, instead of one lump sum at the pharmacy. So the program doesn't reduce the actual cost, it just smooths it out or spreads it out over… over the year, to make it easier for folks who don't, who are filling, you know, quite expensive, medications. This FAQ, though, really digs into, again, the specifics of whether or not this program would be appropriate or really helpful for a person with HIV or… and… and someone who is enrolled into the Ryan White program. So, definitely encourage folks to check that out, if your clients are asking questions about the MPPP. So with that, I'm going to hand it back to Jared, who is going to help facilitate today's Q&A session. Thanks, Jared!

Jared Brumbeloe:
Thanks, Molly, I appreciate it, and thanks, everyone, for dropping in your great questions this afternoon. We are going to do our best to get through them all, and to make sure that we're able to answer everything that's been coming in the chat. As a reminder, if we aren't able to get to your question, or if you have follow-up questions, we will pass… post this again at the end. But you're always welcome to email us at Acetacenter@jsi.org. So, I do want to introduce one additional presenter for our Q&A, Dori Molozanov. Dori is a senior manager on the Health Systems Integration Team at NASTAD. Her work is focused on monitoring and responding to health system changes and supporting NASTAD members in navigating insurance enrollment, assessing coverage options, and ensuring medication access for insured individuals is granted. Thank you, Dori, for joining us, and with that, I will jump into our first question. And Dori, with you being our most recent panelist to join us, I'd love to pass it to you for our first one. Dori, the question is, regarding ADAP coverage, we have a question about understanding deductible. Does ADAP cover the 2100 deductible?

Dori Molozanov:
This would depend on the jurisdiction that you're living in. So, in general, under HRSA guidelines, paying the deductible is allowable, subject to all of the, you know, HRSA guidelines about allowable costs, but deductibles are allowable. And many ADAPs do pay pre-deductible drug costs for most types of coverage. I might even say most ADAPs pay for at least some types of coverage. But some ADAPs may choose to only pay post-deductible cost sharing, and other ADAPs might limit pre-deductible support only to certain types of coverage. So, for example, an ADAP might pay deductibles for individual plans, but not employer plans. As one example that comes to mind. So, really, it's allowable, but it depends on the type of insurance you have and your individual state ADAP's policies. I can drop a link into the chat in, for our ADAP monitoring report that we release every year, and we do have a table in there that lists with reasonably good accuracy, you know, I've caught an error now and then. But overall, I'd say it gives a pretty good picture of where ADAPs stand, in terms of paying deductibles for different types of coverage. And it's, oh, I should put the whole description. Table 19 on the second page. Okay. Yep.

Jared Brumbeloe:
Awesome. Thanks so much, Dori. Christine, the next couple questions I want to pass over to you, and our first one's about Medicare Advantage. The question is: At initial enrollment, a person chooses a Medicare Advantage program, but they later decide they would like traditional Medicare. Can they change during the general enrollment period?

Christine Luong:
Yeah, thanks, Jared. Great question. So, yes, you can always change what type of Medicare coverage option you have. You are not locked in, with your first choice. So, if you have Medicare Advantage, you actually have two time periods where you can change back to Original Medicare. The first is during the Medicare open enrollment period, which is October 15th to December 7th every year. You can also do it during what's called the Medicare Advantage Open Enrollment Period, which is from January 1st to March 31st, of every year. And I will note that even though that January to March date is the same date as the general enrollment period, the GEP, the GEP is meant for folks who are enrolling in Medicare for the very, very first time. But regardless, yes, you can always switch, and there are two times of year that you can do that.

Jared Brumbeloe:
Thanks, Christine. And then, Christine, pivoting to a more specific Medicare question. The question is, for Premium Free Part A, are people automatically screened, or do they have to request to see if they're eligible?

Christine Luong:
So, that is going to depend. So, as a reminder, folks who qualify for Premium Free Part A, have received at least 40 Social Security work credits. So, for folks who have enough work credits, and who are already receiving Social Security retirement benefits as early as age 62, I believe, or if they're already receiving Railroad Retirement Board benefits, those folks will be automatically enrolled in Medicare Part A, when they turn 65. However, if you do not meet those criteria, you will have to actively apply for Medicare Part A through the Social Security Administration.

Jared Brumbeloe:
Got it. Thanks, Christine. Christine, we're gonna pass a question to Dori, and then come back to you next. So, Dori, we do have a question to clarify about Part B. And, reading the question, I want to make sure I have this right, but the question asks for confirmation of if a client does need to take or enroll in Part B, understanding that clients do need it, but wondering for clients who want to enroll or register on their own. What is the process for Medicare Part B? And we may have lost Dori for a second, so I'm gonna put a pin in that…

Dori Molozanov:
Sorry, I'm here, I was muted. Sorry, just to clarify what the question, I thought it was a different question.

Jared Brumbeloe:
Nope, you're good. So, I'll start back at the top.

Dori Molozanov:
Yeah, it's the one about whether or not, like, Part B is optional, basically.

Jared Brumbeloe:
Yes, exactly.

Dori Molozanov:
So, the question of whether someone has to take Part B, depends on the situation. So, first, like, the simple rule is that if someone is paying premiums for Part A, then they have to also have Part B. They cannot decline Part B, if they have a premium for Part A. I know that's not most people, but just to add that to this discussion, but most people are in the premium-free Part A space. So, yes, when you have premium-free Part A, you can decline Part B, but there are some caveats there. First, it's pretty risky to do this unless the client has other group coverage, like through an… like, for example, through an employer or through their spouse's employer. Otherwise, if they don't have Part B, then the client will not have coverage for outpatient medical services, since Part A only covers hospitals and inpatient care, so that means doctors, labs, none of that would be paid for by their insurance if they didn't have Part B, and they also didn't have a group plan. The client would not… if it's just the case that, like, the client doesn't like their employer plan, and they want something else, they're not going to be allowed to purchase an individual market plan, like, through the marketplace, for example, because insurance companies are forbidden from… are prohibited from selling policies to people who have Medicare. Someone who already has a policy and then moves into Medicare, that's, that's different, that's… then we're talking about canceling a policy, but they can't sell new policies, so you wouldn't be able to, you know, sign up for Medicare Part A and then go to the marketplace and get, a plan there to supplement it. And if the client eventually enrolls in Part B later in life, they'll pay late enrollment penalties, which are pretty steep. I think we talked about them today. It's 10% for each year that the client delayed Part B, and then that's added to the Part B premium for as long as the client has coverage, which typically is for life. So, you can drop it, but there's not, there are a lot of downsides, and not a lot of upsides. I will add a caveat about the employer coverage. So, before deciding whether to decline Medicare, and keep your employer plan,

because that is a very valid reason and a common reason why people delay Medicare is because they already have coverage through an employer, before doing that, it is critical to confirm that the group coverage, the employer plan, pays primary, and Medicare pays secondary. If Medicare is the primary payer, then dropping the group plan is gonna leave, oh, sorry, then dropping the Medicare is gonna leave the client underinsured, because then they're only going to they're only going to have the secondary coverage for the group plan, but they're not going to actually have the primary coverage. So, if Medicare pays, if, Medicare pays… sorry, if the employer coverage pays primary, that it's, you… Sorry, I got confused. I always get confused in my head. Right, if Medicare is primary, then you don't want to drop it, because then the client will be without… will be underinsured. If Medicare is secondary, then I suppose you could drop it, but then you're facing the late enrollment penalties later on. Sorry for the confusion there. And I also have, if it's okay to drop into the chat, I look at this all the time. It's a really useful resource, from, Medicare Interactive that has a chart of all of the types of group coverage, and whether they're primary or secondary to Medicare, it's extremely useful. I highly recommend bookmarking it if you're helping clients make these kinds of decisions.

Jared Brumbeloe:
Thanks, Dori. I appreciate that. Next question is go to Molly. Molly, the question is, can you give more information on Medicare and incarceration? Perhaps, what happens if you are on Medicare, but incarcerated? Do you have to sign up again upon release?

Molly Tasso:
Thanks, Jared. So…So federal law prohibits incarcerated individuals or a person in custody under a penal authority from receiving Medicare coverage. So when a person is no longer incarcerated, they would qualify for that SEP, and, this would apply not just to folks, in a carceral or under penal authority, but also someone who is living, or residing in, a halfway house. An individual leaving incarceration has 12 months from the day that they are released from the carceral setting to use the SEP. And using this SEP would also mean that late enrollment penalties for Medicare Part A and B would not be applied. Those would be waived. In terms of the specific situation of if a person is enrolled, and then loses Medicare coverage due to their incarceration, I, would… can clarify maybe with Dori or someone else, but I can also respond to this specific person with specific information, but I'm guessing that the sort of re-enrollment process via a SEP would be sort of standard, moving forward. We have a really great resource on the topic of transitioning from a carceral setting and, sorry, transitioning out of a carceral setting, and what that means for health coverage, not just on Medicare, but also Medicaid and marketplace coverage. And so we can… I can chat out a link to that resource, I got a link to that resource now. Thanks, Jared. Yep.

Jared Brumbeloe:
Thanks so much, Molly. Molly, I'm also going to pass the next question to you as well, and I think this is good for everybody on the webinar to understand. The question's about our website, TA4HIV.org, and the new HIV Resource Hub. Wondering, how should we be using these two sites as our resources transition to the HIV Resource Hub?

Molly Tasso:
Yeah, thanks for this, and I'm glad we are taking a moment to clarify. So, you should be using both websites. Simply put, while Target HIV was down and the HIV Resource Hub was being built up, we, at JSI, built TA for HIV just as a place to house all of our cleared… all of our resources. So that while the new website was being built up, folks still had access to the resources and tools that we've developed. Eventually, everything will be moved, and onboarded to the HIV Resource Hub. They're doing it in a sort of, phased process, and so right now, our resources are really still living on our TA for HIV resource. They'll all move over to the Resource Hub. But, until then, use both websites, and, and if you ever have trouble finding something, or are looking for something specific, and you can't find it on either website,

please reach out to us, ACETACenter@jsi.org, and we are happy to directly email you whatever resource or link that you might be looking for.

Jared Brumbeloe:
Great. Thanks, Molly. Christine, I'm going to pass the next question to you. The question goes, why is Original Medicare better for clients with complex health issues? And why is Medicare Advantage better for clients with less complex health issues?

Christine Luong:
Yeah, thanks, Jared. So, I mean, we can't say that definitively, but if you think about this decision from the perspective of the plan network, so let's, let's, let's look through those examples, right? So, Original Medicare has an extensive nationwide network where you don't need to choose a primary care doctor, you don't generally need a referral to see a specialist, right? So if you are someone who has more complex health issues, maybe you see a lot of different medical providers, and want to continue seeing them. You may be more attracted to the option that allows you that flexibility to continue seeing those providers, right? For Medicare Advantage plans, their networks are generally more narrow, because they are based on your geographic area and the providers that are within that plan's network. So if you are someone that has less complex health issues, and therefore fewer healthcare providers, it may be easier if you're… if you're searching, hey, what Medicare Advantage plans are available where I live, you may have better luck finding a plan that is accepted by your handful of existing providers. You may also be okay with selecting a new provider that is covered by a Medicare Advantage plan in your area. So while we aren't saying definitively, Original Medicare is better if you have more complex health needs, we are saying, you know, think about… the plan network, think about, how flexible you want to be or can be when… when selecting your healthcare provider. So hopefully that's helpful. It's… it's going to be a, you know, client-by-client decision, what's good for one person may not be good for another person. So it's a lot more nuanced than that.

Jared Brumbeloe:
Thanks so much, Christine. Christine, I'm gonna open the next question to you, but welcome Molly to chime in as well. The question is, how can individuals enroll into the Extra Help program?

Christine Luong:
Oops, sorry. I can start, and then Molly, if you want, you can jump in. So the Extra Help program, I know we haven't… we've referenced it a little bit during today's webinar. We will talk more about it during Part 2 in two weeks. So for folks who are not familiar, Extra Help is known as the Part D Low Income Subsidy, or LIS program, it's a federal program. It helps folks who have low income to pay for some of their… some or most of their out-of-pocket costs that are associated with Medicare Part D prescription drug coverage. So folks who are enrolled in a Medicare savings program, and again, we'll talk more about what these things are during Part 2 and Part 3 of our webinar series. So, if you're enrolled in a Medicare Savings Program, if you're enrolled in Medicaid, if you're… if you have SSI, you are automatically eligible for the Extra Help program. You'll get, like, a purple or some other color notice from CMS that'll tell you, hey, you are enrolled, and, here's what the Extra Help program can do for you. And you generally don't have to do anything else to… to receive those extra health benefits. If you're not automatically enrolled in this way, you can actively apply for Extra Help. And I believe that is through SSA, Social Security Administration. So I think our, our general advice, related to the Extra Help program is even if you are not sure if you're eligible, you should still apply. Yeah, so I don't know if, Molly, you want to add anything, about Extra Help?

Molly Tasso:
No, thanks, Christine. Yeah, I mean, I think the worst thing that happens is you apply and you're not eligible, and then you know that information. I guess I'll also just plug to your point, part two of this three-part webinar series is going to go into the financial, the financial piece and supports, related to Medicare

much… in much more detail, including, MSPs and Extra Help. So please do join us, in two weeks for that webinar, and we will be sharing links at the end of this to register for those.

Jared Brumbeloe:
Thanks, Christine and Molly. Dori, I want to pass the next question to you. The question is: Will there be a penalty charge for activating Part B after losing your employer health insurance?

Dori Molozanov:
Will there be a penalty for…Well, I think I kind of addressed it a little bit in my last question, too. It depends on the circumstances. If you delay your Medicare because you have employer coverage, that's fine to do. But when… when you want to move back, when you want to go into Medicare later on, you just have to time it properly, where you, you… you can sign up for Medicare while you're employed, or up to 8 months after losing your employment, after losing your coverage through your employment without incurring any penalties. If you go longer than 8 months after losing your employer coverage, then you're potentially facing late enrollment penalties, and you will have to wait until the next enrollment period comes along.

Jared Brumbeloe:
Perfect. Thank you, Dori. Christine, I want to pass it back to you. Question is, is there a penalty to clients who do not get a Part D plan during the initial enrollment of their Medicare Part A and B?

Christine Luong:
So, depends, right? So, first off, you do not have to enroll in a Part D plan if you don't want to. So, again, if you have Part A and or Part B, you can choose to add on that prescription drug coverage. If you need it, you don't have to. If later on, you decide hey, I want a prescription drug plan, there is a possibility of a penalty if you haven't had any creditable… creditable? creditable prescription drug coverage during that period of time. And so creditable coverage just means that the coverage is as good as or better than what Medicare will offer you. So, for example, if you are on an employer-sponsored plan that provides prescription drug benefits that is on par with or better than Medicare, then you switch to a Part D plan, then you would not incur a penalty.

Jared Brumbeloe:
Thanks, Christine. Christine, while I have you, one other question about Medicare Part A. What happens with Medicare Part A if you do not have a 10-year work history?

Christine Luong:
Yeah, great question. So…If you do not have the 40 work credits to qualify for Premium Free Part A, and you want Part A coverage, you can still buy it, you can still have Part A coverage, you just have to pay that premium. You can also continue to work and earn more work credits, in order to qualify for Premium Part… Premium Free Part A after you turn 65. So, it's not like, oh, I don't have enough work credits, so I can't get Medicare Part A ever. You know, it's a choice. You can keep earning credits if you… if you choose to.

Jared Brumbeloe:
Got it. Thanks, Christine. Dori, I want to pass it back over to you. The question is: If I have commercial insurance, is it an advantage to have Medicare insurance as well?

Dori Molozanov:
I think, well, actually, maybe we didn't really touch on this one. Well, a little bit of it, we did. So I don't… I don't know if the person who wrote this comment wants to clarify whether… what kind of insurance they were talking about. It could have been a marketplace plan, it could have been an employer plan, maybe

something else. Those are the two that I have answers for here, so I'll give both of those. So if this is a marketplace plan that the person has, and you're wondering, is there an advantage to also having Medicare? So, for a marketplace enrollee, generally, no. I guess there would have, like, you know, unusual circumstances of some kind, or maybe, like, someone's kind of unusual personal situation would make it a good idea, but, like, generally, it's not worth it. Medicare and Marketplace coverage duplicate each other. If you already had a Marketplace plan before becoming eligible for Medicare, the plan is not allowed to terminate your coverage. But you will lose your tax credits, so, the client would have to either… would have to terminate the Marketplace plan themselves once they transition to Medicare, or else they would be on the hook for the full cost of that premium, but still recommended to not cancel the marketplace plan until the Medicare coverage is in place, so there's a seamless transition from one to the other. You don't want to cancel too early, and then there's, like, a delay with getting Medicare, and then folks are uninsured for a little bit there. So a client will have to terminate their own marketplace plan if they already have one when they go into Medicare, and advice would be not to keep it unless you have some really unusual individualized circumstance where it makes sense for you. So if… however, if you're already in Medicare, and then you do not have a Marketplace plan already, then you would not even be able to buy one, because insurers are prohibited by federal law from selling new policies to Medicare enrollees. So while they can't cancel an existing plan when you move into Medicare, they are not allowed to sell you a policy once you're in Medicare. So, long, basically, no. Marketplace plans and Medicare plans generally do not work together. It's duplicative and very expensive. If you're talking about an employer plan, again, this goes back to the size of the employer, and whether Medicare is the primary payer or not. If Medicare is the primary payer, then the client is strongly advised to keep their Medicare, and then they can decide, you know, whether the employer plan is worth also having as a supplement. They don't need to keep it if it's secondary, sometimes it's worth it, sometimes it's not. It's not going to be the same plan you had pre-Medicare, it's, like, the supplemental secondary coverage version, that will be less robust, which is why you don't want to have only that on its own. So if Medicare is primary, then the client should keep, is advised to keep their Medicare, and then decide whether the employer plan is worth it. If the employer is larger, and therefore the employer plan pays primary, then the client should, is advised to keep their, well, then, actually, in that case, it's whichever one they prefer, but if they do keep their employer plan, they can drop the Medicare and then move into it later.

Jared Brumbeloe:
Thanks, Dori. Appreciate that. Christine, I am going to pass it to you, and then after that, we have a couple more case-specific scenarios that I want to dive into if we have time. So I'll pass it to the three of you, after that. But, Christine, first for you: does the Part A credits… do the Part A credits need to be earned with consecutive quarters of work, or can they be spread over your work lifetime?

Christine Luong:
So the work credits, no, it does not have to be consecutive. Basically, Social Security will keep sort of, like, a lifetime record of how much you're earning. You can earn up to 4 credits per year, so, like, if you're working for 10 years straight, that would give you the 40 credits that you need, but you can certainly, start and stop, and they will just assess when you turn 65, how many work credits you have at that point.

Jared Brumbeloe:
Thanks, Christine. Dori, I'm going to start with you on this next question, but do welcome Molly and Christine to chime in, kind of more of a specific scenario question. The question is, I have a client who is going 4 days a week to dialysis and has health insurance through Cover California. Should they apply for Medicare now? I'm not sure if they have worked more than 10 years. What advice do you have?

Dori Molozanov:
So, it is pretty much impossible to give, like, individualized client advice in this kind of setting. We can definitely follow up from, like, to get more specific information if you'd like TA on this, but just some general information. I don't… assuming that the client is age 65 or older, or is soon to be age 65, and

meets all of the other eligibility requirements for Medicare, so immigration status, work history… They can apply for Medicare during a valid enrollment period. Whether they should apply at all or apply now, apply at all is kind of an individualized, personalized question, and I don't really know enough about this person to be able to, like weigh in on what factors they might consider, in that decision, but in terms of the right-now question, it's right now is not an enrollment period of any kind, which means that the client would have to be either in their initial enrollment period, meaning they are about to turn 65, recently turned 65, or they have a special enrollment period. For example, maybe they lost their employer coverage in the last 8 months, or one of the other exceptional circumstances that we talked about. But absent any of those, they would need to wait until the general enrollment period to sign up, and then they might pay late enrollment penalties. So it really just depends on, is the client eligible for Medicare right now, and is there an enrollment period that the client can use right now? As for the question about whether the client has, being unsure about whether a client has worked 10 cumulative years, so there is a way to find this out. There's two ways to find out. One is the… actually, they're both a little bit painful in different ways. One involves calling or visiting a Social Security office to request your earning records by mail. The other is to make an account online with My Social Security. Seems like it'd be less painful, but the verification process is… a bit tedious, so you gotta… it's a bit onerous, you gotta stick up, you gotta kind of keep up with that, but very worthwhile once you have access because it allows you to see your entire work history, how much you'd be eligible for retirement benefits based on your current earnings. Also, if there's, like, an error in your earning history, you can catch it, potentially, because your retirement benefits are going to be based on this earning history, so you want it to be as correct as possible. So there are a lot of good reasons to have this information, aside from just knowing whether you're eligible for Medicare. So I would suggest if the client is unsure, and they don't have any way of really confirming it on their own, of getting the information from Social Security, either by phone, or through a visit, or online. And, I can drop a link for the online portal where you can do that. Just also, I don't… I don't know if we brought this up today, but just in general, like, verification processes for Medicare.gov, for all of this, are just getting more onerous, so, when I did… when I made my account on this website, I had to receive a letter in the mail, and that was my verification. So, and that wasn't that long ago, so, you know, it could be a little tedious, but…it's, I think, very worthwhile to have access to that account.

Jared Brumbeloe:

Thank you, Dori, I appreciate that. Just wanting to also lift up as well, and this will be shared on the slides, for any more specific questions, for any specific TA, please do email us at acetacenter@jsi.org. We'll remind you of that email on the slides as well. Gonna pass this next question to Molly, but as always, do welcome Dori or Christine to chime in. The question goes, we have clients that lose Medicare Part D for not paying their premium, or at least letting us know to pay it for them. Are they able to re-enroll in Part D? Or do they have to wait for the annual enrollment period? Especially if they are low income and are getting Extra Help, what are their options?

Molly Tasso:

Thank you. I'll talk a little bit about the re-enrollment process, and Dory, you can talk about maybe the grace period. And then I've just added to my list of to-dos to make a Social Security account for myself, so thank you for that. So clients who lose Part D for nonpayment generally have to wait for the annual election period to re-enroll. That annual election period is October 15th through December 7th. Unless they use a good clause reinstatement. Those on Extra Help have greater flexibility to enroll mid-year, or before that annual election period, but they are still going to face some restrictions. Dori, do you want to talk about the grace period?

Dori Molozanov:

Yeah, sure, I, honestly, admittedly, this was kind of a new situation for me, so I don't have a lot to add, but I learned some things. But there is a grace period. I just wanted to add to that, that there is a grace period when someone is terminated for nonpayment. The plans must provide at least 2 months before disenrolling somebody. Plans can choose to provide a longer grace period, but 2 months is the minimum.

And also, just to keep in mind that full payment of your premium on… like, full on-time payment means including any late enrollment penalties. So, if the client pays the base premium, but not the LEP, they could also lose coverage for… for that. So, important to make sure both are paid.

Jared Brumbeloe:

Thanks, Dori. I'm gonna get one last question, and then we'll wrap us up. Christine, I want to pass this last question to you, specifically to chat about SHIP counselors, but the question goes: What is the best course for patients to take who have utilized ADAP services for over a decade since becoming HIV positive, but then turned 65 and are no longer eligible for ADAP services? They also have not completed enough working credits to obtain premium free Medicare and have no income. What can you advise?

Christine Luong:

I'll start with the same disclaimer that Dori provided earlier, that, you know, we can provide general information, but we don't know enough about this particular client or their situation to really give any super concrete advice. In general, though, it sounds like this person, turned 65 and, is eligible for her Medicare, presumably. So I would definitely recommend consulting with a SHIP counselor in your state to talk about the Medicare enrollment piece. You know, is this client within their initial enrollment period window? If not, you know, there are other things that the SHIP provider can tell you about based on that client's specific situation. If this client does not have income, perhaps, maybe Medicaid is an option. You know, if they're eligible for both Medicare and Medicaid, and, you know, that they're dually eligible, that could be one path. But really, it depends on the client-specific situation. And if this person is no longer eligible for ADAP, you know, we don't know the circumstances around that, so we would need some more information about that state's ADAP policy, in particular, so, I would say, in general, reach out to a SHIP counselor if you can, for the Medicare piece. And, yeah, hopefully that's a piece of the puzzle that we can help solve.

Jared Brumbeloe:

Thanks, Christine, and thanks, Molly and Dori. Appreciate y'all's time and being able to respond to most of these questions. I'm gonna ask our team to pop up the last slide of our slide deck, if possible, just to remind everyone about our email address. And recognizing that even if we were not able to get to your questions today, please be sure to send us an email, at, again, acetacenter@jsi.org. We will do our best to respond and answer to you. And again, please sign up for our mailing list, download tools and resources, and more. The links have been dropped in the chat. Everyone, we do appreciate your time. Please be sure to check your email to sign up for Parts 2 and 3. We're excited to see you and be able to provide more information over the next couple weeks. We thank you for being here today, and everyone have a great rest of the afternoon. Bye all!