



Medicare Enrollment and Coverage for RWHAP Clients Webinar Medicare Part 2 Transcript

June 16, 2026

Molly Tasso:

Good afternoon, folks. It is 2 o'clock, Eastern, top of the hour. We're going to give folks maybe another minute or so to join, and then we're going to get started. We will be...the slides were emailed, this morning to folks who were registered, so you can access those, and we'll also be chatting out a link, to the slides, so you can follow along, as we... as we talk. So we'll get started shortly.

Alright, I think we can actually go ahead and get started. Good afternoon, or maybe good morning to, a handful of you out on the West Coast. Thank you so much for joining us today, for part two of our three-part webinar series on Medicare enrollment eligibility, and Medicare-Medicaid dual eligibility. Today is part two of the three-part series, and today we're covering Medicare enrollment and coverage for a Ryan White program clients. My name is Molly Tasso, I'm the project director of the ACE TA Center, and a consultant at JSI, and I'll be facilitating today, the discussion and Q&A, and again, just want to thank everyone, thank everyone for joining us.

So before we get started, just a couple technical details, for anyone who might be new to our webinars. So first, attendees are in listen-only mode, but please, we encourage you to ask lots of questions using the chat box. We have plenty of time set aside at the end of today's presentation to answer all your questions, so please don't be shy. You can submit questions at any time, and then you can always email us any questions that might pop up after today's presentation, and we can get back to you over email. You can reach us at ACETACenter@jsi.org. So, in terms of tech details, the easiest way to listen to our webinar today is through the computer. If you have trouble hearing, check to make sure that your computer audio is turned on and the volume is turned up, and then if you are still having issues, go ahead and try closing out and rejoining the Zoom webinar session. We're also gonna go ahead and put a call-in, the call-in information in the chat box, in case, for whatever reason, it is helpful for you to be able to call in and listen.

So, a little bit about the ACE TA Center before we start, in case, again, there are some new folks, some new friends here on the line. So, at the ACE TA Center, we help build the capacity of the Ryan White community to navigate the changing healthcare landscape and help people with HIV access and use their health coverage to improve health outcomes. Specifically, we support Ryan White recipients and subrecipients to engage, enroll, and retain clients in health insurance. So, that includes Medicare, Medicaid, and then individual health insurance options, such as marketplace insurance. We help folks build organizational health insurance literacy, thereby improving clients' capacity to use the healthcare system. And we help folks communicate with clients about how to stay enrolled and to use their health coverage. We develop and disseminate best practices and supporting resources, and we provide TA and training through national and localized activities. Our audience, ACE TA Center's audience, we have a number of key audiences. This includes program staff, clients, program managers, and administrators, and then also people who help enroll Ryan White clients, such as navigators and certified application counselors, really whether or not they're associated with a Ryan White-funded program. Today we'll focus primarily on resources for case managers and other staff that work directly with consumers. And finally, we encourage you to visit us, our website at taforhiv.org to access ACE TA Center resources.

The recording from today's webinar, along with the recording from the Part 1 webinar, will be uploaded to our website later this week. And as soon as those are up on our website, folks will get an email that they



are posted, so you can share it with your colleagues. All right, so getting into our plan for today, we're going to briefly recap the Medicare basics that was covered in Part 1, a couple weeks ago. We are going to, discuss best practices and enrollment support, for enrolling folks into Medicare. We're going to walk through some enrollment challenges and also some ways to, sort of troubleshoot or overcome those challenges. We're going to talk about financial help that is available to support Medicare enrollees, and then we're going to finish out, by going over some of our associated or relevant Medicare resources that we have available, and then we're going to finish our time today with a Q&A.

So, just quick, as a quick way to introduce who, who's gonna be, talking with us today, I'm joined by my colleague Liesl Lu, who is the principal investigator of the ACE TA Center, and has been a part of the project since the ACE TA Center started in 2013. Liesl has extensive experience employing a range of learning modalities to build the capacity of the Ryan White community to address the healthcare needs for people with HIV, particularly those aging with HIV. And Christine Luong is our Research and Policy Associate for the ACE TA Center. Christine has, is experienced in mixed methods research, health policy analysis, GIS and data visualization, and materials development for Ryan White recipients, subrecipients, clients, and a variety of other audiences. So, without further ado, I'm going to hand it over to Liesl to, again, walk us through a bit of a recap from Part 1.

Liesl Lu:

Thanks, Molly, and it's great to be with you all here today. So, to jump in, in Part 1, we started with an overview of the changing demographics of the Ryan White program population, including more clients who are becoming... who are aging into Medicare. We discussed the Medicare eligibility pathways for people with HIV, as well as the different parts of Medicare, and those include Part A hospital coverage, Part B medical coverage and Part D, prescription drug coverage. And finally, we discussed the four major Medicare enrollment pathways. So if you missed Part 1, or if you want a refresher on the content, we encourage you to view the on-demand recording at taforhiv.org, and we will be posting that recording very soon.

As a reminder, to be eligible to enroll in Medicare, you must be a U.S. citizen or a legal resident for at least 5 years, with a few exceptions. If you meet the citizenship requirements, there are 3 potential eligibility pathways. So, you can age into Medicare when you turn 65, so this is what comes to mind for most people when they hear of Medicare. You can also, if you're under 65, you can become eligible for Medicare if you have a qualifying disability, though there is a 24-month waiting period, which I'll talk about that in a few more moments. And finally, you can become eligible at any age if you have end-stage renal disease. Medicare on the left-hand side of the table, compared to Medicare Advantage on the right-hand side. So this may look familiar to those of you who attended Part 1. So let's look on the left at Original Medicare first. Original Medicare includes Part A hospital coverage and Part B medical coverage. For Part A hospital coverage, most people do not have to pay a premium as long as they have sufficient work credits to qualify for premium-free Part A. So this applies to anyone who qualifies for Medicare due to age or disability. People who don't qualify for a premium-free Part A can pay a monthly premium, depending on how many work credits they've earned so far during their lifetime. Part B is medical coverage, which is not tied to work credits, so if someone doesn't sign up for Part B when they're first eligible, they may have to pay a monthly late enrollment penalty for as long as they have Part B coverage. And we'll talk more about this penalty again later in the session. And finally, you can add on Medigap supplemental coverage and Part D prescription coverage to Original Medicare. So, looking on the right-hand side, at Medicare Advantage, this includes Part A, B, and D. These plans may or may not have a monthly premium, and they have a yearly out-of-pocket costs for Medicare Part B and Part B covered service. A yearly limit, sorry, for out-of-pocket costs for Part A and Part B.



You can't buy or use supplemental Medigap policies if you have Medicare Advantage plan, but some may have lower out-of-pocket costs than Original Medicare. So there are pros and cons to both options. Medicare Advantage plans are also usually issued by health insurance companies like Blue Cross Blue Shield or Humana, so sometimes that gets a little confusing because folks don't realize they may have a Medicare Advantage plan once they've signed up. So, it's important to compare plans in your area and see which will be best for your client, and you can shop and compare Original Medicare and Medicare Advantage plans at Medicare.gov. We'll chat out that link for you. And it's important to remember that the Ryan White program, including ADAP, may help pay in full or in part for Medicare premiums, deductibles, and co-payments, so it's important to check with your local ADAP to determine how it may be able to help with costs for your client. So we're going to chat out a link for the ADAP directory to help you with your local, contact your local ADAP if needed.

So there are a number of Medicare enrollment pathways: Social Security, the initial enrollment period, and the special enrollment period, and the general enrollment period. You'll see on this slide that we're showing them oriented along the life span to demonstrate when someone can enroll in Medicare based on their age and specific life circumstances. So, going from the top left to the bottom right, first looking at the two boxes, on the top left, a person who's under 65, who receive Social Security Disability Insurance will automatically qualify for Medicare after they have received SSDI payments for 24 months. So you'll sometimes hear people refer to a 2-year waiting period for their disability benefits, but that can be misleading. It's not 24 months, consecutively. They can be spaced apart. The other part of this pathway involves Social Security retirement benefits. You can receive retirement benefits as early as age 62, and you'll be automatically enrolled into Medicare Parts A and B when you turn 65. So the Social Security Administration will take care of the auto-enrollment, and you would receive your Medicare card in the mail about 3 months before your 65th birthday. So that's the gist of it for the Social Security pathway to Medicare enrollment and SSDI disability benefits, or Social Security retirement benefits.

So, moving on to the middle box, this is the initial enrollment period for people who are about to turn 65. So, this is the one that people most often think of when aging into Medicare. So, so for people who are about to turn 65, but have not yet started to receive Social Security retirement benefits, it's a 7-month period centered around the month that someone turns 65. For example, if someone's turning 65 in July, then they can sign up for Medicare between April and October. So next, there's a general enrollment period, so this is the first box below the line going across the slide. And that general enrollment period is from January 1st to March 31st every year for anyone who missed their initial enrollment period and do not qualify for a special enrollment period. In this case, this person who uses the GEP would... their coverage would begin on the first of the month after they enroll. So then I... we have two special enrollment periods highlighted here. The first one is the special enrollment period for people who have continued working past age 65 and past their initial enrollment period. And so now they're transitioning from employer coverage to Medicare. And so when your employer coverage ends, that triggers an 8-month special enrollment period that will allow you to enroll in Medicare. And finally, there's also an SEP for loss of Medicaid coverage, so individuals have a 3-month window to apply for other coverage from the date of their Medicaid... when their Medicaid eligibility ends. So as a general rule, the longer a person waits to enroll once they become eligible, and it's more likely that they will have to pay a penalty. So we want to stress again how important it is to enroll and encourage your clients to enroll when they first become eligible.



So now, let's move on to some best practices for Medicare enrollment and enrollment support for clients who are transitioning to Medicare. The four best practices that we'll cover are ensuring continuity of coverage, actively enrolling in Medicare coverage, avoiding penalties, providing one-on-one enrollment support, and actually, sorry, there are five, and being able to identify misleading marketing practices. So let's explore each of these in detail. So the first best practice is to ensure continuity of coverage for a client's existing providers and medications whenever possible. So it's important for case managers to confirm with clients that their current providers accept Medicare. So you can do this by either visiting the Medicare.gov website and using the Care Compare tool, or you can help your clients call their providers, letting them know that the client's insurance will be changing to Medicare, and confirming whether the provider accepts original or Medicare Advantage. And to make sure and ask if they are referring to an HMO plan or a PPO plan in the case of a Medicare Advantage plan. Case managers should also help their clients compare Medicare drug plans in their area, and choose one that covers their HIV medications and their other non-HIV medications, and you can do this by visiting Medicare.gov and using the Plan Compare tool. And just a reminder, the Ryan White program, including ADAP, may help pay for Medicare premiums, deductibles, and co-payments.

So, the second best practice is to help clients actively enroll in Medicare. So, clients who opt for Original Medicare, which again includes Medicare Part A hospital insurance and Medicare Part B medical coverage, should enroll through the Social Security Administration. Clients who choose Medicare Advantage or who want to add on Medicare Part D prescription coverage or a Medigap supplemental coverage to Original Medicare, should also enroll through Medicare.gov. So most people who are eligible for Medicare must actively enroll in coverage, but there is a small subset of people who are automatically enrolled, and this includes people who are already receiving Social Security retirement benefits, and people under age 65 with a qualifying disability who've received 24 or more months of Social Security disability benefits, as well as people with end-stage renal disease, or ALS. The third best practice is to encourage clients to enroll when they are first eligible. So, you can do this by creating automated reminders in your electronic health record, or asking medical case managers to flag clients who are approaching their 65th birthday, or clients who will be receiving their 25th month of Social Security disability benefits. This is a reminder... this reminder is an opportunity to start the discussion with clients about their healthcare needs and preferences, whether that's Original Medicare or Medicare Advantage, and start scheduling enrollment appointments. So really starting to have those discussions before those key dates come up. And it's important to take these steps because if a client doesn't enroll in Medicare when they are first eligible, they may face late enrollment penalties for Medicare Part A, B, or D, and in some cases, these are lifetime penalties. So this is a common enrollment challenge that we'll explore in the next section. And in addition to avoiding penalties, enrolling when the client is first eligible will help to minimize gaps in coverage if the client isn't transitioning from another type of health coverage. So just in terms of changing Medicare payment plans after enrollment, sorry, so the Medicare open enrollment period is each year from October 15th to December 7th, so this is on the left in the orange. And anyone with Medicare coverage, whether it's Original Medicare or Medicare Advantage, can make a change to their medical and prescription drug coverage for the following year during this time period, from October 15th to December 7th. And then that coverage, that new coverage would begin on January 1st. On the right is the open enrollment period for Medicare Advantage, so that's January 1st to March 31st each year. So, individuals with Medicare Advantage can switch to a different plan within Medicare Advantage during that time, or return to Original Medicare. And any changes they make will be effective the first of the month after the plan gets the request. So, some key dates and, and, options there during these, open enrollment periods to make changes.



The next best practice is to provide one-on-one enrollment support by establishing a relationship with a local state health insurance assistance program, or SHIP, which provide local one-on-one Medicare counseling and assistance. So, SHIPS are a really, really great resource. They're state-based programs that provide local objective insurance counseling and assistance to Medicare-eligible individuals, their families, and caregivers. They can help clients review their health and drug plan options, explore financial assistance, answer questions about how Medicare works with other types of health coverage, help with more complex issues like dual eligibility for both Medicare and Medicaid, and navigating appeals processes and more. You can find a ship program near you by visiting shiphelp.org and using the locator tool on that website. There is a ship program in all 50 states, Washington, D.C, Puerto Rico, Guam, and the U.S. Virgin Islands, but, note that your local SHIP program may have a different name or act... acronyms, such as it's SHINE in Massachusetts, it's HICAP and MAP in other places. So, they do sometimes have different acronyms, and they're often co-located with your area aging agency. So, along... continuing on with this best practice around one-on-one enrollment support, one way to really harness the benefits of, of the SHIP, training is, is for your Ryan White and ADAP program staff to become SHIP counselors. In this case, they really would be really ideal SHIP counselors, because they would understand the eligibility requirements for both Medicare and the Ryan White program, and the unique coverage needs for your clients, as well as state-specific programs to support Ryan White program clients. So we really encourage, if you are able to, to have your organization become a SHIP-certified organization, and have some of your case managers or navigator staff also become trained as SHIP counselors. The training and certification requirements vary from state to state, but it typically includes a blend of self-paced online training, webinars, virtual and or in-person group sessions.

There's no cost associated with the training or certification, and is considered voluntary, and then they do provide updates every year for SHIP counselors, on the changes to Medicare. So in order for a case manager or another staff member to become a SHIP counselor, your organization must first be a SHIP site. So if your organization is not already a SHIP site, your program director can reach out to your State Department of Public Health or your local SHIP to find out more about the qualifications, for becoming a SHIP site. And then once you do that, folks can become trained as counselors, SHIP counselors.

So, the final best practice is to be able to identify misleading marketing practices. Marketing or Medicare fraud and scams have increased in number and in terms of tricky tactics that, that people are using in recent years, so it's really important to talk to your clients about being aware of, providers, if providers happen to be billing Medicare for services or supplies that they were never provided, providers charging Medicare twice for services or items that were provided once, unauthorized use of a person's Medicare number to submit false claims. So really, looking out for these, sort of you know, off... off base, claims that they may have additional services to pay for. And you can help clients prevent fraud by reviewing Medicare statements and comparing dates and services with them, also understanding the marketing rules, and if you think you've spotted fraud, you can report fraudulent activity by calling 1-800-MEDICARE. And I know we're all learning how to spot fraud and phishing attacks right now, as it's increasing with AI, and it's important for you and your clients to really trust your gut if you feel something is off and pay attention to that. Some of the common misleading marketing practices are using deceptive language that makes the ad seem to be sponsored by a government agency. Promises of extra benefits, that often aren't true. Attempts to convince people to switch to a Medicare Advantage plan that may not suit their needs, or work with their existing providers, encouraging folks to call a phone number to learn more about a plan or program. So, really looking out for those items and cluing those into your clients. Additionally, some common misleading marketing materials are TV advertisements by private insurance



carriers and insurance brokers, promising better plans, unsolicited promotional marketing mailings, and unsolicited phone calls. So, some key reminders for your clients, include consult with your... to make sure that they consult with you, or their Ryan White case manager, or a Medicare SHIP counselor to review Medicare plans.

Can you go to the next... oh, yeah. Yeah, to review Medicare plans, never enroll in a Medicare plan based on an unsolicited phone call, TV, advertisement, or marketing mailing. Really, always making sure to go and call the numbers on your card, and not to use numbers that are provided through an advertisement, never to give their Medicare number or personal information to someone they don't know. Then, it's important to remind them that Medicare and the Social Security Administration don't call people with sales pitches, and that Medicare Advantage plans have specific provider networks and may not be the right choice for everyone. So, some key reminders here, and also, I would just say, you know, what I mentioned up top is that to trust your gut. If it doesn't seem right, then always refer back to and encourage clients to refer back to their Medicare card for contacting their plan. And with that, I'll hand it over to Christine to go into enrollment challenges.

Christine Luong:

Thank you so much, Liesl. Hello, everyone. Thank you for having me. So, I will, start off by talking about some of the most common Medicare enrollment challenges that we, have faced, at the ACE TA Center. So, enrollment challenge number one is avoiding late enrollment penalties. I've already seen quite a few questions come in about penalties, so... so let's get right into it. So as we know, there are 3 different parts to Medicare, so I'll explain how that penalty works for each of those parts. So starting with Medicare Part A, that penalty only applies to people who do not qualify for what's called Premium Free Part A, right? So, as a reminder, most people qualify for Premium Free Part A by earning enough Social Security work credits over the years. Now, anyone who does not have enough work credits to qualify for Premium Free Part A, and who also didn't enroll in Part A when they first became eligible for it, they will face a penalty, that's calculated as an additional 10% on top of their monthly Part A premium cost. And this penalty will last for twice the number of years that you were eligible, but you did not enroll. So, for example, let's say you have a client that waited 2 full years to enroll in Part A, they will have to pay 10% more of that premium amount, on top of their usual premium every single month, and that'll, and they'll have to pay that for the next 4 years, so the 4 is the 2 times... 2 times 2, 2 years times 2. You can avoid the Part A penalty if you defer enrollment in Part A while you have employer-sponsored coverage that's considered creditable, and you'll hear me use this term a lot. So, creditable basically means that that coverage is as good as or better than what Medicare offers. The Part B penalty, kind of similar, so anyone who didn't enroll in Medicare Part B when they were first eligible will face a penalty of 10% on top of their monthly Part B premium for every 12-month period that they were eligible or didn't enroll. And the main difference here is that this Medicare Part B penalty lasts for a lifetime, so it doesn't go away. So... some... some numbers as an example. Let's say you have a client that waited 3 full years to enroll in Medicare Part B, they will have to pay, so, 10% times 3 years, that's 30%. They'll have to pay 30% more on top of their usual premium amount every single month for as long as they have Medicare Part B.

Now, there are a few ways to avoid the Part B penalty. First, and this is similar to Part A, right, so, if you defer enrollment in Part B while you have employer-sponsored coverage that's creditable, again, that means that coverage is as good as or better than Medicare's coverage, then you can avoid the Part B penalty. Second, if you qualify for and enroll in a Medicare savings program, you can eliminate the Part B



penalty. And third, this applies to folks who incurred a Part B penalty before the age of 65, meaning they became eligible for Medicare for reasons other than age. If that's the case, then their Part B penalty will reset to zero when they turn 65. And then for the Part D penalty, so this one applies to people who do not have prescription drug coverage, either through a standalone Medicare Part D plan, through a Medicare Advantage plan, or through some other form of creditable coverage, so, through an employer or union, TRICARE, Indian Health Service, or individual health coverage. So anyone who's eligible for prescription drug coverage through either of those routes, but chose not to enroll, will face a penalty that's calculated as, 1% of a national benchmark amount, on top of that monthly Part D premium. And they'll have to pay that for each full month that they did not have coverage. Similar to the Part B penalty, this one is also a lifetime penalty. But unlike Part A and Part B, it's generally a lot easier to defer your enrollment in Part D coverage, and these Part D penalties are usually significantly smaller and easier, to resolve. So you can avoid the Part D penalty, again, if you have creditable coverage, from another source. Or, if you qualify for the Federal Extra Help Program, also known as the Part D Low Income Subsidy, or LIS, program. And most Ryan White clients do qualify for this program, which is income-based. So, overall, to avoid Medicare late enrollment penalties, you'll want to make sure that your Ryan White clients are enrolling in Medicare Parts A, B, or D when they are first eligible.

And by first eligible, what we really mean is the initial enrollment period, right? That's the IEP, that's that 7-month period, that's centered around the month that you turn 65. There are some legitimate reasons to defer enrollment in Medicare, so that would be, like, if the client's still working and has employer-sponsored insurance, so that'll eliminate the Part A and Part B penalty. If the client is eligible for a Medicare savings program, that eliminates the Part B penalty. If the client has other creditable prescription drug coverage, that'll eliminate the Part D penalty, and again, if the client qualifies for the Extra Help program, that will also eliminate the Part D penalty. But keep in mind, you know, like, whether the particular client that you're working with is going to incur a Medicare late enrollment penalty or not, and just how much that penalty is going to be, really is going to depend on that client's individual circumstances. So, you know, for the purposes of our webinar, we're just sharing some of the most common reasons for deferring enrollment, and some common ways to be exempt from those penalties. It's still very important for you to check in with Social Security, about deferring Medicare enrollment and just making sure that there won't be any surprises later on.

Okay, and moving on to enrollment challenge number two. This is, basically, deciding whether and how to defer Medicare enrollment if your client has employer-sponsored insurance. So, let's say, you have a client that becomes eligible for Medicare at age 65, but they're still working, and they plan to keep their employer-sponsored insurance. First thing they should do is to check in with their employer's HR department. Because the employer can tell the client if the plan that they provide is considered creditable by Medicare standards. And if it is, that's when you can proceed having that discussion with your client about, which Medicare part or parts that they want to defer. So, for Medicare Part A specifically, if your client or their spouse has at least 40 work credits and they qualify for that premium free Part A, they do have the option to enroll in just Part A, still keeping their employer-sponsored plan, and then defer enrollment in Parts B and D until later on. For Medicare Part B in particular, keep in mind that retiree plans and COBRA coverage, those are not considered qualifying coverage or creditable coverage, so that means it will not exempt you from the Part B penalty. And again, also just very good practice to contact Social Security to confirm whether deferring that particular part is going to result in a penalty, and you'll also want to let Social Security know during your initial enrollment period that you don't want to be automatically enrolled in Part B. And then down the line, if and when your client chooses to quit or retires,



their employer will need to complete a Medicare enrollment form that the client has to bring back to Social Security, along with their own enrollment form. And all of this is to make sure that when your client's employment ends, and their employer-sponsored coverage ends, that they will be eligible for a Medicare special enrollment period that's going to allow them to enroll in those parts of Medicare that they're missing, and also avoid those penalties.

Okay, so we're going to do a very quick knowledge check. So a question should pop up on your screens, and the question is: Which of the following is a legitimate reason to defer enrollment in Medicare Part B? So you can select one of these responses. Is it A) having COBRA coverage, B) having employer-sponsored coverage, C) having retiree insurance, D) all of the above, or E) none of the above? So, let me give folks a little bit of time to think on that, and select a response. Alright, let's end the poll and share back the results, see what y'all said. Okay, so 59% of you selected B, having employer-sponsored coverage, and 35% of you said D, all of the above. So, the answer is B, having employer-sponsored coverage. So again, keep in mind, COBRA coverage is not considered creditable coverage by Medicare standards. Retiree insurance is not considered creditable coverage by Medicare standards. So, if you're working with a client that has COBRA or retiree insurance, and they're thinking about deferring their Medicare, then it's not gonna prevent them from getting penalties. So, only if they have employer-sponsored insurance will that help them avoid a penalty.

Alright, and let's... move on. We have one more knowledge check for you. So similar scenario. Let's get that poll up. So the question is: what steps should Ryan White clients take if they're considering deferring Medicare enrollments and keeping their employer-sponsored insurance? So the response options are: A) contact their employer's HR to confirm if the employer-sponsored coverage is considered creditable by Medicare standards, Option B is contact Social Security to confirm if deferring Part B will incur a penalty, C) contact Social Security during their 7-month IEP to defer automatic enrollment in Part B, D) all of the above, or E) none of the above? So again, I'll give folks, a little bit of time to answer this poll. Alrighty, let's end the poll and share the results. Okay, so 63% of you said D, all of the above, 23% of you selected A, and a handful of y'all chose B and C. So, the answer is D, all of the above, do all of these things, do A, B, and C. Check with your HR to ensure that that employer-sponsored coverage is considered creditable by Medicare standards. Definitely talk to Social Security to identify any potential conflicts or or penalties. Definitely time the, your Part B def deferral during the IEP to avoid future penalties.

Alrighty... And let's move on to Enrollment Challenge. Alright, enrollment challenge number 3, and this is transitioning from the marketplace to Medicare coverage. First thing to keep in mind in this scenario is the timing. Clients who are enrolled in Marketplace coverage should enroll in Medicare when they first become eligible. Again, that's usually during their 7-month initial enrollment period. This is really the best way to avoid those late enrollment penalties, and to avoid any potential gaps in coverage. Now, if your client misses that initial enrollment period, that's alright. They can enroll during the next general enrollment period, or the GEP. They might also be eligible for a special enrollment period if they miss both their IEP and the GEP. And in some cases, they might also be eligible to apply for equitable relief. This is an administrative process through Social Security. Basically, it's meant to help fix any Medicare enrollment issues that might have happened due to the error, misrepresentation, or inaction of a federal employee. So if equitable relief is granted, then that person can receive immediate or retroactive Medicare enrollment, and eliminate any... any Part B penalties that... that they might have incurred. The second thing to keep in mind when transitioning from Marketplace to Medicare is that Marketplace coverage termination usually doesn't happen automatically. So, once your client has made that transition



over, they've enrolled in Medicare, they still need to go back and make sure to terminate their Marketplace coverage. And then if you work with clients who receive advanced premium tax credits, or APTCs, from the marketplace, there are some additional considerations. And just, quick note here, as a reminder, APTCs, these are not the same as enhanced premium tax credits, or EPTCs, which you may have heard about in the news. So, enhanced PTCs, these were introduced in 2021, and these were meant to be temporary, expanded subsidies that help to reduce the cost of monthly marketplace premiums. Those EPTCs expired at the end of 2025, but the APTCs that we're talking about here, these remain available. So, if you have a client who's Medicare eligible, and they currently receive those APTCs through the marketplace, they will lose their APTCs if they stay enrolled in Marketplace despite being eligible for Premium Free Part A, or if they're enrolled in both Marketplace coverage as well as Medicare Part A with the premium. And the only situation in which you can keep your marketplace coverage with APTCs despite being eligible for Medicare is if you qualify for Medicare Part A with a premium, but you choose not to enroll in it. So to that end, it's very important that if when you're helping your clients transition from Marketplace to Medicare coverage, please encourage them to check their mail frequently for any notices from the Marketplace or from CMS. Make sure to find out when their Medicare Part A, B, and D coverage begins before they go back and terminate their marketplace coverage, so that they can avoid those coverage gaps. And then contact Social Security if you're encountering any enrollment issues, or if you haven't received confirmation of your enrollment into any of those Medicare parts in a timely manner.

And next up, the last enrollment challenge that we'll talk through today is transitioning from Medicaid to Medicare. So we... we saw during the Medicaid unwinding process, a few years ago that there was a lot of confusion about how to navigate this particular coverage transition. You know, we saw some folks who were no longer eligible for Medicaid for the very first time in their lives. We saw some folks who became dually eligible for both Medicare and Medicaid for the very first time. We also saw other folks who remained eligible for Medicaid in their state, but, qualified due to a different eligibility category and the different rules once they turn 65. But the key thing for you all to keep in mind during this transition from Medicaid to Medicare is to avoid gaps in healthcare coverage. So as a case manager, make sure that your clients are updating their contact information with the state Medicaid agency. Make sure that they are checking their mail frequently for any letters from Medicaid. Help them complete their Medicaid renewal form if they do receive one, because we do know that in some states, that Medicaid eligibility criteria does change once the person turns 65, because they'll fall into a different eligibility category. And then if, after all that, the individual, the client, is found ineligible for Medicaid, that's when you'd help them enroll into another form of healthcare coverage, right? Like, into, into Medicare.

So, next slide, thank you. So...if the client loses their Medicaid eligibility completely, and they're now newly eligible for Medicare, they can take advantage of a Medicare special enrollment period to help them enroll in Medicare. That special enrollment period begins when their Medicaid eligibility ends, or when they receive notice that their Medicaid coverage is terminated, whichever happens later. This SEP will allow people to choose between retroactive coverage, going all the way back to the date of their termination from Medicaid, no earlier than January 2023, or they can choose coverage beginning the month after they enroll. But do keep in mind, if they opt for that retroactive coverage, they are going to be responsible for paying the premiums for that retroactive time period.

Okay, so let us move on, to financial help for Medicare, and I will say now that, what we're going to present in this section definitely is not an exhaustive list of financial assistance options for people with



Medicare coverage. There might be state-specific or regional programs that are available in your area as well. So, first up, how can the Ryan White program help? The Ryan White program can help with premiums and cost sharing for Medicare Parts B, C, and D coverage. So this includes outpatient and ambulatory health services under Medicare Part B, as well as prescription drug coverage under Medicare Part D. That includes at least one drug in each class of core antiretroviral therapeutics.

The Ryan White program might also provide additional services, you know, like case management, transportation assistance, etc, that Medicare does not provide. Ryan White funds cannot be used to pay for Medicare Part A premiums. But as a reminder, right, most people don't have to pay Part A premiums anyway if they have enough work credits. If you are not sure what the Ryan White program covers in your area, check with your state ADAP or your local Part A program for more information. And you can also learn more about what Ryan White funds can be used for, by reading the HRSA HAB Policy Clarification Notice 18-01. So, when you are helping clients, use the Ryan White program to help with those Medicare costs, always remind them that Ryan White and ADAP is the payer of last resort. So what this means is, if your client is headed to the pharmacy to pick up their medications, they should be paying those co-pays with their Medicare Part D or their Medicare Advantage card first. And then their ADAP card second, if that's needed. This is to help make sure that they're paying towards that deductible for their Medicare plan, if that plan has a deductible requirement.

One other tip is to be aware that premium amounts can change throughout the year. So you want to avoid having your coverage terminated or, accruing past due amounts, so clients and case managers should be keeping an eye out for any notices in the mail about changes to their premium amounts, and this will ensure that their Ryan White program is helping clients pay their premiums in full and on time, as long as that is an allowable cost by your local Ryan White and ADAP program.

Okay, next up, Medicare Savings Programs, or MSPs. We'll be talking much more about this in detail during Part 3 of our webinar series next Tuesday, but here's some basics here on this slide. So, Medicare savings programs are federally funded, but state-administered programs for certain low-income people that help pay for some or all of their Medicare premiums and out-of-pocket expenses. So, they're available to folks who are dually eligible, meaning they qualify for both Medicaid and Medicare. There are 4 different types of Medicare savings programs. The first is called the Qualified Medicare Beneficiary, or QMB, program. This one is the most comprehensive and pays for all Medicare costs, 100%. And then there's 3 others called the Specified Low-income Medicare Beneficiary, SLMB. There's the Qualifying Individual, QI, and the Qualified Disabled and Working Individuals, or QDWI. And these last three, they only pay for some Medicare costs. All four of these Medicare savings programs have different eligibility criteria. Not every state is going to offer all four of these programs, and they might also have slightly different names, depending on where you live. But if you think your client might be eligible for a Medicare savings program, you can help them apply through your state's Medicaid website. And again, we'll talk about MSPs in a lot more detail next week.

Okay, and then there's also the Extra Help program, so I mentioned this earlier, also known as the Part D Low Income Subsidy, LIS program. So this is a federal program. It helps folks pay for some or most of the out-of-pocket costs that are associated with their prescription drug coverage, their Medicare prescription drug coverage, particularly. So, this program itself is not prescription drug coverage. You have to already be enrolled in a Medicare Part D plan in order to apply for extra help with those costs. As a reminder, beginning in 2024, the eligibility criteria has been simplified, so if your income is under 150%



FPL, you will qualify for the Extra Help program. If you're working with a client that is enrolled in a Medicare savings program, so one of those four from the previous slide, they will usually also qualify for Extra Help automatically. And since both MSPs and Extra Help are income-based, most Ryan White clients will qualify for both of these programs. Reminder, enrolling in Extra Help will eliminate any Medicare Part D penalties that you may have incurred, and you can help your clients enroll in Extra Help through the Social Security Administration. You can do that online, in person, or with a paper application.

Some other sources of financial help on this slide. So first up, we have State Pharmacy Assistance Programs, or SPAPs. These are offered in some states to help eligible clients pay for their prescription drugs based on their financial need, based on their age, or whether they have a certain medical condition, such as HIV, AIDS. There are patient assistance programs, or PAPs. These are offered by major drug manufacturers to people who are eligible, and depending on the specific PAP, the client might be able to get their medication for free, or at a very low cost. Each of these paths has different requirements, including whether there's a copay and how to apply, but most of these programs do have an online application nowadays. There's also what's called PACE programs, programs of all-inclusive care for the elderly. So these are state-administered, they're designed for folks who require a nursing home level of care, but are still able to live in the community. Most people who are eligible for PACE are dually eligible for Medicaid and Medicare, although it's not a requirement that you are dually eligible. PACE will pay for some or all of your Medicare costs. If you think your client might be eligible for a program like this, you should check with your state's Medicaid agency to see if that's offered in your state and how to enroll.

All right, there's also something called the LINET Program, that stands for Low Income Newly Eligible Transition Program, and this provides temporary and sometimes retroactive Medicare Part D coverage for folks who are transitioning off of Medicaid, but they're still waiting for their Medicare coverage to begin. And this is available specifically for low-income seniors who are age 65 and older. And as I said earlier, there might be other state or local resources near you, so there could be a financial assistance program through a clinic, a hospital, or an FQHC that your client might qualify for. And then lastly, beginning in 2025, there is a new program called the Medicare Prescription Payment Program, or MPPP, MP3, whatever you want to call it. And this program is basically designed to help Medicare Part D beneficiaries spread out their out-of-pocket costs over, over the course of the plan year, rather than having to pay it all up front at the beginning of the year. Alrighty, and with that, I'm going to pass it back to Liesl to share some great resources with you all, and then we'll jump into Q&A afterwards. Thank you.

Liesl Lu:

Great, thanks so much, Christine. So just to close this out here, I'm going to go over a number of resources that we have. So, we have a whole suite of tools about Medicare coverage, that are listed here, and I'm gonna go into each one in a little bit of detail. So, during Part 1 of this series, we covered the topics that are addressed in these three resources. So the first on the left is the basics of Medicare for Ryan White program clients, and this one talks about the common eligibility pathways for people with HIV and the different parts of Medicare, and it's also available in Haitian Creole and Spanish. The second middle tool is Medicare prescription drug coverage for Ryan White program clients, and this talks, obviously, about prescription drug coverage, the donut hole, coverage for HIV medications, and how ADAP can help with cost. And the third tool is how Medicare enrollment works. So, this one goes into detail about the initial enrollment period, special enrollment periods, and the general enrollment period,



as well as how to avoid penalties and make changes to your existing coverage. So, a number of the topics that I covered early on today.

Next is, a tool about one-on-one Medicare enrollment assistance, so... or SHIP, counselors, which I mentioned and went and, described to you all, so this goes into those details about the benefits of partnering with a local SHIP program, as well as the benefits of becoming a certified SHIP counselor. The next one is our transitioning from Marketplace to Medicare health coverage tool, which is, really a comprehensive FAQ and decision trees to help make this process as painless as possible and answer as many of the questions as, you and your clients may have about transitioning from Marketplace to Medicare. We also have a tool on financial help that goes into many of the details Christine just covered, so the common sources of financial assistance, like Medicare savings programs and the Federal Extra Help program, that Christine just talked about. And then finally, we have, the Medicare Prescription Payment Plan FAQ, so again, another comprehensive FAQ that goes over the MPP in detail. And finally, a client that... I mean, sorry, a resource that is client-facing, so this is the ABCDs of Medicare coverage. This one is specifically designed, and written to give to clients. The other ones I've just gone over are for case managers and Ryan White program staff. This one is specifically to give to clients. It's a plain language tool that describes the different parts of Medicare and the difference between Original Medicare and Medicare Advantage, so you can print this out to give to your clients, and you can find all of these tools at TA4HIV.org, and we've included, we'll include that link right now. So now I'm going to hand it back to Molly to get us started with the Q&A session.

Molly Tasso:

Great, thank you so much, Liesl and Christine. That was incredibly helpful, and important information. We received many great questions, and so we've got 30 minutes, so we're going to dive right in. I also want to note we have Dori Molozanov from NASTAD, who's joining us today for the Q&A. So Dori, thank you so much for being here, and looking forward to helping us out here. So, Liesl, I'm gonna start with you up top with a couple questions, that are related to, creditable coverage, both prescription drug coverage and insurance. So, we'll start with this: Can you remind us what qualifies as creditable employer-sponsored insurance? And then the next question will be around, sort of, ADAP and Part D.

Liesl Lu:

Sure, so, credible drug coverage, is, is good or better than basic Part D coverage, so, credible coverage need not go through an employer. It could be through other benefits that you receive, but enrollees should receive a notice from their plan around September each year, letting them know if the coverage is considered creditable for Part D purposes.

Molly Tasso:

Thanks Liesl, and then following up on that, if a person does not have Part D, Medicare, can't enroll until, until open enrollment, and they're, they're receiving medication assistance through ADAP, would that ADAP assistance count as creditable prescription drug coverage to hopefully or to potentially avoid penalties?

Liesl Lu:

Yeah, it's a good question. Unfortunately, no ADAP medication assistance is not considered credible coverage, because it's not actually health insurance, it's just paying for a person's HIV medications. So while receiving medication assistance through ADAP, it will help... it won't help client avoid the enrollment



penalties, but it does support uninterrupted access to care and support continuity of care. So, it's very important, but unfortunately, it doesn't satisfy the creditable coverage requirement.

Molly Tasso:

Thank you, Liesl. Okay, let's see here. I'm wondering, Dori, if you are able to come off mute. We've got a question around penalties. So, if a person does incur penalties, how are those penalties being, how are those penalties sort of being collected? Are they automatically deducted?

Dori Molozanov:

There's a question, sorry, about late enrollment penalties.

Molly Tasso:

Correct. And Social Security.

Dori Molozanov:

If for the Part B enrollment penalty, like, enrollment penalty, that would just be paid the same way that the person's premium is paid, so for most people, that means deducted from their social security check. If you're paying it directly, like, if you don't receive retirement benefits yet, then it would just be, like, added on, basically, to your premium. And, for Part D, it works the same way, except that, not... maybe not as many people have automatic deductions for their Part D premium, but it's the same rule applies, it's kind of tacked on.

Molly Tasso:

Okay, great. Thanks, Dori.

Dori Molozanov:

Also itemized on the invoice, where you can, like, see how much it is. Yeah.

Molly Tasso:

Okay, so a person would see on their invoice exactly how much and why it's being taken out. Okay, awesome. Thanks, Dori. Christine, I'm gonna turn to you for a couple questions around sort of sticking with the penalties. Someone asked why there are Medicare penalties around enrollment or late enrollment, and then also someone asked how to explain or talk to a client about why they would get charged a penalty if they don't enroll when they're eligible, and just, if we have language around why it's important to avoid those penalties.

Christine Luong:

Yeah, so, I mean, I don't, I don't know why CMS does certain things, but, you know, the general, reasoning for these penalties is it's really a way to encourage folks to enroll in coverage as soon as they're eligible for it. In general, it is a good thing to reduce any gaps in health coverage. It is generally a very good thing to stay enrolled in coverage, rather than waiting until you become sick to enroll in health coverage. You know, this applies to any form of health coverage, not just Medicare. And, you know, we know that for people with HIV and Ryan White clients, it's very important that they maintain their health coverage, so that they can continue seeing their HIV providers, their non-HIV providers, so that they continue having access to their medications as well.

So the second part of that question is, how do I explain to someone that they'll get charged a penalty if they don't enroll? You can borrow some of that language that I just shared. I think it's also part of a... larger conversation, right, about, why continued engagement in care is important for overall health, not just because there's a penalty, a financial penalty associated with it. So, I hope that helps.



Molly Tasso:

Yeah, thank you, Christine. Liesl, I'm gonna turn to you, again, sort of sticking with our penalty, sort of theme right now. Wondering... someone's asking how you could... how a person could determine how much a client's premium and or penalty would be for each part.

Liesl Lu:

Sure, so, during, my portion of the slides, I had mentioned that, you can go to Medicare.gov, and use the plan compare tool, and there's also an Estimate My Premium tool, which I'll chat out once I'm done talking here. But, those will help you estimate a client's premium. In terms of late enrollment penalties, they differ by each part, so I'm gonna go through it quickly, but then also share a link that you can access. So, the amount is different for each part. So if a client isn't eligible for premium free part A, and they have to buy Part A, and they don't buy it when they're first eligible for Medicare, their monthly premium may go up, to... up 10%, so they'll have to pay the penalty for twice the number of years that they didn't sign up. For Part B, if a client waits 2 years to enroll and does not qualify for an SEP, they will pay an extra 10% for each year that they could have signed up for Part B, but did not. And then for Part D, if they don't have creditable coverage, prescription drug coverage, or extra help, they'll pay an extra 1% for each month, so that's 12% a year if they don't join a Medicare prescription drug plan when they first get Medicare. So it's a... It's a multifaceted calculation, and also depending on which pieces, or which parts they may or may not have, signed up for.

Molly Tasso:

So... Dori, I'm going to turn to you for a couple questions around, sort of, paperwork questions. So, the first one, first question, does a client need to obtain a letter from HR confirming that the employer's coverage is, is creditable? Creditable coverage?

Dori Molozanov:

I... employers are required to provide a notice to Medicare-eligible employees every year, so I guess, no, you shouldn't need to proactively obtain a custom letter. Of course, if you didn't get it, if you can't find it, you might want to reach out and get it, because, they're only required to send it one time per year, so if you missed it, then, you know, you would have to ask for one, but no, workers who are Medicare eligible should get a notice of creditable coverage. I think it comes, like, around September? Around the fall.

Molly Tasso:

Okay, great. And then, sticking with the sort of, paperwork administrative questions, do you... does a person have to submit something to officially defer enrollment in Medicare? Like, do you have to sort of tell someone?

Dori Molozanov:

Possibly, it depends on the situation. So, people... I wasn't here for the beginning of today's presentation, but I think we talked about people being automatically enrolled in Medicare versus having to actively enroll. So, you know, there's some folks who are automatically enrolled, and if the client is automatically enrolled, then yes, they would have to, like, take action to be disenrolled.

The automatic enrollment happens when someone is already receiving retirement benefits, so if the person already is receiving their retirement benefits, they get automatically enrolled. They're gonna get their Medicare card in the mail, and there will be a welcome packet there that has information about how to delay Part B. The welcome packet is also available on the internet, like, you can look at everything that it says. So, you know, if the client lost it, like, there is information in there about how to delay Part B if the client's already been enrolled and gotten their Medicare card. If the client is... knows that they're soon to be automatically enrolled, so let's say they're already getting retirement benefits and they know they're about to turn 65, they don't want to wait for that to happen, they can call Social Security and tell them that



they want to delay Part B. But if they fail to do that, or if that somehow doesn't work out, like, they can, once they get their Medicare card, they will still be able to do it. If the client is not automatically enrolled in Part B and is not going to be, they don't have to actively defer, they just simply don't sign up during their initial enrollment period. But of course, there's a couple of, like, caveats there. First, the client should make sure if they're gonna do that, that, you know, they know that they have other coverage, and, you know, if not, that they've considered, like, the late enrollment penalties that might come down the road.

And also, even if the client does have other coverage, they should confirm whether that coverage pays primary or secondary to Medicare. If they work for a smaller company, like fewer than 20 people, then their Medicare would pay primary, in which case they might not want to drop their employer coverage, because they will have only secondary coverage in that case, and secondary coverage without primary coverage is not especially useful, and the client would have really high costs for their coverage. So, before they drop Medicare, for employer coverage, just make sure that, Medicare is not paying... that Medicare is the secondary payer, and that it's okay to drop it. And then, on... I assume this question was about Part B, but since the person didn't specify, I'll just say for, on Part A, if the client is eligible for Premium Free Part A, they can also drop it, similarly to how I described, except that they won't be able to receive their retirement benefits until they've enrolled in Premium Free Part A.

Molly Tasso:

Thank you so much, Dori. Christine, I'm gonna come to you, with a question around Medicare Advantage. A really good question here. Are there specific considerations for case managers or other program staff, and the considerations that they should discuss with clients, when selecting or changing Medicare Advantage plans. Really, here the question notes looking to ensure continuity of care and medication access.

Christine Luong:

So, I see two parts, sort of, within this question. The first part is, like, choosing between Original Medicare versus Medicare Advantage, and then the second part is, if you're choosing Medicare Advantage, how do you select an advantage plan that works for you, right? So... so for the first part, Original Medicare versus Medicare Advantage, if you joined us for part one of this webinar series, did go into a lot of detail about some of the pros and cons and other considerations for each of those options. We... we're not advocating for one option over another, but there are a few, there's a few benefits and a few drawbacks, right? So, Original Medicare, again, that's administered by the... by the federal government. It is sort of a la carte. If you know me, you know I use this analogy a lot. It's like going out to eat. Usually people go a la carte. You just sort of order what you want, and you pay for what you want. So, it offers a bit more flexibility, so you can pick and choose. If I just want Part A and Part D, I can do that. If I just want B, I can do that as well, part, sorry, Original Medicare in general has a much broader network, nationwide, so any provider or facility that accepts Medicare assignment, throughout the country, is in that network. And you generally don't need to see a specific primary care provider, you generally don't need a referral to see a specialist. So these are all good things if you're someone who travels around the country a lot, and you want to have that broader network of providers to see. So, if you have a long-standing, established relationship with your HIV provider, for example, and you know that they accept traditional Medicare, that might be one major consideration for you to keep in mind.

On the Medicare Advantage side, these are plans that are administered by those private insurance companies, so they're geographically, sort of limited in terms of their provider network. You may, depending on who you currently see and whether you're open to changing providers, you may or may not be able to find a Medicare Advantage plan within your particular geographic area where those preferred providers are, are in-network, right? So, in terms of, your continuity of HIV care, that's something to keep in mind. You know, advantage plans in general, I think, it's more similar to, an employer-sponsored plan or a marketplace plan in the way that it's structured, so folks might be, more familiar with it, and, you



know, if the plans that are offered where they live are providing the types of benefits that they want, so they can see their providers. That might be a reason for them to... to choose a Medicare Advantage over Original Medicare.

And then, so the second part of that question, sorry, I'm being very long-winded here, choosing between one Advantage plan versus another, every year, the... the Medicare Advantage market will change, so, just because you live in the same place this year and next year doesn't mean that all the same plans will be offered the following year. So, you'll have to do a lot more legwork as a case manager to work with your client to really compare line by line what those Medicare Advantage plans are offering, confirming that your providers are still in those networks. And so on and so forth. So, hopefully that answered everything, and if I did not, please feel free to follow up in the chat.

Molly Tasso:

Thank you, Christine. Dori, I'm going to turn to you for a question around, what Medicare Part D, or Advantage plans are required to cover. Specifically, someone asked if they are required to cover all antiretrovirals, and whether there are any restrictions around prior authorization.

Dori Molozanov:

Sorry, can you repeat the first part of the question again?

Molly Tasso:

Yeah, are all Medicare Part D or Medicare Advantage plans required to cover all antiretrovirals?

Dori Molozanov:

Yes, Medicare Part D must cover all, or substantially all, ARVs used to treat HIV, and plans are not allowed to require prior authorization or step therapy. I had the standard- It's, and antiretrovirals belong to one of the six protected classes for Part D coverage, which means that plans are legally required. But Part D prescription drug plans, and that includes Medicare Advantage plans that offer prescription drugs, must cover basically all of the drugs in that category.

Molly Tasso:

Okay, great, thank you. Christine, I think I'm... actually, Liesl, I'm gonna go to you for a quick question. Because then I'm going to give Christine two-parter questions, so I'm going to give her a minute to catch her breath. All right, Liesl, so, what should a client do for insurance, or medication while they are in the SSDI 24-month waiting period?

Liesl Lu:

Yeah, so, it's important to try to help them identify other coverage options, such as Marketplace, Medicaid, employer-sponsored insurance, rather than staying uninsured, while waiting to become Medicare eligible, via the SSDI. So during that time, if they're eligible, individuals can, continue to access their HIV medications via ADAP, but always important to try to, to, to enroll in available insurance options, in order to maintain continuity of care, beyond just someone's HIV medications, because often they have additional other needs, that can... that can't be met by ADAP.

Molly Tasso:

Is that so? Alright, Christine, so we are going to, cover a little bit, a couple questions around financial assistance, for Medicare. And so, first, wondering, someone asked if you could say a little bit more, or say again, sort of some, some details on the Part D Extra Help program. And should individuals enroll in a Part D plan first, if they don't already have one? Sort of, what's the order of operations here?



Christine Luong:

Yeah, so the Part D Extra Help Program, right, so this is a program that's administered by the federal government. It is helping you, with the costs of your prescription, your Medicare prescription drug coverage. Extra Help itself, as I said before, that itself is not coverage. So, you do need to be enrolled in a Medicare Part D plan in order for that extra help to apply. You can apply for Extra Help before your Part D coverage starts, or you can enroll in Extra Help afterwards as well. Some people are automatically enrolled in the Extra Help program, and some people have to actively apply. It really kind of depends on your particular situation. I had mentioned earlier that if, you are enrolled in a Medicare Savings Program, that is one of those criteria that will automatically qualify you for Extra Help as well.

Molly Tasso:

Great, thank you, Christine. And then, can you please, elaborate or sort of talk through again what the Medicare Savings Program, or the MSPs, are?

Christine Luong:

Yeah, MSPs, you... some folks may call them Medicare buy-in programs, so they're kind of...similar terminology. They're administered by state Medicaid programs to help with the costs of Medicare. So, folks who are, on the Medicare savings programs are considered, partially dually eligible, and again, we'll get into more detail about that next week. So it is a... it is something that is related to dual eligibility. There were those four different MSPs that I had described earlier, and basically they're just different tiers of financial assistance. They'll have their own, sort of, income and asset requirements, so... in general, the lower your income, the more financial assistance that that particular Medicare savings program can provide to you. Again, the caveat sort of varies by state, right, because they're administered by Medicaid, and some states will choose not to have all four of those MSP options. So I can't really say too much across the board here, but if you are interested in learning about MSPs, you should definitely go to your state Medicaid agencies' website and see what is offered, what those names are, what those eligibility criteria are.

Molly Tasso:

Thanks, Christine. And we will touch again on some of this during next week's... next Tuesday's Medicare-Medicaid Dual Eligibility Webinar, so I hope folks are able to join us for that. Christine, one... another question for you here. Would switching to Medicare Advantage also incur late penalties if a person didn't apply for Medicare when they were first eligible?

Christine Luong:

So... Okay, so there's two parts, again, to this question, right? So the, the...The act of switching from Original Medicare to Medicare Advantage itself, that is not subject to penalties. You always have the freedom to switch between traditional versus Advantage. Vice versa. You can switch from one advantage plan to another advantage plan, that would not be subject to penalties. But enrolling in... in any form of Medicare late, without having any other form of creditable coverage between now and when you were first eligible, that is what would result in a penalty. I'll keep that short.

Molly Tasso:

Awesome. Thank you, Christine. I think the big takeaway: do not enroll late. Those penalties are lifetime penalties. And we want to avoid those, as much as possible. Dori, I have one more question for you, and then I think we've answered most questions that we're going to be able to get to today. This question is around SEPs, Medicare SEP, specifically. So, can you say a little bit about the SEP after the loss of Medicaid, and how long, that SEP... a person would be eligible for the SEP after the loss of Medicaid?

Dori Molozanov:



Oof, this wasn't on the top of my head. I'm gonna say 6 months? I believe it's 6 months after... Yes. Sorry, I'm gonna need a second one.

Molly Tasso:

No, that's okay.

Dori Molozanov:

I did not have that one at my fingertips.

Molly Tasso:

No, you... it was a pop quiz, and you got it correct. It is six months, yeah. It starts... it's 6 months starting from the date that you receive notification that your Medicaid is terminated, or the date that your Medicaid actually ends, whichever is later. So, either date you receive notification, or it actually ends, whichever of those is later, you've got 6 months then to enroll into Medicare.

Dori Molozanov:

That's great.

Molly Tasso:

Okay. Good job, Dori.

Dori Molozanov:

Teamwork makes the dream work.

Molly Tasso:

There we go. Okay, I think unless anyone wants to take any, like, late-breaking questions in the chat, take them live. I'll pause for a few minutes, or a few moments. On the next slide, we're just gonna show information for where you can connect with us over email and our website. Thank you. So, contact us. There's our email, ACETACenter@jsi.org.

You can also... we'll chat out a link to join our mailing list, and to go straight to our website. And on our website is where you will be able to sign up for, if you're not already, next week's third and final installment of this webinar series. Again, it's going to be Christine, Liesl, Dori, our experts here, talking to us about Medicare-Medicaid dual eligibility for Ryan White clients. So, pretty complicated. We also have a SHIP counselor, who's going to be joining us as well to talk about her experience, and answer some questions from the sort of front, line... frontline sort of work, and so really encourage folks to join us next Tuesday, if possible.

With that, I think we will close out. Really, encourage you all, there will be a pop-up for an evaluation, a survey, to provide some feedback for us today. We take this information very seriously. It's helpful for us to know, what's useful and helpful and relevant to you all doing this important work, so please take a few moments to fill it out, let us know, what you think. And with that, have a wonderful day. Thank you, everyone.