AIDS Drug Assistance Program (ADAP) Considerations for the 2024 Plan Year

October 20, 2023

Dori Molozanov
NASTAD
Senior Manager, Health Systems Integration

Molly Tasso
Senior Consultant, JSI
ACE TA Center Project Director

NASTAD

Presentation Overview

- Marketplace and Medicare Enrollment
- Plan Year 2024: Policy Updates
- Medicaid “Unwinding” Updates
- Addressing Churn and Maintaining Access All Year Long
- Insurance Cost-Effectiveness
- Preparing for Open Enrollment
- ACE TA Center Technical Assistance Needs Assessment

Marketplace and Medicare Enrollment

Marketplace Enrollment

Annual Open Enrollment Period (healthcare.gov):

November 1 through January 15

State-based Marketplaces (SBMs) may have shorter or longer Open Enrollment Periods, but must run through at least December 15.

Must enroll by December 15 for coverage to begin on January 1.

- Some State-Based Marketplaces have a later deadline for January 1 coverage (e.g., December 23)

Medicare Enrollment

Medicare Fall Open Enrollment Period

October 15 through December 7

During this time, clients currently enrolled in Medicare* may:

- Switch between Original Medicare and Medicare Advantage
- Switch to a different Medicare Advantage plan
- Change or drop their Part D plan
- Join a Part D plan for the first time
  - Clients may face Late Enrollment Penalties (LEPs)

Coverage start date: *January 1*

* Original Medicare or Medicare Advantage

Medicare Enrollment

Medicare Advantage Open Enrollment Period:

January 1 through March 31

During this time, clients currently enrolled in Medicare Advantage may:

- Switch to a different Medicare Advantage plan
- Return to Original Medicare
  - NOTE: Switching *from Original Medicare to Medicare Advantage* is permitted only during Fall Open Enrollment Period (October 15 – December 7)

Coverage start date: *First day of the month following enrollment*

Medicare Enrollment

Medicare General Enrollment Period (GEP):

January 1 through March 31

During this time, clients who do not have Medicare Part B because they missed their Initial Enrollment Period or Special Enrollment Period may:

- Enroll in Medicare Part B for the first time
  - Clients may face Late Enrollment Penalties (LEPs)

Coverage start date: *First day of the month following enrollment*

Plan Year 2024: Policy Updates

Inflation Reduction Act (IRA)

Medicare

- Caps out-of-pocket costs for insulin ($35/mo) (2023)
- Eliminates cost-sharing for vaccines* covered under Medicare Part D (2023)
- **Eliminates 5% coinsurance in Part D "catastrophic coverage" phase** (2024)
- **Expands eligibility for Part D low-income subsidy (150% FPL)** (2024)
- **Limits annual Part D premium increases (max 6%/yr)** (2024)

* Applies to vaccines recommended by the Advisory Committee on Immunization Practices (ACIP)

New! Marketplace Regulations in 2024

- Increase access to certain Essential Community Providers (ECPs)
  - Mental Health Facilities
  - Substance Use Disorder (SUD) Treatment Centers
  - Federally-Qualified Health Centers (FQHCs)
  - Family Planning Providers
- Limit the number of non-standardized health plans offered through the Marketplace
- Expand allowable outreach activities for Marketplace Assisters
- Ease requirements for resolving Income Data-Matching Issues (DMIs)
- Reduce coverage gaps with Special Enrollment Period (SEP) flexibilities

Marketplace Assister "Direct Contact" Outreach

OLD RULE

Marketplace Assisters* may make "direct contact" (e.g., door-to-door, phone calls) with consumers only for "outreach and education."

Assisters may not directly contact consumers to provide enrollment assistance.

NEW RULE

Marketplace Assisters may directly contact consumers to provide enrollment assistance.

* Marketplace "Assisters" include Navigators, Certified Application Counselors (CACs), and non-Navigator assistance personnel.

Income Data-Matching Issues (DMIs)

A data-matching issue (DMI) happens when information entered on a Marketplace application does not match trusted data sources, such as Social Security or Internal Revenue Service (IRS) data.

Common reasons for income DMIs:

- Change in pay or employment status (e.g., reduced hours, receiving unemployment or retirement benefits)
- Demographic mismatches (e.g., name changes)
- Household changes (e.g., divorce, marriage)
- Irregular income (e.g., self-employment, one-time payments)
- No tax data available

Income Data-Matching Issues (DMIs)

Self-projected income may trigger a DMI if:

- No tax information is available through the federal data hub, **OR**
- Projected income is substantially lower than the client's most recent tax filing
  - The difference must exceed the DMI threshold*

*DMI threshold: Income DMI is triggered if the difference between the client's projected income and the most recent income tax data from the IRS is more than $12,000 AND more than 50% of 2022 income.

Resolving Income DMIs

If a DMI is generated because the projected income on the client's Marketplace application is substantially lower than their most recent tax filing:

- The client can resolve the DMI by submitting either:
  - Evidence of income – e.g., pay stubs, self-employment ledgers, OR
  - A signed statement explaining the client's income
- If the client fails to resolve the DMI on time, their Advance Premium Tax Credits (APTCs) will be automatically adjusted based on the higher income reflected in IRS tax data
  - Premiums will be higher (and APTCs will be lower) than the initial Marketplace estimate
  - Failure to pay the full, new premium amount will trigger a non-payment grace period

Resolving Income DMIs

If a DMI is generated because there is no tax information for the client available through the federal data hub:

OLD RULE

The client can resolve the DMI by submitting evidence of income or a signed letter of explanation.

If the client fails to resolve the DMI on time, their APTCs will be terminated.

NEW RULE

The Marketplace must accept a consumer's self-attestation of income when no IRS tax data exists, without generating a DMI.

- Applies to state and federal Marketplaces
- Does not apply to income DMIs where IRS tax data is available

Restoring APTCs After An Income DMI

- NEW RULE: The Marketplace must grant an automatic 60-day extension to the current 90 days permitted to resolve an income DMI
  - Applies to state and federal Marketplaces
  - Applies only to DMIs based on income – deadlines for other DMIs are unchanged
- Over one-third of income DMIs are resolved after the initial 90-day deadline
- A client can resolve an income DMI and restore APTC by:
  - Submitting documentation after the deadline
  - Correcting their projected income on their application
  - Filing an appeal with the Marketplace

Special Enrollment Period (SEP) Flexibilities

Extended Special Enrollment Period (SEP) following loss of Medicaid coverage.

- OLD RULE: Enrollment in Marketplace coverage through an SEP is permitted up to 60 days before & 60 days after loss of Medicaid coverage.
- NEW RULE: Enrollment in Marketplace coverage through an SEP is permitted up to 60 days before & 90 days after loss of Medicaid coverage.
  - Optional for State-based Marketplaces
    - Flexibilities: May allow more than 90 days, may start implementation early (in mid-2023)

Special Enrollment Period (SEP) Flexibilities

Flexibility in Marketplace coverage effective dates following mid-month loss of other coverage.

- OLD RULE: Marketplace coverage begins the month after loss of previous coverage, or the month after a new plan is selected.
- NEW RULE: Marketplace coverage may begin retroactively on the first day of the month in which coverage loss occurs.
  - Example: Client is losing coverage on August 15.
    - To begin Marketplace coverage on September 1 → choose a plan by August 31
    - To begin Marketplace coverage on August 1 → choose a plan by July 31
  - May result in overlapping coverage for part of the month
  - Optional for State-based Marketplaces

Medicaid “Unwinding” Updates

Unwinding Medicaid PHE Requirements

- Did Medicaid begin my client's renewal at the permissible time?
- Did Medicaid perform a proper renewal for my client?
- Did Medicaid properly terminate my client?
- Did Medicaid provide proper notices to my client about their renewal and termination?

Requirements for Medicaid Forms and Notices

Medicaid notices, requests for information, and/or forms must:

- Be clear and specific
- Be written in “plain language”
- Clearly state relevant dates – e.g., last date of coverage, deadline to return information
- Clearly explain the reason for the action being taken – e.g., basis for termination
- Include information about relevant rights and protections (when applicable) –e.g., language access, disability access, appeals process
- Be individualized to the client

Medicaid "Reconsideration Period"

- If a client's Medicaid coverage is terminated because they failed to return a renewal form or provide other requested information, Medicaid must reconsider eligibility without requiring a new application if:
  - The client belongs to a Modified Adjusted Gross Income (MAGI)* eligibility group, AND
  - The client submits the requested information within 90 days of the termination
- States may choose whether to provide a reconsideration period for non-MAGI groups

42 C.F.R. § 435.916(a)(3)(iii)

* MAGI groups: pregnant women, children, parents/caretakers, adult "expansion" group

Transitioning from Medicaid to the Marketplace

Coordination with other insurance affordability programs

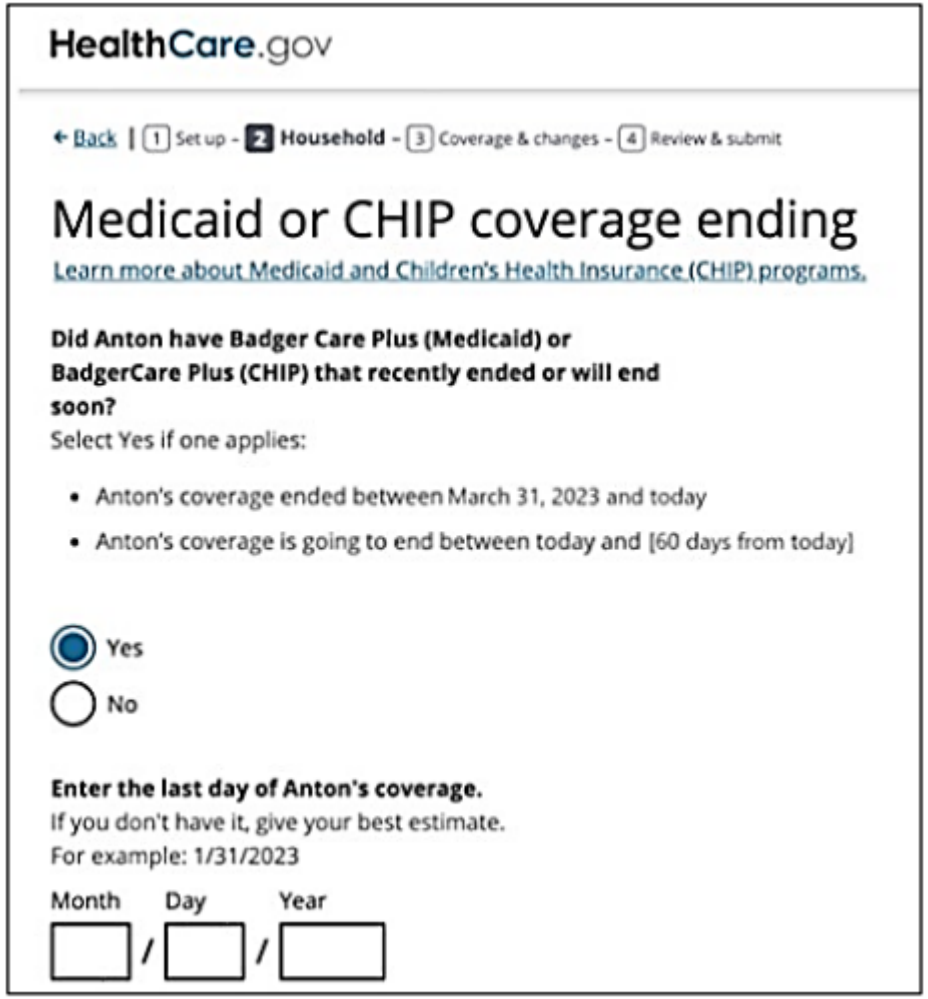
- If client is potentially eligible for another insurance affordability program, Medicaid must transfer their account to the other program
  - Insurance affordability programs include: Medicaid/CHIP, Basic Health Plan, and the Marketplace
- States vary widely in terms of infrastructure for seamless transition between programs

42 C.F.R. § 435.1200

Transitioning from Medicaid to the Marketplace

"PHE Unwinding" Special Enrollment Period (SEP)

- Available March 31, 2023 - July 31, 2024
- Available to clients who self-attest to losing Medicaid due to "unwinding" between 3/31/23 and 7/31/24


HealthCare.gov

← Back | 1 Set up – 2 Household – 3 Coverage & changes – 4 Review & submit

Medicaid or CHIP coverage ending

Learn more about Medicaid and Children's Health Insurance (CHIP) programs.

Did Anton have Badger Care Plus (Medicaid) or BadgerCare Plus (CHIP) that recently ended or will end soon?

Select Yes if one applies:

- Anton's coverage ended between March 31, 2023 and today
- Anton's coverage is going to end between today and [60 days from today]

(•) Yes

( ) No

Enter the last day of Anton's coverage.

If you don't have it, give your best estimate.

For example: 1/31/2023

Month / Day / Year

Transitioning from Medicaid to the Marketplace

PHE Unwinding SEP

- Timing: No deadline. Clients do not need to know the date of Medicaid termination.
- Documentation: None. Clients self-attest to losing Medicaid during specified timeframe.
- Access: Available in all states using healthcare.gov. State-based Marketplaces may choose to adopt.

Loss of Minimum Essential Coverage (MEC) SEP

- Timing: Available up to 60 days before or 90 days* after Medicaid ends.
- Documentation: Clients may need to document loss of Medicaid before new coverage can begin.
- Access: Available in all Marketplaces.

* State-based Marketplaces may have shorter or longer SEP window

Transitioning from Medicaid to Medicare

Medicare SEP to Coordinate with Termination of Medicaid Coverage

- New Medicare Part B SEP for clients who delayed Medicare enrollment because they were enrolled in Medicaid
  - SEP starts on the date that client *receives the notice* of Medicaid termination
  - SEP ends 6 months after date of Medicaid termination
- No Late Enrollment Penalty (LEP)
  - Clients who lost Medicaid and enrolled in Medicare with an LEP before January 1, 2023 may contact Social Security to have the penalty removed and seek reimbursement for penalties already paid
- Coverage begins the month after enrollment
- After signing up for Part B, client has 2 months to join Medicare Advantage or Part D plan

Transitioning from Medicaid to Medicare

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-1426
Expires: 11/24

**APPLICATION FOR MEDICARE PART A AND PART B –
SPECIAL ENROLLMENT PERIOD (EXCEPTIONAL CONDITIONS)**

WHAT IS THE PURPOSE OF THIS FORM?

If, due to an exceptional condition, you didn't sign up for Medicare Premium Part A or Part B during your Initial Enrollment Period (IEP), General Enrollment Period (GEP), or a Special Enrollment Period (SEP) you were previously eligible for, you can sign up without a late enrollment penalty during a SEP for Exceptional Conditions. If you think that you may be eligible for a SEP for Exceptional Conditions, please contact Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

NOTE: Your IEP lasts for 7 months. It begins 3 months before your 65th birthday (or 25th month of disability) and ends 3 months after you reach 65 (or 3 months after the 25th month of disability). The GEP is from January 1 – March 31 each year. The most common SEPs apply to the working aged, disabled, and international volunteers.

WHAT INFORMATION DO YOU NEED TO COMPLETE THIS FORM?

You will need:

- Your Medicare Number or Social Security number (SSN)
- Your current address and phone number
- Qualifying documentation of eligibility for the SEP

HOW DO YOU SUBMIT THE FORM?

Complete and sign page 4 of the form and send it to your local Social Security field office.

HOW DO YOU GET HELP WITH THIS FORM?

- Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.
- Contact your local field office. Find an office near you at **www.ssa.gov/locator**.
- **En español:** Llame a SSA gratis al 1-800-772-1213 y oprima el 7 si desea el servicio en español y espere a que atienda un agente.

This SEP also applies to clients who missed or delayed Medicare enrollment due to an emergency or disaster, incarceration, or other "exceptional circumstances."

☐ **SEP for Termination of Medicaid Eligibility**

Select this SEP if you have lost or will lose Medicaid coverage on or after January 1, 2023.

The SEP starts when you are notified of the loss of Medicaid coverage and ends 6 months after Medicaid ends.

Coverage Effective Date Options: Choose ***one*** of the following options. If you leave this section blank, your coverage effective date will be option 1.

○ **Option 1:** Your coverage will begin the first day of the month following the month of enrollment. Medicare will not cover items or services prior to that date.

○ **Option 2:** Your coverage will begin the first day of the month in which you lost Medicaid coverage. You will need to pay premiums back to the month you lost Medicaid coverage. Coverage can begin no earlier than January 1, 2023.

Please attach a document or copy of a document from your state or health plan showing the date your Medicaid coverage will end or has ended. If you do not have documents, SSA will contact your state to confirm your loss of Medicaid coverage.

Form CMS-10797, https://www.cms.gov/files/document/cms-10797-application-medicare-part-and-part-b-special-enrollment-period-exceptional-conditions.pdf

Transitioning from Medicaid to Employer Coverage

Special Enrollment Rights

- Clients have 60 days after loss of Medicaid/CHIP eligibility to enroll in an employer-sponsored plan
  - 30 days for other qualifying life events
  - COVID-19 protection: **Clients who lose Medicaid/CHIP eligibility on or before July 10, 2023 can request enrollment in their employer plan until at least September 8, 2023.**
- Applies to employees and eligible family members (if employer offers dependent coverage)
- Applies to all types of employer plans

ADAP Medicaid Unwinding Updates

Program challenges

- Increase in new client enrollment in ADAP
- Difficult to estimate the number of people with HIV enrolled in Medicaid
  - (Even more) difficult to estimate the number of people with HIV expected to lose Medicaid
- Confusing letters from Medicaid
- Client reticence to take action to keep Medicaid
- Call center wait times
- Confusion about when and how client accounts are transferred from Medicaid to the Marketplace
- Lack of awareness about special enrollment rights outside the Marketplace (e.g., employer coverage, Medicare)

ADAP Medicaid Unwinding Updates

Program strategies

- Most common strategies reported:
  - Training case managers and enrollment staff
  - Increasing resources/capacity for insurance navigation
- Other strategies identified:
  - Coordination with Marketplace Assisters and pharmacies
  - Data-sharing with Medicaid to identify people with HIV at risk of coverage loss
    - Less common: data-sharing with Medicaid to update client contact information
  - Coordination with Medicaid to ensure client premiums are paid
  - Client outreach via mail, email, and/or text message
  - Changes to program policy to facilitate client outreach and enrollment

Addressing Churn and Maintaining Access All Year Long

Addressing Churn and Maintaining Access

- **Screen clients who lose coverage for eligibility for other health insurance**
  - Medicaid: year-round enrollment
  - Marketplace: Special Enrollment Periods (SEPs)
  - Medicare: Part B SEPs for clients who delayed enrollment
  - Employer coverage: Special Enrollment Rights for workers (and their dependents) who initially declined coverage
- **Update Marketplace application if client's circumstances change**
  - Circumstances impacting eligibility for financial assistance: changes in income or household size, availability of other coverage
  - Maintain up-to-date information about client premiums so that ADAP premium payments are accurate

Addressing Churn and Maintaining Access

- **Caution clients against non-traditional, non-ACA compliant products**
  - E.g., short-term limited duration insurance
- **Ensure Medicaid-eligible clients maintain coverage**
  - Help clients gather needed documents and submit Medicaid renewals on time
  - Help clients with appeals or coverage reinstatement/reconsideration if Medicaid is terminated
- **Coordinate with organizations providing enrollment assistance in the community**
  - Ensure consistent messaging with Marketplace Assisters who may increase “direct contact” outreach activities

Insurance Cost-Effectiveness

Insurance Cost-Effectiveness

- Insurance cost-effectiveness is assessed at the aggregate program level, not the individual plan level
  - Is the average cost per client for all insured clients lower than the average cost per client of all full pay clients?
- Less expensive insured clients (Medicare Part D, younger clients with lower premiums) can offset higher expenditures for other insured clients

See: HRSA/HAB PCN 18-01, consolidating several previous policy notices related to insurance purchase.

Insurance Cost-Effectiveness

- Consider the net costs of both insurance and drug purchase, inclusive of discounts and rebates
  - If anticipated rebates exceed the cost of the insurance, plan is clearly cost-effective
- If you include discounts in your drug cost estimate, need to include rebates in your insurance cost estimate
- ADAP Cost-Effectiveness tool estimates rebates relative to the premium and cost-sharing payments

Insurance Cost Projection Checklist

Are there opportunities for additional outreach to increase the number of insured clients?	• Moving full pay clients to health insurance will provide more comprehensive coverage for the client and will create efficiencies for ADAP
Are there opportunities to increase rebate revenue through more prescriptive guidance about ADAP-supported plans?	• ADAPs that do extensive plan review and limit ADAP-supported plans have been able to maximize rebate revenue while providing access to comprehensive insurance to clients
How are ADAPs adapting to newer, expensive therapies?	• Have new therapies been added to ADAP formularies?
Are ADAPs assessing emerging client needs and adapting programs?	• Does Part B/ADAP help clients with medical copay assistance? • Has Part B/ADAP adapted to increase assistance for Medicare as more clients age into that program?

The ACE TA Center

helps organizations

Engage, enroll, and retain
clients in health coverage (e.g., Marketplace and other private health insurance, Medicare, Medicaid).

Communicate with RWHAP clients
about how to stay enrolled and use health coverage to improve health care access, including through the use of Treatment as Prevention principles.

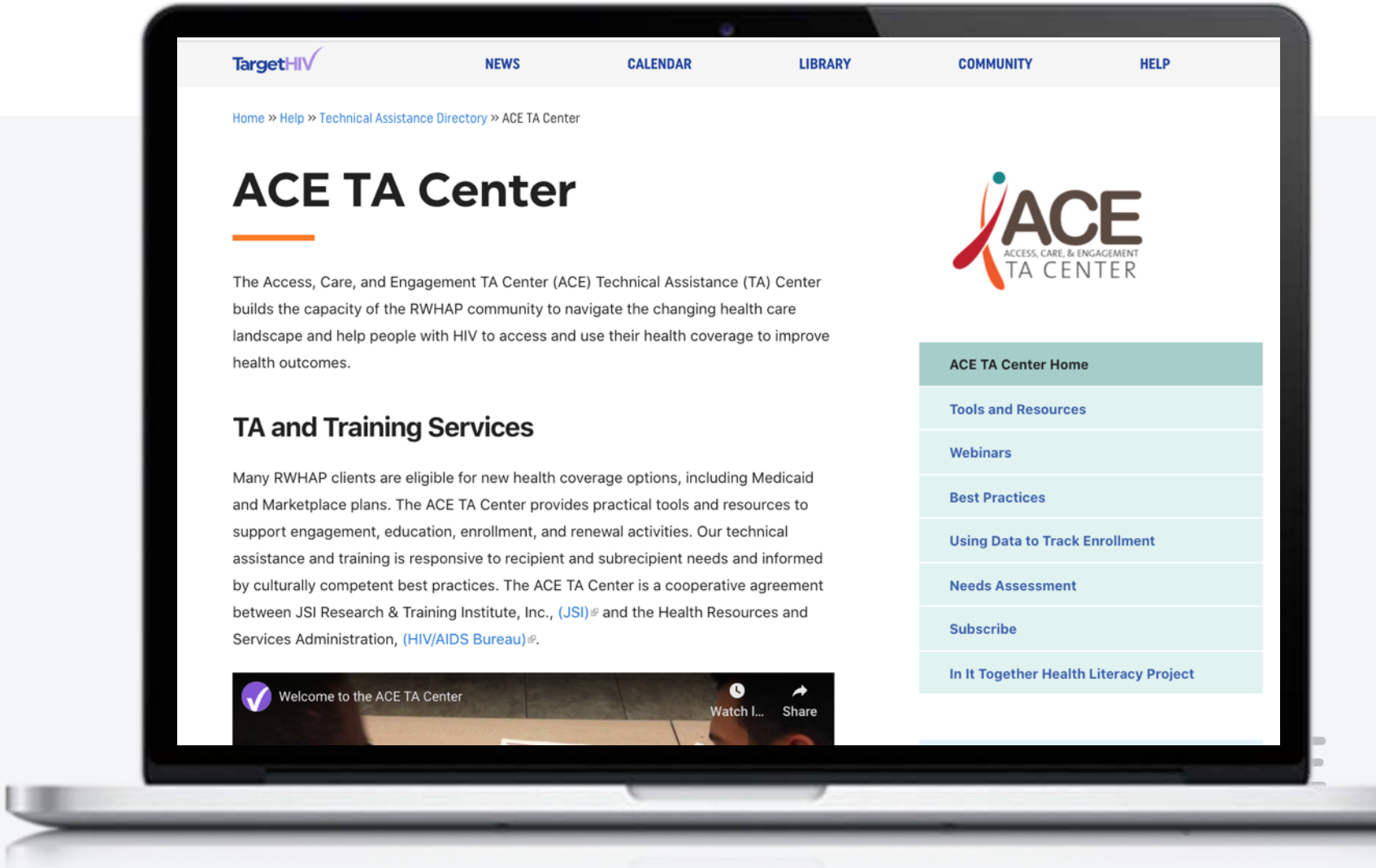
Improve the clarity
of their communication around health care access and health insurance.

Audiences

- RWHAP program staff, including case managers
- RWHAP organizations (leaders and managers)
- RWHAP clients
- Navigators, State Health Insurance Assistance Programs (SHIP) counselors and other in-person assisters that help enroll RWHAP clients in health coverage

Visit us at

targethiv.org/ace



Preparing for Open Enrollment: What can be done now

What can programs do to make sure they are ready for Open Enrollment?

1. Conduct training and build enrollment staff capacity
2. Build enrollment partnerships
3. Conduct Account Tune-Ups
4. Assess health plans and conduct client outreach

1. Build health insurance literacy and enrollment capacity among staff

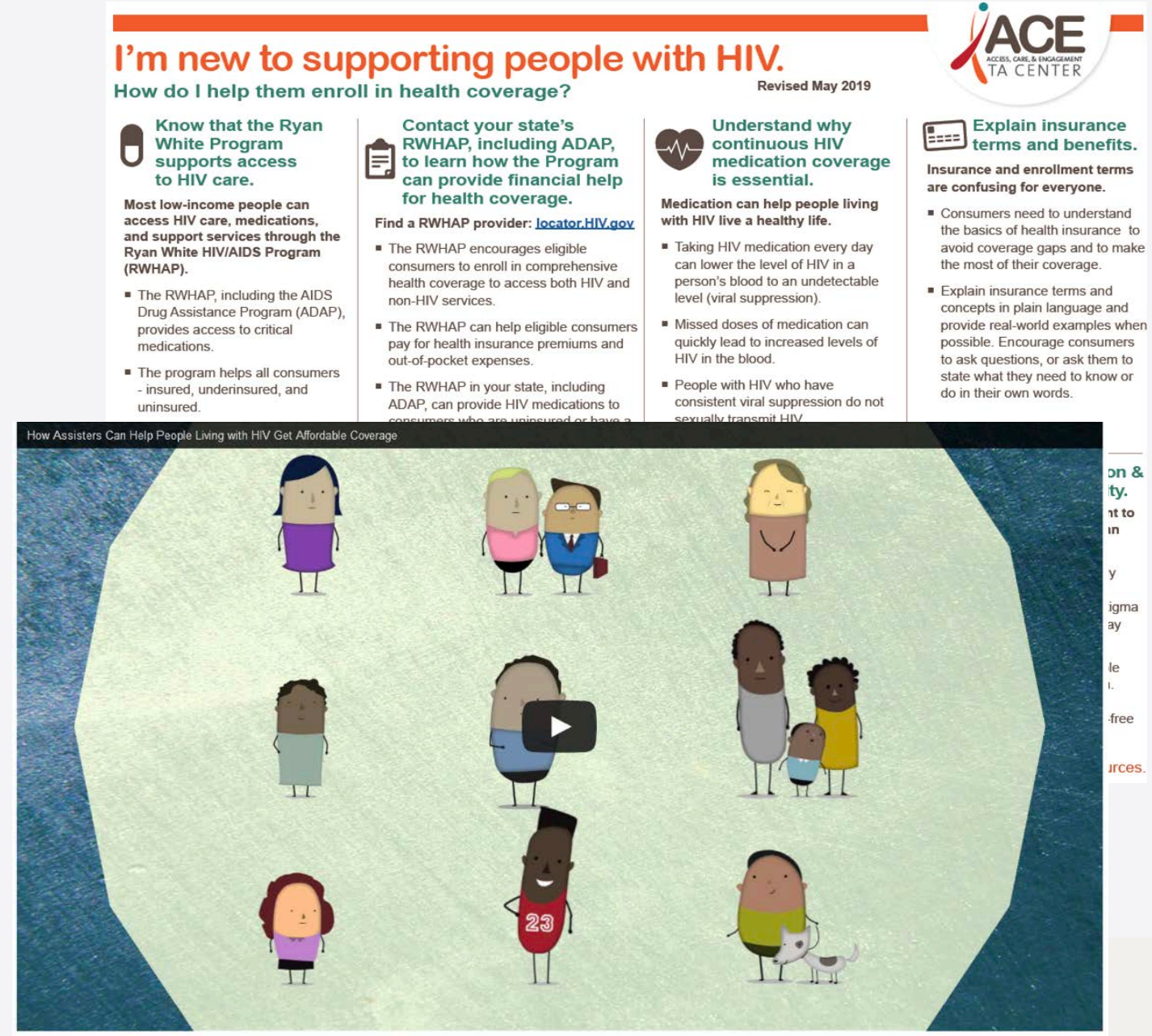
- Train staff on health insurance enrollment basics.
  - Focus on specific plan considerations for people with HIV.
- Provide health insurance literacy training.
- Train staff to conduct ‘Account Tune-ups’ for all insurance-eligible clients.

2. Build enrollment partnerships

- If needed, identify and establish partnerships with Navigators, CACs, and other enrollment assisters.
  - Assisters may be found at partner organizations or within your health system.
  - Train your program staff to refer clients to these partners before and during Open Enrollment.
- Make sure partners are aware of RWHAP, including role of the RWHAP Part B Program AIDS Drug Assistance Program (ADAP) in health coverage.

Training for external enrollment partners

targethiv.org/assisters



I'm new to supporting people with HIV.

How do I help them enroll in health coverage?

Revised May 2019

ACE ACCESS, CARE, & ENGAGEMENT TA CENTER

Know that the Ryan White Program supports access to HIV care.

Most low-income people can access HIV care, medications, and support services through the Ryan White HIV/AIDS Program (RWHAP).

- The RWHAP, including the AIDS Drug Assistance Program (ADAP), provides access to critical medications.
- The program helps all consumers - insured, underinsured, and uninsured.

Contact your state's RWHAP, including ADAP, to learn how the Program can provide financial help for health coverage.

Find a RWHAP provider: locator.HIV.gov

- The RWHAP encourages eligible consumers to enroll in comprehensive health coverage to access both HIV and non-HIV services.
- The RWHAP can help eligible consumers pay for health insurance premiums and out-of-pocket expenses.
- The RWHAP in your state, including ADAP, can provide HIV medications to

Understand why continuous HIV medication coverage is essential.

Medication can help people living with HIV live a healthy life.

- Taking HIV medication every day can lower the level of HIV in a person's blood to an undetectable level (viral suppression).
- Missed doses of medication can quickly lead to increased levels of HIV in the blood.
- People with HIV who have consistent viral suppression do not sexually transmit HIV.

Explain insurance terms and benefits.

Insurance and enrollment terms are confusing for everyone.

- Consumers need to understand the basics of health insurance to avoid coverage gaps and to make the most of their coverage.
- Explain insurance terms and concepts in plain language and provide real-world examples when possible. Encourage consumers to ask questions, or ask them to state what they need to know or do in their own words.

How Assisters Can Help People Living with HIV Get Affordable Coverage

3. Conduct Account Tune-Ups

An account tune up is an in-person or virtual pre-enrollment appointment to:

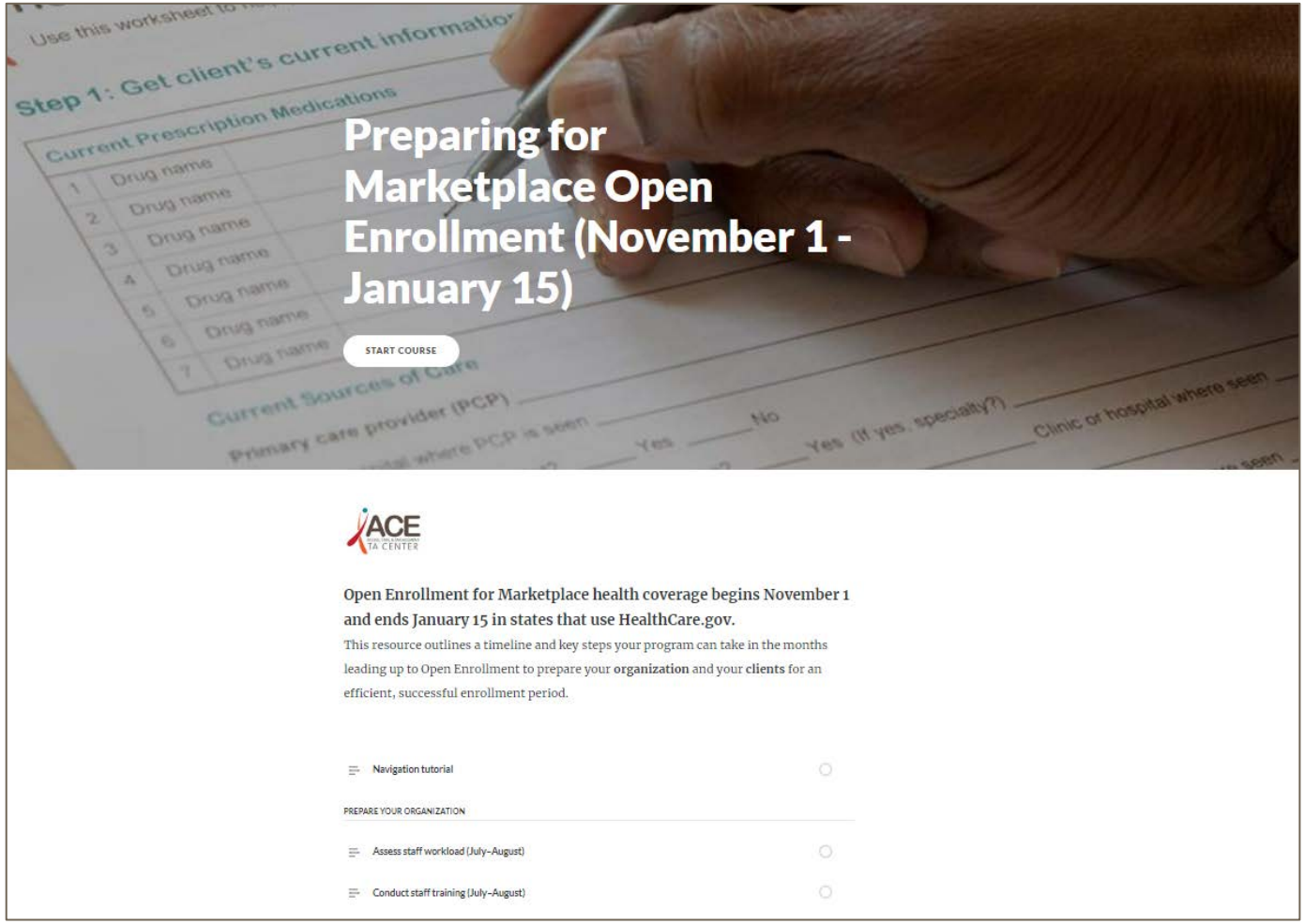
1. Check client paperwork, accounts and payments.
2. Review finances.
3. Confirm enrollment in relevant RWHAP insurance assistance, including ADAP.
4. Help clients prepare for their enrollment appointment.

4. Assess health plans and conduct client outreach.

- For RWHAP recipients purchasing insurance:
  - Assess all plan options, including off-Marketplace plans.
  - Consider locating a third-party to do a plan assessment once plan information becomes available.
  - Train subrecipient staff on plan options as soon as they have been assessed.
- For RWHAP-funded direct service providers:
  - Check with ADAP and/or other RWHAP insurance purchasing programs on plan options available to clients.
  - Train program staff on plan options as soon as they have been assessed.

Preparing for OE eLearning package

- Tool outlines the timeline with key steps your program can take to prepare in the months leading up to Open Enrolment.



NASTAD & ACE TA Center: Here to Help!

ACE TA Center needs assessment findings

- Training and TA (T/TA) needs of RWHAP recipients and providers continue to evolve across health care coverage options.
  - “Using data systems” for enrollment is a re-emerging training/TA need.
  - "Helping clients compare health coverage plan options" ranks among the highest needs for supporting clients with enrollment.
- Providing "culturally responsive and age-appropriate" enrollment support was the highest training and TA need related to Medicare and Medicaid enrollment.

Findings, cont.

- Respondents identified “Helping clients compare and choose” the best Medicare plan options as a high area of need for training and Technical Assistance.
- RWHAP recipients and providers continue to navigate high staff turnover.
  - 66% of respondents agreed that staff turnover has impacted their program's ability to support clients in accessing and maintaining health coverage.
- ACE TA Center resources, particularly Medicare-focused resources, continue to be highly utilized and valued.

RWHAP recipients and providers continue to navigate a changing health care landscape

"…nearly half of all employees in state and local public health agencies left between 2017 and 2021."[1]

Staff turnover impacts our HIV or infectious disease program's ability to support clients in accessing and maintaining health coverage.

	Count	Percent
Strongly agree	36	36%
Agree	30	30%
Undecided	10	10%
Disagree	13	13%
Strongly disagree	10	10%
Not sure	2	2%
Grand Total	101	100%

Top organizational challenges experienced due to staff turnover:

	Count	Percent
Training new staff on Marketplace eligibility and enrollment	46	46%
Covering day-to-day tasks to assist clients in accessing, using, and maintaining health coverage	44	44%
Maintaining institutional knowledge and capacity	35	35%
Assigning case managers to assist clients in need of enrollment assistance	24	24%
Finding specialists to advise on complex enrollment and coverage challenges	27	27%
Other	23	23%
Grand Total	101	100%

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.01251

ACE
ACCESS, CARE, & ENGAGEMENT

ACE TA Center TA strategy

The work of the ACE TA Center involves…

- Identifying, documenting, and disseminating best practices related to health coverage and health care access across coverage types, including **Marketplace** coverage, **Medicaid**, and **Medicare**.
- Developing T/TA resources that lead with health equity, focusing on content areas and resources that will help RWHAP recipients and subrecipients reduce disparities in health coverage enrollment and access.

ACE TA Center Webinars

- Build the capacity of RWHAP managers, staff, and enrollment assisters to engage, support, and enroll RWHAP clients in health coverage.
- Feature presenters from national, state, and community organizations who are experts in health policy, health care access, HIV, and the RWHAP.
- All webinars are recorded and available at https://targethiv.org/ace/webinars

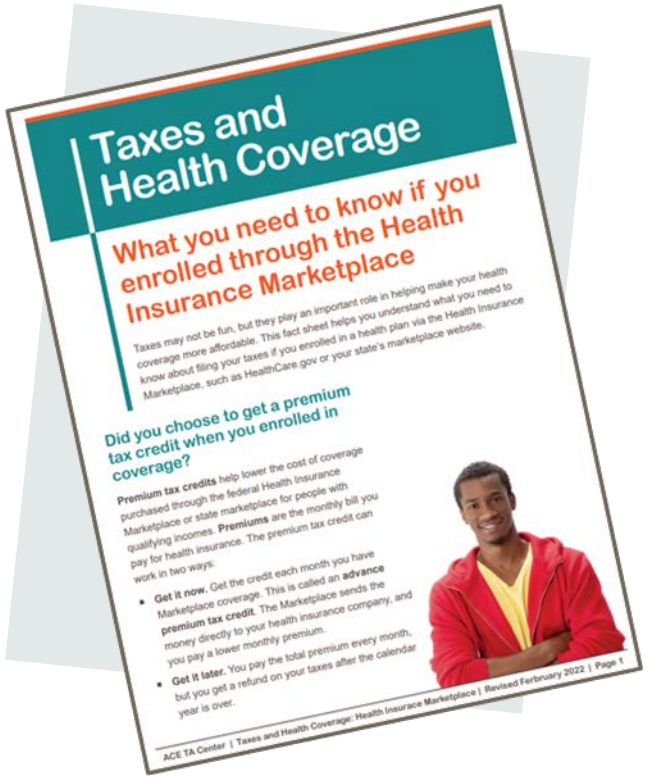
Recent webinar topics

- Navigating Medicaid Continuous Coverage Unwinding for RWHAP Clients
- Preparing for Open Enrollment: Policy Updates and Account Tune Ups
- Helping Clients Understand Tax Filing and Health Coverage
- The Basics of Medicare Eligibility for Ryan White HIV/AIDS Program (RWHAP) Clients
- Medicare-Medicaid Dual Eligibility for RWHAP Clients

ACE Tools & Resources

- Tools and resources are developed for a variety of audiences, including RWHAP administrators, case managers, staff, and clients.
- Resources are organized by coverage type
  - Marketplace
  - Medicare
  - Medicaid
- Consumer resources are available in Spanish and Haitian Creole

Marketplace, Medicare, & Medicaid resources


Taxes and Health Coverage

What you need to know if you enrolled through the Health Insurance Marketplace

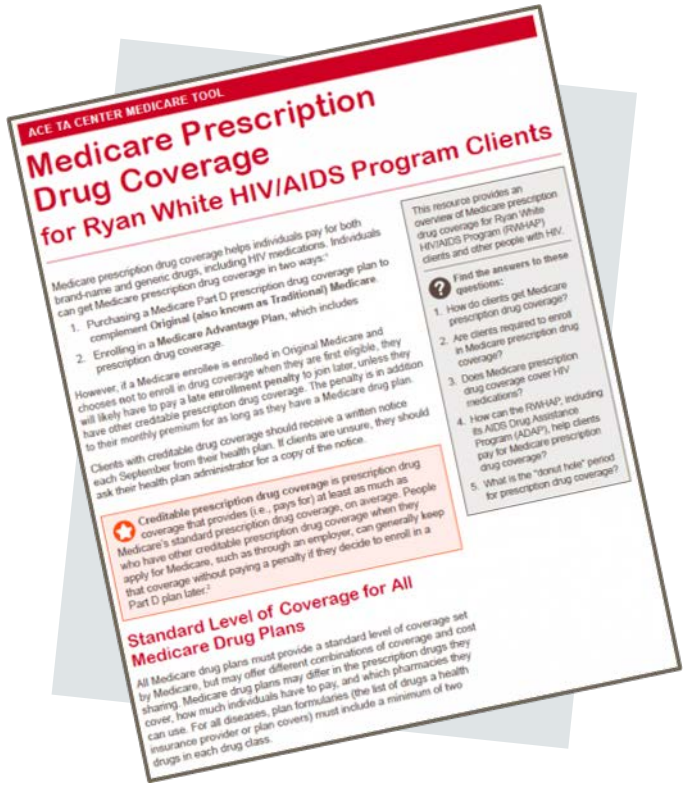
Taxes may not be fun, but they play an important role in helping make your health coverage more affordable. This fact sheet helps you understand what you need to know about filing your taxes if you enrolled in a health plan via the Health Insurance Marketplace, such as HealthCare.gov or your state's marketplace website.

Did you choose to get a premium tax credit when you enrolled in coverage?

Premium tax credits help lower the cost of coverage purchased through the federal Health Insurance Marketplace or state marketplace for people with qualifying incomes. **Premiums** are the monthly bill you pay for health insurance. The premium tax credit can work in two ways:

- **Get it now.** Get the credit each month you have Marketplace coverage. This is called an **advance premium tax credit**. The Marketplace sends the money directly to your health insurance company, and you pay a lower monthly premium.
- **Get it later.** You pay the total premium every month, but you get a refund on your taxes after the calendar year is over.

ACE TA Center | Taxes and Health Coverage: Health Insurance Marketplace | Revised February 2022 | Page 1


ACE TA CENTER MEDICARE TOOL

Medicare Prescription Drug Coverage for Ryan White HIV/AIDS Program Clients

This resource provides an overview of Medicare prescription drug coverage for Ryan White HIV/AIDS Program (RWHAP) clients and other people with HIV.

Find the answers to these questions:

1. How do clients get Medicare prescription drug coverage?
2. Are clients required to enroll in Medicare prescription drug coverage?
3. Does Medicare prescription drug coverage cover HIV medications?
4. How can the RWHAP, including its AIDS Drug Assistance Program (ADAP), help clients pay for Medicare prescription drug coverage?
5. What is the "donut hole" period for prescription drug coverage?

Medicare prescription drug coverage helps individuals pay for both brand-name and generic drugs, including HIV medications. Individuals can get Medicare prescription drug coverage in two ways:[1]

1. Purchasing a Medicare Part D prescription drug coverage plan to complement **Original (also known as Traditional) Medicare**
2. Enrolling in a **Medicare Advantage Plan**, which includes prescription drug coverage.

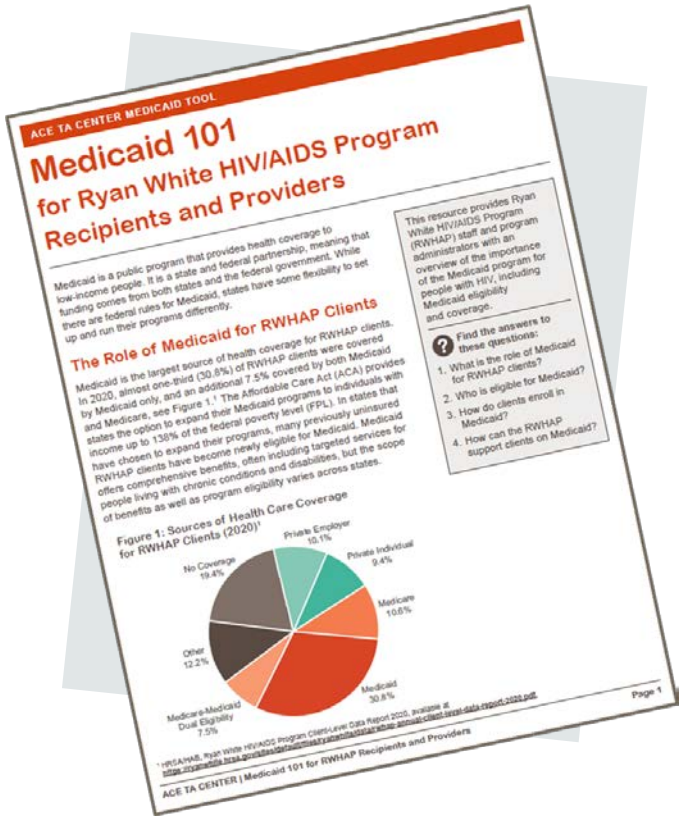
However, if a Medicare enrollee is enrolled in Original Medicare and chooses not to enroll in drug coverage when they are first eligible, they will likely have to pay a late **enrollment penalty** to join later, unless they have other creditable prescription drug coverage. The penalty is in addition to their monthly premium for as long as they have a Medicare drug plan.

Clients with creditable drug coverage should receive a written notice each September from their health plan. If clients are unsure, they should ask their health plan administrator for a copy of the notice.

Creditable prescription drug coverage is prescription drug coverage that provides (i.e., pays for) at least as much as Medicare's standard prescription drug coverage, on average. People who have other creditable prescription drug coverage when they apply for Medicare, such as through an employer, can generally keep that coverage without paying a penalty if they decide to enroll in a Part D plan later.[2]

Standard Level of Coverage for All Medicare Drug Plans

All Medicare drug plans must provide a standard level of coverage set by Medicare, but may offer different combinations of coverage and cost sharing. Medicare drug plans may differ in the prescription drugs they cover, how much individuals have to pay, and which pharmacies they can use. For all diseases, plan formularies (the list of drugs a health insurance provider or plan covers) must include a minimum of two drugs in each drug class.


ACE TA CENTER MEDICAID TOOL

Medicaid 101 for Ryan White HIV/AIDS Program Recipients and Providers

This resource provides Ryan White HIV/AIDS Program (RWHAP) staff and program administrators with an overview of the importance of the Medicaid program for people with HIV, including Medicaid eligibility and coverage.

Find the answers to these questions:

1. What is the role of Medicaid for RWHAP clients?
2. Who is eligible for Medicaid?
3. How do clients enroll in Medicaid?
4. How can the RWHAP support clients on Medicaid?

Medicaid is a public program that provides health coverage to low-income people. It is a state and federal partnership, meaning that funding comes from both states and the federal government. While there are federal rules for Medicaid, states have some flexibility to set up and run their programs differently.

The Role of Medicaid for RWHAP Clients

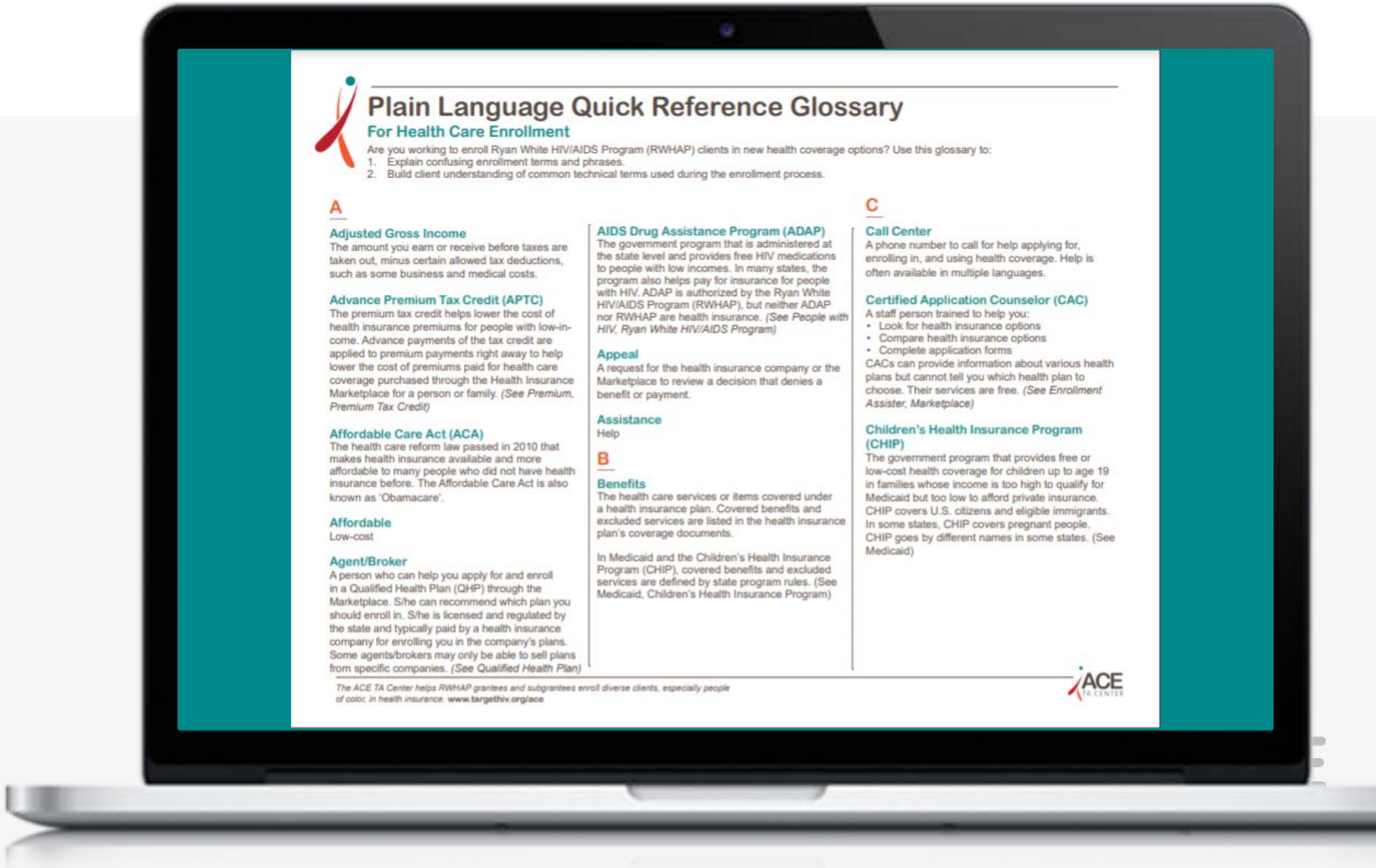
Medicaid is the largest source of health coverage for RWHAP clients. In 2020, almost one-third (30.8%) of RWHAP clients were covered by Medicaid only, and an additional 7.5% covered by both Medicaid and Medicare, see Figure 1.[1] The Affordable Care Act (ACA) provides states the option to expand their Medicaid programs to individuals with income up to 138% of the federal poverty level (FPL). In states that have chosen to expand their programs, many previously uninsured RWHAP clients have become newly eligible for Medicaid. Medicaid offers comprehensive benefits, often including targeted services for people living with chronic conditions and disabilities, but the scope of benefits as well as program eligibility varies across states.

Figure 1: Sources of Health Care Coverage for RWHAP Clients (2020)[1]

[1] HRSA/HAB, Ryan White HIV/AIDS Program Client-Level Data Report 2020, available at https://ryanwhite.hrsa.gov/sites/default/files/media/publication/rw-hiv-aids-annual-client-level-data-report-2020.pdf.

ACE TA CENTER | Medicaid 101 for RWHAP Recipients and Providers | Page 1

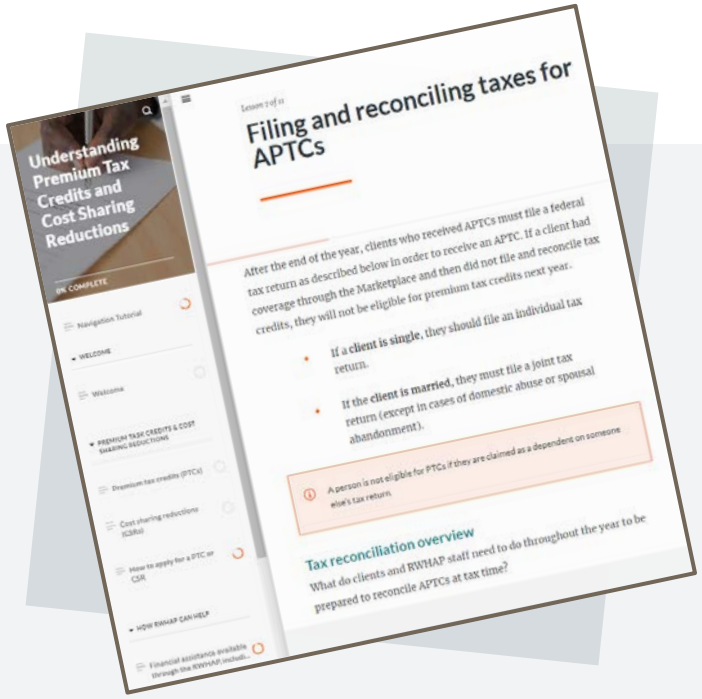
Plain Language Glossary

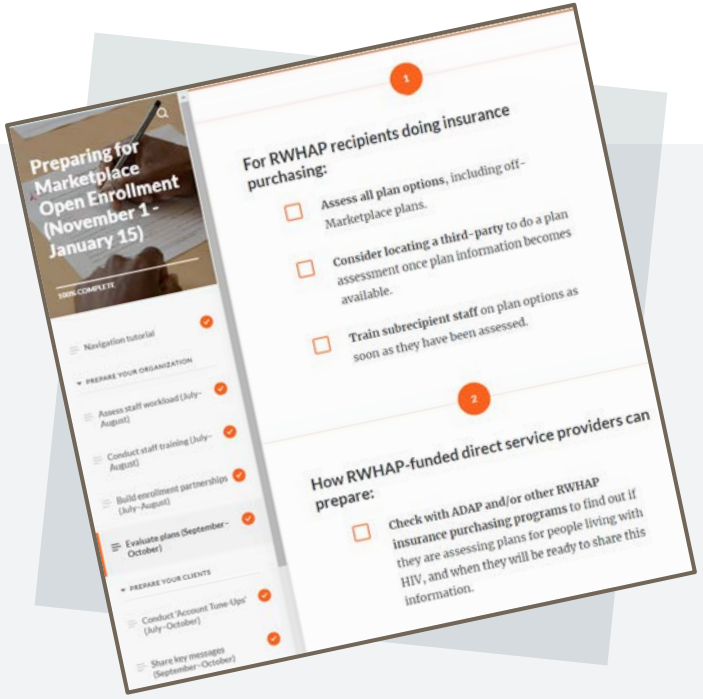


Also available in Spanish and Haitian Creole!

E-Learning modules

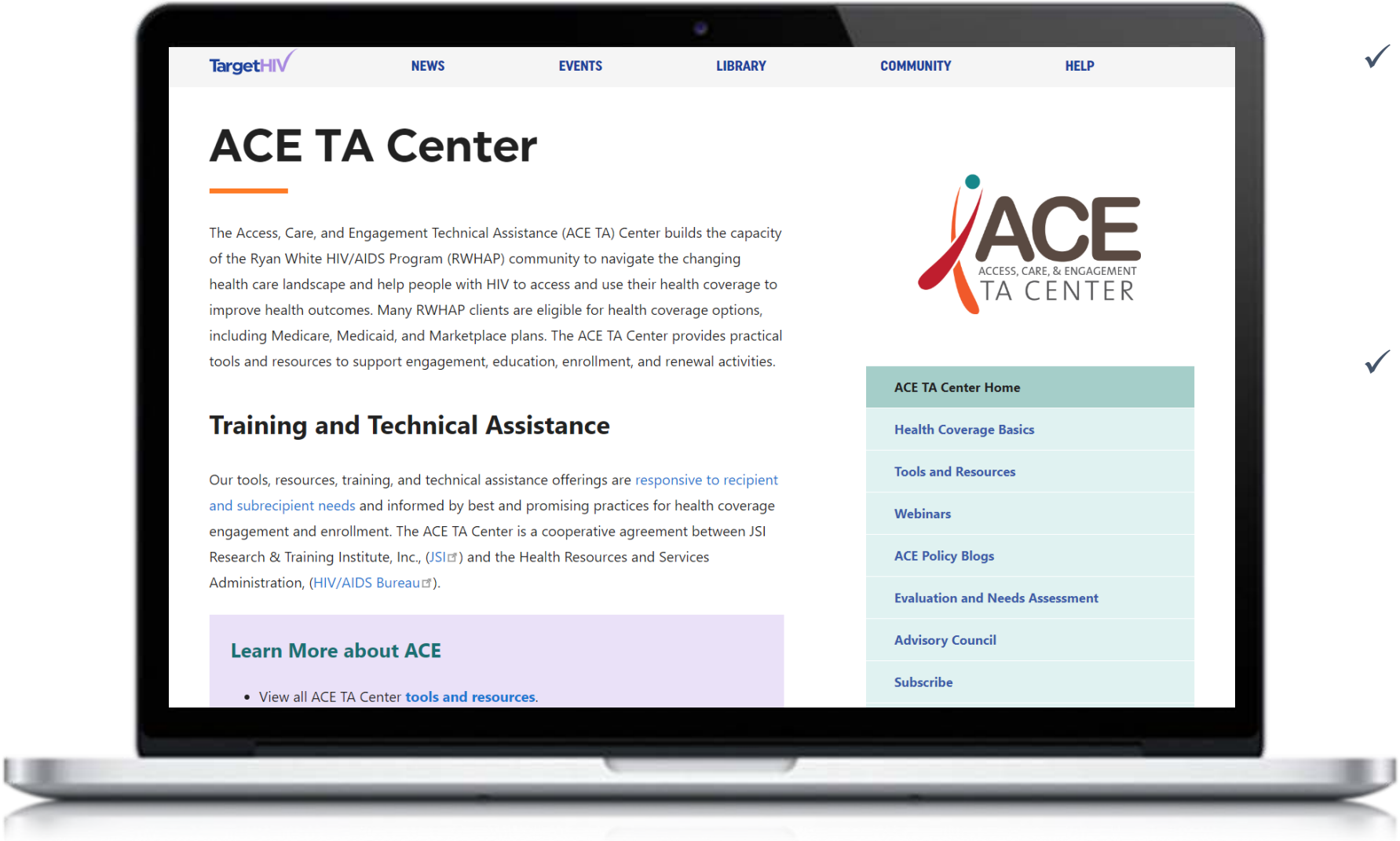
- Online training modules that provide RWHAP staff access to the content and tools at any time, and in a more interactive format than an archived webinar.
- Users can freely navigate between topics and access tools related to each topic, including implementation tips.
- Introductory level courses are great for new RWHAP staff, or those new to enrollment
  - *Introduction to the ACE TA Center*
  - *Basics of Health Coverage*
  - *Preparing for Open Enrollment*





ACE
ACCESS, CARE, & ENGAGEMENT

Visit Us: targethiv.org/ace



- ✓ Want to receive policy updates, webinar announcements, and new tools and resources directly in your email inbox? Sign up for the ACE TA Center email list.
- ✓ Encourage your subrecipients and partners to also join our email list!

Contact Information

Dori Molozanov

NASTAD

Senior Manager, Health Systems Integration

dmolozanov@nastad.org

ACE TA Center

acetacenter@jsi.com

Sign up for our mailing list, download tools and resources, and more at **targethiv.org/ace**

Questions?