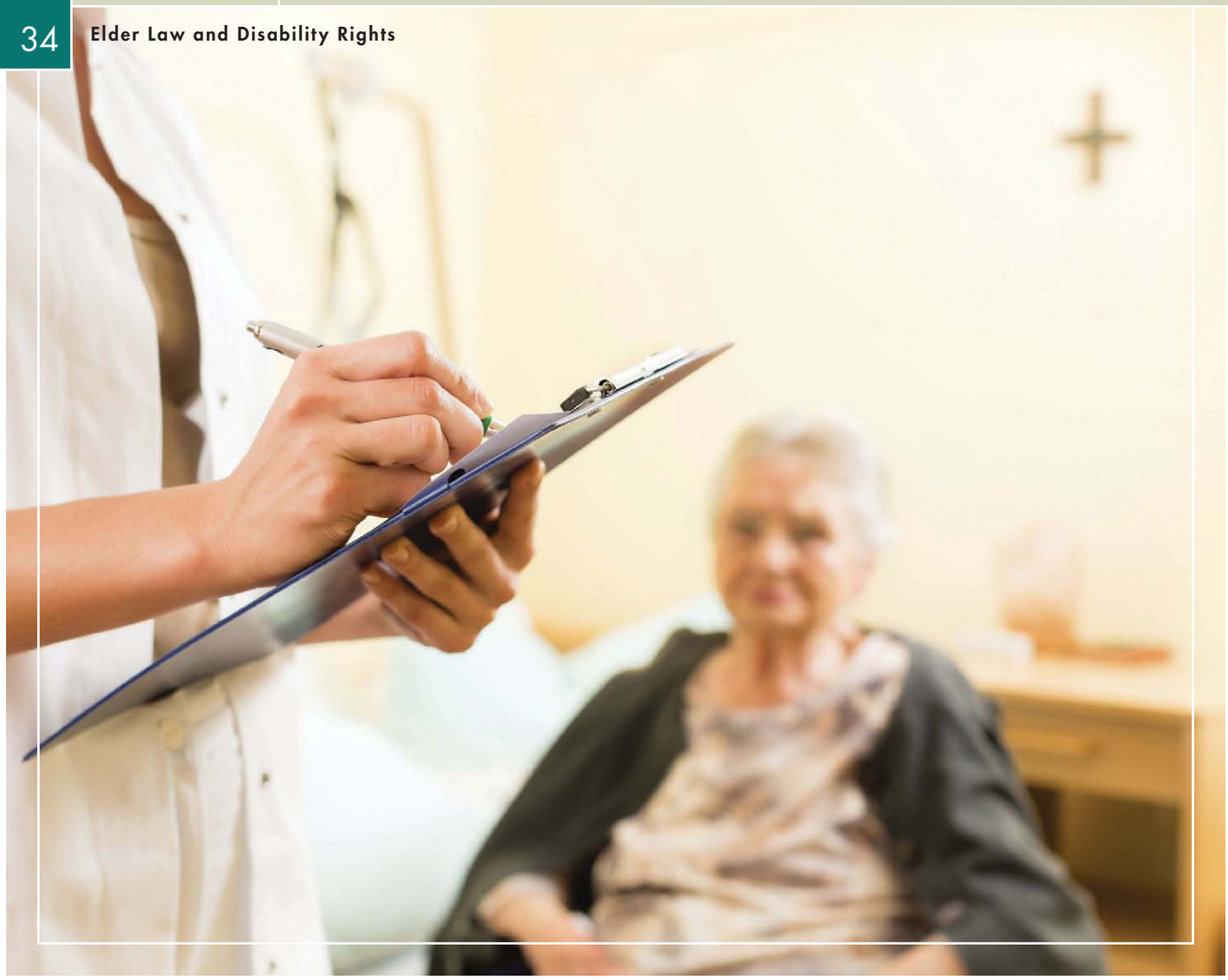

Advising Clients on Medicare

By Christopher W. Smith

For too long, Medicare has been the forgotten stepchild of elder law. Few attorneys know its ins and outs, and most struggle to profitably integrate it into their law practices. Yet Medicare will impact nearly every client and is a crucial component of our clients' long-term financial and physical health. It is true that few, if any, attorneys are currently getting rich advising only on Medicare benefits. But with the rise of private insurers delivering Medicare coverage and a corresponding financial pressure on Medicare providers to cut costs, clients need our assistance obtaining proper coverage and services in this increasingly complex area.

So where do you begin? First, split Medicare into two categories: (1) ensuring clients have proper Medicare coverage (what I refer to as Medicare planning) and (2) making sure clients receive the Medicare services to which they are entitled (what I refer to as Medicare advocacy). A good overview of these distinctions is not only useful for our practices, but also for our own families.

Medicare planning: ensuring proper Medicare coverage

For its first 30 years, Medicare was fairly simple. Clients had Medicare Parts A and B and a Medigap or retirement plan, and

generally had comparable, quality coverage. Today, the landscape is much different. What is driving the change?

- Almost one in three Michigan Medicare beneficiaries now receives Medicare coverage from private insurance companies in the form of Medicare Advantage plans.[1]
- Medicare Part D prescription drug plans began in 2006.
- The benefits in employer-sponsored retirement health plans are being cut almost universally.
- In June 2016, more than 200,000 Medicare beneficiaries in Michigan face an uncertain future when Blue Cross Blue Shield of Michigan is no longer required to offer its reduced-priced medical underwriting Legacy Medigap plans.

Our clients are understandably overwhelmed and have few places to seek unbiased advice. No, lawyers are not insurance salespeople. But if we do not ensure that clients have good Medicare coverage, can we really claim to be providing them with comprehensive long-term planning advice?

While a full discussion of Medicare coverage is beyond the scope of this article, the following are some general tips.

- **Know when a client first enrolls in Medicare**. For most people, that is three months before turning age 65 (and coverage becomes effective the month of birth), even if an individual receives early Social Security. However, if an individual is receiving healthcare coverage *through current employment* (including a spouse's employer), Medicare enrollment can be delayed until retirement. Failing to enroll at the right time can result in substantial lifetime penalties.
- **Medigap ("Medicare Supplemental") plans remain the benchmark**. All clients should have medical coverage beyond Medicare Parts A and B, and Medigap still provides the most comprehensive coverage. Further, there are no networks with these plans, meaning clients are generally covered at all Medicare providers throughout the country. Medigap is simple to understand, and the main difference between companies is price. Importantly, an individual is entitled to a Medigap plan without underwriting for the first six months he or she starts receiving Medicare Part B, so this can be an important time to enroll. However, if an individual gets Medigap, he or she will still need to enroll in a prescription drug plan (Part D).
- **Medicare Advantage plans serve a purpose**. Medicare Advantage plans (now more frequently called Medicare Health plans) are basically an alternative way to receive Medicare from private insurers. Most look very similar to employer-based insurance with networks and co-pays. Many Medicare advocates readily dismiss Medicare Advantage, yet there are clients who may be unable to afford a Medigap plan or have a preexisting condition that may prevent enrollment in such a plan. Because Medicare Advantage plans now have out-of-pocket limits (a component of the Affordable Care Act), they generally provide greater protection than having only Medicare Parts A and B. So while I usually prefer to see clients enrolled in a Medigap plan, a Medicare Advantage plan is generally better than no supplemental coverage at all.
- **Always shop for prescription drug plans and Medicare Advantage plans at Medicare.gov**. In contrast to the government's recent struggles with the health exchange website, Medicare runs an excellent website for comparing prescription drug plans and Medicare Advantage plans at Medicare.gov. Clients should use this website when reviewing and choosing plans and never go directly to one insurance company. As advocates often say, if you have seen

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FAST FACTS

Medicare is much more complicated than it was a decade ago.

Ensuring proper Medicare coverage is an important component of good elder planning.

Because Medicare insurers and health providers are typically paid a flat rate regardless of the services provided, clients increasingly need our advocacy to receive the services to which they are entitled.

one Medicare Advantage plan or prescription drug plan, you have seen one plan. Each one is different, and Medicare.gov is the best place to review all the options. Offer to help a friend or client use Medicare.gov to review plans to get an understanding of how the site works.

- **Prescription drug plans and Medicare Advantage plans require annual reviews**. Our clients must review prescription drug plans and Medicare Advantage plans and prepare to change plans each year, if appropriate. I often say that prescription drug plans and Medicare Advantage plans are one-year marriages. The plans can (and probably will) change the terms of the "marriage" yearly beginning January 1. Thus, our clients need to determine whether to stay with the plan or choose another one each year during the period between October 15 and December 7.
- **Retirement plans must be reviewed**. Over the years, employers and unions have increasingly placed their members in plans more akin to Medicare Advantage. These retirees are often unaware of the changes until faced with significant medical bills or service denials. So we cannot assume a client with a retirement plan has appropriate coverage. Yes, the plan may be cheap (or even free), but the client must compare the plan to original Medicare benefits (i.e., Medicare Parts A and B with no additional coverage) to determine what, if any, additional benefits he or she is receiving.
- **Understand special enrollment periods**. You can often help clients by knowing that Medicare has certain exceptions to when they can get or change plans. These are called special enrollment (or special election) periods. The elder practitioner should know that a beneficiary in a facility or on Medicaid (including the Medicare Savings Program and Extra Help for prescription drugs) can generally make changes to his or her Medicare plan at any time.

It may not be cost-effective for you or your staff to assist clients with choosing specific plans (although many clients will be willing to pay for this service, particularly when they first reach age 65). Some independent insurance agents will use Medicare.gov to review plans and honestly choose the best plans for clients as opposed to those that pay the best commissions. But you should interview these agents closely and remain involved in the plan selection process until you are confident that the agent is putting your clients' interests first. Alternatively, develop a relationship with a reliable volunteer counselor from MMAP, Inc.—Michigan's federally funded Medicare counseling organization—who can assist your clients with selecting and reviewing plans.

Medicare advocacy: getting Medicare services for your client

Historically, most elder law attorneys have not actively assisted clients in obtaining Medicare services and appealing denials. This is a missed opportunity. But as Medicare Advantage plans become more prevalent, and as healthcare providers deal with greater reimbursement pressures, clients will increasingly find themselves being denied services and will need our assistance.

While the entire range of Medicare services is important, attorneys are most likely to find themselves advocating for Medicare Part A services: hospitals, skilled nursing and rehabilitation facilities, home health (which can be Parts A or B), and hospice. These services are generally the most expensive and are crucial to our clients' long-term recovery and quality of life.

There is no one right way to do Medicare advocacy. A copy of *How to Win Friends and Influence People* is probably more useful than the actual Medicare rules themselves. There are also hundreds of reasons why Medicare advocacy may be warranted. If something "does not feel right" about what a client is being told concerning his or her coverage, it often means that the client is not receiving the Medicare benefits he or she is entitled to and needs our assistance.

If you have a good relationship with a Medicare provider (e.g., a hospital or skilled nursing facility), I encourage you to talk with

that provider about your anticipated role in Medicare advocacy well in advance of needing to advocate for a particular client. Because Medicare appeals typically occur on a tight timeline (sometimes minutes), you may not have a chance to talk to a facility's representatives before an appeal deadline. There are plenty of ways to create wins for both your client and the provider, but it may be difficult to achieve once an appeal has been filed. Talking with a provider before filing an appeal may prevent a bruised relationship and even the need for an appeal.

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There are times when the interests of our clients and the interests of providers are in direct conflict. This is because the reimbursement rates for most Part A services are at least partially based on a client's diagnosis and not the client's actual use of services. This method of reimbursement, called the prospective payment system, can create a direct conflict between our clients and providers who do not want to lose money.

If you must appeal, make every effort to appeal before the expedited appeal deadline. This is typically the day of a hospital discharge and by noon of the day before a skilled nursing discharge. Otherwise, a client may have to pay for services while an appeal is pending, and the appeal process may take longer. The client should receive proper notices explaining the appeal process and discharge date; if he or she does not, that itself is a basis for appeal. While expedited appeals are initiated by a telephone call, always follow up in writing to explain your arguments and, if possible, include supporting medical evidence.

There are also different ways to advise clients on Medicare advocacy. Some attorneys prefer to coach clients, which typically involves a series of phone conversations to help clients navigate the Medicare processes. A simple phone call can often calm emotions and empower clients to assert themselves. If you have the resources to do it (and your clients will pay you), nothing beats doing the advocacy yourself. Ideally, you will involve independent nurses or social workers to help make your case, and it may require that you visit the hospital or facility. Statistically, if you can do full-service advocacy, your chances of success are very good.

Currently, these are some of the most pervasive issues in Medicare advocacy:

- **Clients failing to be admitted to the hospital**—Ensure clients are actually admitted to the hospital *instead* of being placed on observation status. The latter can harm clients in several ways, but the greatest harm is that our clients do not meet the three-night requirement to qualify for skilled nursing benefits.
- **Incomplete discharge plans**—Discharge planning is supposed to be a Medicare benefit for our clients, but it is more commonly used as a way to get patients out of the hospital or facility more quickly. If a client does not have a safe and effective discharge plan, that may be a basis for appeal.
- **Skilled-care discharges because clients have plateaued or failed to show improvement**—Even today, many clients will be told that skilled-care services are ending because they plateaued or failed to show improvement. This has never been the rule, and was reconfirmed in a recent settlement entitled *Jimmo v Sebelius*.[2] The restoration potential of a client is not the deciding factor for skilled services; rather, a patient may need skilled services to prevent further deterioration or preserve current capabilities.

Conclusion

It will be a while before Medicare assumes the same prominence as Medicaid or veterans benefits in elder practices. However, Medicare's time will eventually come. Starting to integrate Medicare into your practice will not only put you ahead of the policy and demographic curve, but will also give you more advocacy tools to directly improve the lives of your clients. ■

Christopher W. Smith is an attorney at Chalgian & Tripp Law Offices, PLLC, where he practices elder and special-needs law. He is a former volunteer Medicare counselor for MMAP, Inc., and a frequent speaker on Medicare topics. He can be reached at (517) 787-7600 or smith@mielderlaw.com.

ENDNOTES

1. Kaiser Family Foundation, *Medicare Advantage Fact Sheet* (May 1, 2014) <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet> (accessed October 13, 2014).
2. *Jimmo v Sebelius*, unpublished opinion and order of the U.S. District Court in Vermont, issued October 25, 2011 (Docket No. 5:11-CV-17).