



ELDER LAW LETTER

The Newsletter for the TBA's Elder Law Section



Finding Your Way Through the Part D Maze — Getting Started

by Pam Wright

Are you struggling to get your arms around the new Medicare Part D insurance plans? Sadly, you are not the only one. Medicare recipients and providers are understandably overwhelmed by the difficulties in navigating the system. The good news is that there is a wide array of tools available to help advisors and consumers learn the basics of the system. The bad news is that most of these tools are found on the internet — not enough help for seniors and disabled Medicare recipients, most of whom are not “wired” or “tech savvy.” Therefore, beneficiaries are relying on family members, social agencies, elder law attorneys and other advisors for help. With the new year, you can’t put off learning about Medicare Part D any longer. Here are some tips to get you started.

Start with the basics. These publications do a good job covering the basics:

AARP’s *Medicare Prescription Drug Coverage — Your Questions Answered* (this can be downloaded at

<http://www.aarp.org/bulletin/medicarerx/>);

Consumer Union’s “Basic Facts about the New Medicare Prescription Drug Plan” (available at <http://www.consumersunion.org/pdf/MedicareQA.pdf>) and *Medicare Drug Coverage 101* and other materials from the Medicare Rights Center (<http://www.medicarerights.org/>).

Try the *Medicare Formulary Finder* for comparison shopping. Part D prescription drug insurance is available to every Medicare beneficiary. Part D coverage is a privatized system — meaning that the insurance plans are marketed and administered by private insurance companies.

Every plan has a different cost-sharing arrangement and formulary. There is no standardization as there is with Medigap policies. The “formulary finder” at www.medicare.gov is a tool which consumers should use to organize their shopping and find the plan that best meets their needs. To make a general search using the

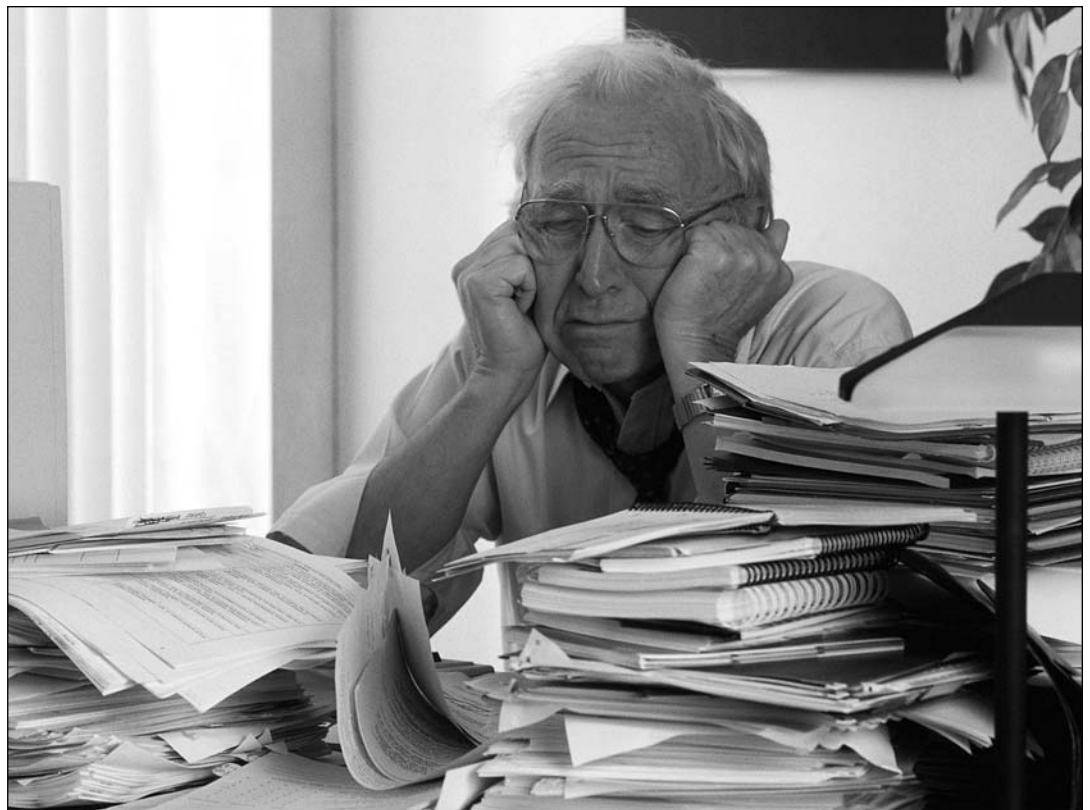
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Letter from Chair: TBA's August 19, 2005 Elder Law Basics Program

By Kelly Frere

The Opryland Hotel in Nashville, Tennessee brings together many intriguing features: indoor tropical oases, flatboats navigating a lagoon, roaming performers, sumptuous restaurants, unique shops — even Relâche, a state of the art spa and fitness center. On August 19, 2005 it also brought together 75 attorneys from all reaches of the country for a serious, get-down-and-dirty study in the basics of Elder Law.

Jointly sponsored by NAELA and the Elder Law Section of the Tennessee Bar Association, these two and one-half days of substantive study gave newbies, and a few seasoned practitioners, an opportunity to take a long hard look at what it means to be an Elder Law attorney — one who approaches the practice of Elder Law from a holistic standpoint. The presenters — Stu Zimring, Larry Frolik, Steve Silverberg, Bill Browning, Pam Wright, David McGuffey, Tim Takacs, Lauchlin Waldoch and Jo-Anne Jeffreys — are simply the best at what they do, and all took time to emphasize that it is the many needs of the client that must be considered, not just the “spend down” needs with a focus on Medicaid qualification.

Session evaluations gave a clear indication that this seminar is one to be repeated. “Best program I’ve been to in fifteen years!” “I have been in law practice for 27 years. This is one of the best seminars I have ever attended.” “I brought extra reading in case this seminar was boring. I NEVER TOUCHED IT! Every speaker was excellent.” And, a comment that we would like to hear from a client: “I felt nurtured and accepted notwithstanding my extreme ignorance on this subject.”

At the heart of this program was the passion of the speakers for the specialty they have so warmly embraced, and the desire to convey to the attendees that the practice of Elder Law is unique. The clients are seniors, but not old. They are frail, but not useless. They are often sick, but not without the right to determine their destiny. Medicaid is not always the answer. At all times, the client is our priority, not the desires of other family members or the strictures of the government.

This seminar began on Friday with the words of Rebecca Morgan as presented so aptly by Stu Zimring, “What is Elder Law?” It would end two and one-half days later, at the end of six hours of intensive case study. The number and diversity of practice areas covered might appear mind-boggling; the certified Elder Law attorney is expected recognize a minimum of 18 senior related issues, both legal and non-legal.

Friday continued with several excellent presenta-

tions. David McGuffey spoke on ethical issues in his program, “Who’s the Client?” Larry Frolik with the assistance of materials prepared by Tim Takacs, crammed Social Security, SSI, SSDI, Railroad, Veteran’s, Medicare, Department of Defense, and even Housing benefits into an hour lecture. Planning with Retirement Funds with Bill Browning and Wills, Trusts, and Basic Taxation with Steve Silverberg followed. Cindy Barrett’s presentation on Guardianship/Conservatorship went beyond the basics by touching on same sex couple plan-

ning, interstate guardian disputes, and using a guardianship to establish and fund a special needs trust. In his presentation on Housing Issues, Stu Zimring introduced attendees to a NORC, a Naturally Occurring Retirement Community, “a cluster of people 55 and over who come together to provide supportive services to enable them to age in place.”

Saturday brought a new day, and with it the meat of medical assistance planning. Basics of Medical Assistance (Pam Wright), Medicaid Eligibility (Lauchlin Waldoch), Spousal Impoverishment (Tim Takacs), Medicaid Basics (Jo-Anne Herina Jeffreys), and finally, the case studies with small breakout groups all led by advanced practitioners. Every attendee walked away with a review of two case studies — start to finish — which included not just the assumption of Medicaid, but issues relating to ethics, children with special needs, veteran’s benefits, property (both real and personal), retirement benefits, income cap, inheritance, estate planning documents, guardianships, and tax consequences.

The partnership between the Elder Law Section of the Tennessee Bar Association and NAELA has hit on something with this program, which provided superior instruction and insight to attorneys who are in the early stages of an Elder Law practice (or even just considering one). As one attendee remarked, “There is more to this than I thought.” This is not the practice for everyone. But, some will use this seminar as a catalyst to crossing that line into the true, noble (don’t laugh, it’s still a good word!) practice of Elder Law. What more can you ask of two and one-half days? ■

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Medicaid Update: Qualified Income Trusts

By William King Self, Jr.

As most section members know, the Department of Human Services eliminated the “medically needy” income exception for long term care Medicaid as of April 29, 2005. Formerly, applicants could be financially eligible for Medicaid if their incomes were less than their monthly cost of medical care in the nursing home (hence, “medically needy”). The new income cap for Medicaid is \$1,809/month beginning January 1, 2006. That means that all new Medicaid applicants with income above that amount will be ineligible unless they put their income into a qualified income trust (sometimes called a “Miller trust”). These trusts are actually a form of special needs trust, which are described in U.S.C. §1394p(d)(4)(B). The QIT basically makes any of the income placed in the trust non-countable against the income cap limit in the month received and transferred. The trusts are relatively simple to prepare but they require the attorney to have a working understanding of how they work so the attorney can explain them to the client.

DHS personnel have told me and other attorneys that the current nursing home residents who are already Medicaid recipients are “grandfathered” in under the old rules: they will not have to qualify under the income cap guidelines when their cases come up for annual review. We had all feared a torrent of cases from the large number of Medicaid recipients already in the nursing homes, so that has been good news, even though DHS apparently hasn’t issued a formal bulletin with notice of the policy.

DHS has issued guidelines and even a basic trust form to follow, so the cost of the trusts to the client shouldn’t be as much as a normal SNT. I’ve been recently told by one DHS worker that they were being cautioned not to accept a simple re-typing of their sample trust, so you’ll need to be sure to properly “flesh out” the one you use so that it has the provisions that should be put into a basic SNT. The sample form is about 3-4 pages long, and it is definitely bare bones construction. (Section members may download DHS bulletins from the Section web page on the TBA website.)

The trust must be signed by the trustee and the grantor or his agent. If the applicant doesn’t have the mental capacity to act as grantor of the trust, someone holding a power of attorney will be needed to sign as grantor. If there is no power of attorney, you will need to petition for appointment of a conservator and request the court grant the conservator authority to sign the trust for the grantor. Obviously, this is much more time-consuming than simply preparing and explaining to the client how the trust works, and unfortunately the applicant and the client often have little money to pay for this work.

The basic QIT format gives alternative methods for operating it: the grantor (more typically a family

member who is his agent) transfers either (a) all the monthly income received by the grantor into the trust each month when received, or (b) enough of the income so that the amount of income received but left outside the trust is no more than the monthly income cap amount (\$1,809). (Obviously, the Medicaid recipient’s non-trust countable assets are limited to \$2,000 because of the basic Medicaid asset limitations.) DHS workers have told me that they prefer, for simplicity reasons, that the grantor put all his monthly income into the trust rather than just the amount that is over the monthly cap.

Here’s how the trust should work, assuming all income is put into it each month:

Assuming the patient/grantor is unmarried and has received his \$2,400 monthly income but has not paid the nursing home for that month, the grantor transfers \$2,400 from the non-trust bank account into the trust in the first month he is otherwise eligible for Medicaid. That makes his bank account go from \$3,400 down to \$1,000, and so he’s asset-eligible. He has a monthly Medicare supplemental policy costing \$140/month which he can keep in place.

Once DHS approves the application, they will send a standard letter confirming his eligibility and saying the patient’s monthly responsibility for nursing home care is \$2,200.

The trustee then writes a \$40 check for the patient’s personal needs allowance, a \$140 check paying the supplemental insurance premium, and \$2,200 to the nursing home for his patient liability. (Currently DHS allows \$20/month to stay in the account to cover bank charges, but they may modify that in the future, since the accounts rarely have high monthly costs.)

If the grantor is married, the DHS letter should tell him how much can be paid from the trust to the spouse.

The trustee will have to file an accounting on an annual basis to DHS, but there is no word yet on how involved that accounting might be.

I have met with the two Shelby County Probate judges about the conservatorship problem for incapacitated applicants without powers of attorney and little money to pay for legal services. While they are sympathetic, our judges are afraid to routinely simplify the conservatorship process by waiving appointment of a guardian ad litem, bond and accountings. They have been willing to work with us on a case by case basis to waive some requirements, however. One concern the judges have is the potential for abuse of the conservator who will be transferring substantial income each month into the trust and then paying it out from the trust. To protect the disabled person’s assets, they are inclined to require we establish a conservatorship of the estate (rather than just of the person with specific authorization to sign the trust and act as trustee),

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formulary finder, the consumer will enter his zip code, list of medicines and preferences for pharmacies. Using that information, the plan organizes a list of insurance plans available in the geographic area and sorts them by costs or best formulary match. The consumer can also do a personalized search, entering his Social Security number, and then proceed to enroll on-line. The personalized search also enables the consumer to apply for low-income assistance if appropriate. Once consumers narrow down the choices they want to consider, they will want to double-check formulary, cost and other information by visiting the web sites of the particular plans they are considering.

Learn who needs to enroll before May 15, 2006. Beneficiaries can choose to enroll or not. But, as with Part B enrollment, delayed enrollment is penalized by increasing the cost of the monthly premium (for most people). Some Medicare beneficiaries have drug coverage through other medical insurance or through a retirement plan. They should have received a notice

telling them if their present drug coverage has been deemed “creditable” by Medicare. That means that the drug coverage is equivalent to or better than the part D coverage. Anyone with creditable coverage can ignore part D or can choose to enroll at a later time without penalty. Drug coverage through TriCare or the VA is creditable. There is a helpful sheet explaining how the VA program compares with Part D at <http://www.cms.hhs.gov/partnerships/downloads/VA.pdf>.

Persons who are dually eligible for Medicaid and Medicare can enroll at any time without penalty. Medicaid no longer covers prescription drugs for persons who also have Medicare. For that reason, it is usually advantageous to enroll early, especially if they can qualify for low-income assistance. In fact, anyone who had TennCare during 2005 should have been automatically enrolled in Medicare Part D and qualified for some low-income assistance. Unfortunately, national news reports tell us that this “auto enrollment” portion of Medicare Part D has failed, so those folks are struggling to get through the transition.

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There are other helpful web sites which have educational information geared to the consumer or advocate, policy discussions and updates.

- www.aarp.org
- www.healthassistancepartnership.org
- www.medicareadvocacy.org
- www.medicarerights.org
- www.kff.org/medicare/index.cfm
- www.familiesusa.org
- www.consumersunion.org

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appoint a guardian ad litem, and set a minimal bond.

Hopefully this simplified explanation will clarify some issues for elder law attorneys who wish to prepare qualified income trusts for clients. If there is enough interest, the section may consider posting a pro-forma trust on the TBA website for reference. ■

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Finding Your Way Through the Part D Maze *(continued from page 4)*

Brush up on your knowledge of Medicare managed care. There are two kinds of prescription drug insurance plans. The media coverage has focused on the stand alone Prescription Drug Plans (PDPs). The Medicare Modernization Act, in addition to adding Part D, included significant initiatives to encourage more private Medicare plans, like HMOs, PPOs and private-fee-for-services plans. These plans (once called Part C plans) are called Medicare Advantage plans. Some of the Medicare Advantage plans also include the Part D coverage.

In Tennessee, there are 17 companies offering 41 stand-alone Prescription Drugs Plans. The list is at <http://www.medicare.gov/medicarerereform/mapdpdocs/PDPLandscapetn.pdf>.

There are 9 Medicare Advantage Part D companies offering another 41 plans in Tennessee. The list, sorted by county, can be found at <http://www.medicare.gov/medicarerereform/mapdpdocs/MALandscapetn.pdf>.

In the midst of the Part D confusion, salesmen are aggressively marketing Medicare Advantage plans, especially in areas of the state that have not had Medicare managed care plans before. Unfortunately, many seniors are purchasing these plans without fully understanding how they work; and they are sometimes devastated when they learn that they have opted to leave traditional Medicare coverage.

Share your knowledge. Check your local paper and you will see a large array of advertisements and seminar announcements touting the benefits of Part D insurance plans. You won't find a long list of seminars offering

objective information and advice for consumers. Medicare is relying on a system of counselors called the State Health Insurance Assistance Projects to counsel beneficiaries. When anyone calls the 1-800-medicare number, they are routed to the local SHIP counselor. In Tennessee, there are 876,000 enrolled in Medicare (based on 2002 figures). Our State Health Insurance Assistance Project has only 9 paid staff who work with about 80 volunteers. You can also reach the SHIP counselor by calling 1-877-801-0044.

If you are looking for an opportunity to raise the profile of your elder law practice, this may be it. Medicare recipients are clamoring for unbiased advice and help in navigating this confounding system. SHIP counselors are confined in their role to giving information and guidance, as they cannot make specific recommendations for the individuals who call them. If you are interested offering educational seminars or materials, Medicare has handouts and presentations to help you get started at <http://www.cms.hhs.gov/center/partner.asp>. (Don't worry you can browse the materials without registering or being a formal partner.)■

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