ELDRS Update

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The End of a Legacy? How Converting BCBSM into Nonprofit Mutual Conversion Company Could Impact Our Clients

By Christopher W. Smith, Michigan Law Center, PLLC

On September 11, 2012, Governor Snyder announced a proposal to convert Blue Cross Blue Shield of Michigan (BCBSM) from a nonprofit corporation to a nonprofit mutual insurance company. Wasting no time, the full Senate approved the legislation on October 17, 2012, with a bipartisan vote of 33-4. The Michigan House is expected to consider the legislation in its lame duck session after the election and hearings are expected to be scheduled for November 13, 19, and 20. The legislation is currently contained in Senate Bills 1293 and 1294.

Justifying the legislation, Governor Snyder argues that BCBSM's special status as the "insurer of last resort" under Public Act 350 of 1980 is outdated, particularly given the requirements of the Affordable Care Act. The Governor and BCBSM further argue that there should be a "level playing field" for all insurance companies so the future market can be fair and balanced for all insurers. BCBSM will also contribute "up to" $1.5 billion over 18 years (an average of $83 million a year) to the new Michigan Health and Wellness Foundation to continue BCBSM's social mission commitment.[1]

How the Current Blue Cross Legislation Would Impact Our Clients
(It's the End of Medicare as We Know It)

The largest component of BCBSM's obligations under Public Act 350 of 1980 is a subsidized Medigap plan that is intended to be available to every Michigan Medicare beneficiary at the same price regardless of age and health condition.[2] These Medigap (aka Medicare Supplemental) plans are called the Blue Cross Blue Shield Legacy plans and are offered either as

[1] Under SB 1294, the current foundation board will consist of 13 members from 10 different interest groups who are initially appointed by the Governor with the advice and consent of the Senate.

[2] BCBSM is supposed to offer these plans to every Michigan Medicare beneficiary. Since April 2012, BCBSM unilaterally decided to stop offering these plans not only to individuals who receive premium assistance from a prior employer but also individuals who have access to a health plan through a former employer or spouse.

standardized Medigap Plan A (currently $40.42/month with tax) or Plan C (currently $122.86/month with tax). If you've ever told your client to "get the $112 Blue Cross plan" (its former price), that is the plan at risk. These plans have allowed Michigan to have the most affordable average premiums for Medigap Plans A and C in the country.[3] BCBSM subsidizes these plans by approximately $175-200 million a year.[4]

For all practical purposes, the Governor's proposal and passed Senate legislation eliminates the protections and benefits that these plans currently offer. Specifically:

- **Medicare beneficiaries under 65 (e.g., individuals with disabilities) will not be guaranteed a Medigap plan.** Federal law does not require an insurer to sell a Medigap plan to Medicare-eligible individuals under 65. Twenty-nine states have certain protections in place that allow most or all Medicare beneficiaries under 65 to get a Medigap plan.[5] Michigan is one of those states because of the BCBSM legacy plans but will lose this protection under the current legislation.

- **Medicare beneficiaries 65 and over will lose access to a Medigap plan without underwriting outside of guaranteed issue periods.** Under federal law, an insurer must sell a Medigap plan within the first six months after a person joins Medicare Part B, when an insurer stops offering a client's Medigap policy, and in a few other limited circumstances.[6] Outside of those "guaranteed issue" periods, an insurer does not have to offer an individual a Medigap policy under federal law. Because BCBSM must currently offer these plans to almost all Medicare beneficiaries, Michiganders have paid little attention to guaranteed issue periods. This will change significantly if the BCBSM legislation becomes law—and a significant Medicare protection will be lost.[7]

- **Current BCBSM Legacy Medigap policyholders will likely see significant premium increases in or around 2016.** Approximately 200,000 current BCBSM Legacy policyholders will likely see significant premium increases in or about 2016. Michigan Attorney General Bill Schuette

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[3] Gretchen Jacobson, et al., Medigap Reform: Setting the Context, Kaiser Family Foundation Issue Brief, September 2011.

[4] See, e.g., Rick Haglund, Uncertainty Surrounds Future of Blue Cross Medigap Coverage, MLive, October 9, 2012 (stating BCBSM provides a Medigap subisidy of about $200 million); Schuette Praises Agreement to Secure Permanent Protection of Blue Cross Assets for the People of Michigan, Urges Stronger Protections for Michigan's Most Vulnerable, Press Release, October 17, 2012 (stating that there are 200,000 policyholders with a subsidy of $73, equating to about $175 million a year).

[5] Three states limit this protection to individuals who do not suffer from end-stage renal disease.

[6] For more information on guaranteed issue periods, see Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare, published by the Center for Medicare & Medicaid Services.

[7] Efforts to get BCBSM to commit whether it will continue to offer Legacy to individuals outside of its guaranteed issue period for a period after this legislation has passed have been unsuccessful.

did enter into an agreement with BCBSM last year to freeze Legacy premiums until 2016, and BCBSM has stated that it plans to honor that rate freeze.[8] However, with an average subsidy of approximately $73/month, policyholders will likely see premium increases of over $875/year in or around 2016. The Senate insurance committee did pass an amendment that requires the new foundation to spend 60% of its distributions between 2016 and 2021 on Medigap subsidies. However, this will amount to only $25 million a year or replace a maximum of 12.5% of the current subsidy, which will probably not even cover inflation increases between now and 2016.

- **There will be an increased number of our clients on Medicare Advantage plans, Original Medicare without additional insurance, or even Medicaid.** Because of the increased premiums and lack of guaranteed issue rights, a notable percentage of current and future Medicare beneficiaries will be forced onto Medicare Advantage plans or original Medicare without supplemental insurance. Furthermore, there are many Michiganders who budget in the affordable Legacy premium (or a family member or a trust pays for it) but are otherwise eligible for Medicaid (either AD-CARE or Medicaid with a deductible). Additionally, for those on long-term care Medicaid, increased medical costs will decrease the patient pay amount and increase Medicaid expenditures. Thus, this legislation will not only increase medical costs for our clients, it will undoubtedly increase Medicaid expenditures in Michigan.[9]

Responding to BCBSM's Arguments Regarding the Legislation's Impact on Medicare

Over the past two months, BCBSM (along with the bill's supporters) have made a number of statements claiming that these bills will have a minimal impact on Medicare. Most of these statements are, at best, misleading. Specifically:

- **Medicare Advantage is not an equal alternative to Medigap coverage.** BCBSM has been effective in convincing many legislators that Medicare Advantage plans are a robust or even equal alternative to Medigap/Medicare Supplemental plans. As most ELDRS attorneys know, a comprehensive Medigap plan is almost always better than a Medicare Advantage plan if it is affordable to a client. With a Medigap plan, there are no doctor networks, co-pays/deductibles are predictable (if there are even any at all), there is not a mandatory prescription formulary that you must use, the rules for what the plan covers are easy to follow, most coverage decisions are made between you and your doctor without an insurance company's involvement, and you can immediately appeal a denial to an independent entity as opposed to the insurer itself.

[9] The current fiscal impact statement of the bill does not take this into consideration.

- **The Affordable Care Act does not eliminate the need to have a Medigap insurer of last resort.** BCBSM and Governor Snyder are inaccurately using the Affordable Care Act ("Obamacare") to explain why an "insurer of last resort" is unnecessary in Michigan. Regarding Medigap plans, this statement is wholly inaccurate. The Affordable Care Act did nothing to change the underwriting requirements of Medigap plans. Individuals 65 and older are only entitled to a Medigap plan without underwriting under certain limited circumstances. Individuals under 65 are never guaranteed a Medigap plan without underwriting. If anything, the Affordable Care Act makes Medigap plans more attractive because of the planned 14% cuts to Medicare Advantage plans to bring federal reimbursements in line with what the government spends on Original Medicare.

- **The rate freeze until 2016 is politically convenient but does not prevent BCBSM Legacy plans from ultimately being cut.** As stated above, BCBSM entered into an agreement with the State of Michigan to hold Legacy rates constant until 2016, and BCBSM plans to honor this agreement. However:
    - Nothing currently guarantees Legacy plans after 2016.
    - Nothing (except a miniscule subsidy by the proposed foundation) prevents significant rate hikes after 2016.
    - Nothing currently guarantees that Michiganders not in a guaranteed issue period will be able to enroll in Legacy once the legislation becomes law.
    - Nothing guarantees that Michiganders with disabilities will be able to enroll in Legacy plans once the legislation become law.

- **A $1.5 billion fund over 18 years is woefully insufficient.** BCBSM has argued that it spent at least $353 Million on subsidies for safety-net health insurance in 2007.[10] If spread out equally over 18 years, BCBSM is only going to replace this with an average annual contribution of $83 million in payments to the newly created foundation. In other words, BCBSM is practically cutting over $270 million a year in insurance subsidies or over $4.8 billion over this same 18-year period. The vast majority of these cuts affect older adults and individuals with disabilities.

Taking Action

Because the legislation is moving so quickly, it is important for as many section members as possible to contact your legislators (particularly your representative in the Michigan House) and let them know your concerns about how this legislation will impact your clients. We are finding that few legislators truly understand even the basics of Medicare, and they may appreciate

[10] Avalere Health, LLC, Valuing the Social Mission Activities of Blue Cross Blue Shield of Michigan, January 2008.

your assistance in educating them so that they can make an informed decision. The Section's Council has been working with Capitol Services on opposing the cuts to the Medigap Legacy program in the legislation. I have personally created an advocate's website at http://www.ProtectMichiganMedicare.org that may be of interest to Section members.[11] To make a difference, members of the ELDRS Section must act quickly, and your involvement is welcomed.

Legislative Update

By Ellen Hoekstra and Todd Tennis, Capitol Services, Inc.

The legislature had an active September but only the Senate returned in October for just a single day on October 17 before the November 6 election. However, a there was a great deal of administrative interest, and one significant leadership change occurred with James Haveman returning to his past role as Director of the Department of Community Health.

Blue Cross Blue Shield of Michigan Legislation Priority of Governor

The package of bills currently before the Senate Insurance Committee, SB 1293 and SB 1294, was drawn up as Governor Snyder's plan to change the insurance code to convert Blue Cross Blue Shield of Michigan (BCBSM) into a nonprofit mutual company to deal with the upcoming implementation of the Affordable Care Act (ACA). Under the current tax code, BCBSM is the only "insurer of last resort" in Michigan and thus cannot turn anyone away for prior medical conditions, and in return BCBSM has operated free from all local and state taxes. The ACA will greatly alter this dynamic by making *all* insurance companies insurers of last resort, which makes the special deal for BCBSM no longer necessary. To remedy this, the plan would convert BCBSM into a nonprofit mutual company, the only one in Michigan, and remove its tax-free status.

BCBSM agrees with the need for a change and supports the governor's plan. BCBSM states that it is in favor of fair competition among all of the state's insurance providers, and that by converting the company in such a manner, it could more easily adapt to the changing environment created by the ACA. BCBSM also claims that it is hindered by the level of government oversight under which it currently operates, resulting in rate approval taking two to ten times longer than for its competitors. The removal of such oversight, according to BCBSM, would allow the company to match the lag time of its competitors, and also allow it to take on more individual clients. The current market has almost a five times larger share of

[11] This website reflects my personal views and not necessarily the views of the ELDRS or the EDLRS Council.

individual clients than BCBSM has under its certificates (under, of course, BCBS's original intent and design).

Kevin Clinton, the Commissioner of the Office of Financial and Insurance Regulation, explained in his report to the Senate Insurance Committee that BCBSM, on top of newly paying $100 million annually in taxes, will be required to pay $1.5 billion over 18 years to a newly-created nonprofit organization. This money is meant to remove the tax-exempt advantage BCBSM has had for so many years. The new nonprofit would have a social mission to assist in children's and senior issues, and coupled with other taxes and revenues, the newly created nonprofit foundation will likely receive closer to $3.6-4.3 billion over the 18-year period. Safeguards will be put in place to ensure that BCBSM stays a nonprofit and stays in Michigan. If it converts to a for-profit enterprise or leaves the state, it must pay the fair market value of BCBSM at that time to the new nonprofit.

Attorney General Schuette has expressed opposition to the bill package. He wants to see a full financial review of the company before the conversion is made. Clinton responded by asserting that BCBSM would only need a fairness assessment because the company is only undergoing a conversion, and not an outright sale. Clinton believes the safeguards in place will not leave the state at risk should BCBSM attempt to turn into a for-profit company. AG Schuette also voiced worries about the care of seniors after BCBSM is no longer required to provide added care for them in their social mission. Clinton points out that the new nonprofit would likely take charge of senior care, due in part to the fact that it would be in charge of the subsidy provided under the current five-year Medigap rate freeze negotiated by AG Schuette.

Concerns about Medigap were also expressed by groups specifically representing seniors, including the Area Agencies on Aging Association. Executive Director Mary Ablan spoke specifically to the lack of guarantee that Medigap Legacy policies Plans A and C would be continued after four years. These policies are guaranteed issue, community rated and subsidized, unlike other Medigap products under Blue Care network. She stated that she was not aware of any other Medigap policies available that are community rated, have no pre-existing waiting period and are available to people under 65.

One other consequence of Governor Snyder's proposal to repeal Public Action 350, which controls BSBSM, would be that the Blues would move into other areas of insurance—auto, home, life—beyond health, as a nonprofit mutual company, an impact which greatly concerns other insurance companies. Although the Blues says it has "no immediate interest" in doing so, it has not said the same for the Accident Fund, which deals with workers' compensation and has been owned by Blue Cross Blue Shield since the state sold it in the 1990s. BCBSM has said

that the Accident Fund has wished to expand for a long time, and it would only make sense for the government to take away any restrictions to growth for a Michigan-based company.

The legislation appears to be a move in how BCBSM conducts its business, not necessarily a move in what types of benefits it offers. Benefits offered will be largely governed by the ACA, the state's benchmark plan, and participation in the health care exchange. SB 1293 and 1294 are designed to change BCBSM's business model rather than dictate benefits or covered services.

The bills remain in the Senate Insurance Committee, although the House Insurance Committee has had a preliminary background meeting. These bills are of high importance to the Administration and widely expected to pass during the lame duck session. The Council will be considering a position on the legislation at its November meeting.

Health Care Exchange to be Joint State/Federal

So much for our fearless predictions that once the U.S. Supreme Court ruled on the Affordable Care Act—and then, once the August primaries were over—the Michigan House would approve SB 693 (Senator Jim Marleau, R–Lake Orion) to create the "MIHealth Marketplace," which would have been Michigan's exchange authority. SB 693 passed the Senate 25-12, meaning a scant handful of Senate Republicans joined Senate Democrats to move the bill out of the Chamber. Since that vote, conducted last November, the bill has been stuck in the House of Representatives Health Policy committee. We continued to assume that strong states' rightists would recognize that it would be better for Michigan to shape its own exchange rather than having the feds involved any more than they had to be. We were wrong.

Governor Snyder ultimately decided to pull the plug on SB 693, citing "opposition from House Republicans" and will instead pursue a state-federal partnership to create Michigan's exchange. This is indeed an option the federal government has left on the table for states, but it also means the state will have to find more of its own funding to run the program. The pressure from the legislature to deny the fully state-run exchange, and the Governor's decision to move away from that model to the more-costly partnership model, seem counterintuitive; in the fully state-run option, the state gets to define almost every detail of how the exchange will operate. In this new model, the state clearly loses some control.

The two big items related to Michigan's health exchange are the identification of a "benchmark plan" both in terms of essential health benefit requirements and the selection of the plan that carries those benefits. This plan and these benefits are the "floor" of what will then be offered

in an exchange environment. The other big item is the state's blueprint for what the federal-state partnership should look like in Michigan.

As for essential benefits and the benchmark plan, these can be found on the Licensing and Regulatory Affairs website via the Office of Financial and Insurance Regulation link. OFIR is recommending that the Priority Health HMO be selected as the benchmark plan. Additionally, OFIR is selecting FEDVIP pediatric vision plan and MIChild dental plan be selected to supplement Priority Health.

Interestingly, federal HHS guidelines for essential health benefits *prohibit* state-mandated benefits enacted *after* January 1, 2012 from being included in those benefits for 2014 or 2015 *unless* those benefits are already included in the plan selected as the benchmark plan. Thus, Michigan's recently-passed autism law *cannot* be included in essential health benefits unless Priority Health already has a similar benefit. The better news, however, is that the ACA requires all benchmark plans to comply with the federal Mental Health Parity and Addiction Equity Act. Full mental health parity must be a part of Priority Health's offerings. However, in some recently-released documents, it is not clear what "parity" means in terms of current offerings (which appears to be limited to 20 days per contract year), so the State will have to (according to ACA regulations) add parity to the plan.

Medicaid Expansion?

Part of the ACA is the option for states to extend Medicaid eligibility to anyone at or below 133% of the federal poverty level. Currently, that would be individuals making $14,856 or less or households of two making $20,123 or less.

If Michigan chooses to expand the Medicaid program eligibility to 133% of the federal poverty level (as opposed to 100% where it now stands), the Michigan House Fiscal Agency estimates a *savings* of $211.1 million in GF/GP, and a savings of $1.1 *billion* in 10 years. It seems counter-intuitive that bringing an estimated 400,000 new people into Medicaid would *save* the state money. However, the federal government will pay all of the costs for the Medicaid expansion for three years beginning in 2014. After that, the match rate drops to 95% starting in 2017 and then to 90% in 2020. As the House Fiscal Agency notes, even without looking at factors that save money for the state by expanding Medicaid eligibility, the move would have no GF/GP cost but would bring $2 billion of federal dollars into the state. Over ten years, federal funds would bring $21.6 billion into the state and only require the state to pay $1.3 billion over what it currently pays.

The savings in the state's budget for opting-in to this move are outlined in detail by the House Fiscal Agency, but the highlights include:

- Non-Medicaid mental health services; $175 million saved starting in 2014 as the state no longer has to pay for 3 years and must only provide a 10% match by 2020, saving $2 billion in 10 years;
- The Adult Benefit waiver savings from state participation dropping from 33.61% to 0% in 2014 and eventually 10% by 2020, saving $36.1 million in 2014 to $414.1 million in 10 years;
- The Department of Corrections may save roughly $40 million in medical costs that are currently only GF/GP but may now qualify under the ACA expansion for federal funding.

The Senate Fiscal Agency has prepared a similar memo for the legislature, finding similar savings.

Enter, then, SB 1245 (Senator Bruce Caswell, R–Hillsdale). The one-page bill prohibits the state from expanding Medicaid eligibility under the ACA to 133% of the federal poverty level. If the bill passes (and is signed by Governor Snyder), the state loses out on the federal funds designed to cover the new population of Medicaid enrollees between 100% and 133% of the federal poverty level. However, the Supreme Court decided that the federal government cannot penalize a state for choosing NOT to expand Medicaid; it just doesn't get all the extra money at the 100% federal match and won't experience the savings outlined above (with the slight uptick in spending required to maintain the expansion in 2017 and 2020). The objection inherent in SB 1245, then, is purely philosophical: there's no penalty for objecting, the state would have to spend a pittance of funds in 2017 and 2020, so it *does* cost *something*, and the new Medicaid enrollees—those between 100% and 133% of the federal poverty level—will qualify for federal subsidies to buy private insurance under Michigan's health exchange.

Given the analyses from the Senate and House Fiscal agencies demonstrating this expansion results in a net *gain* for the state, SB 1245 does not yet seem destined for a hearing. Further, given that there are a few other more pressing issues for the Senate to take up, SB 1245 does not seem likely to head for a vote. The legislature won't return again until *after* the election in November, so the political points scored for voting on SB 1245 seem moot. That said, there are rumors that the state may shift Medicaid from DCH to the Michigan Department of Human Services. So while right now, SB 1245 seems to be on a road to nowhere, there's still "lame duck" and there's still next session, starting in January, a year before all the 2014 ACA requirements and funds start to hit.

However, SB 1245 is legislation requiring a governor's signature for enactment. If Governor Snyder, an accountant by trade, sees Medicaid expansion as beneficial, he, of course, has the option of vetoing the bill.

SB 564, Expansion of Freedom to Work

SB 564, introduced by Senator Tonya Schuitmaker (R-Lawton) to amend the Social Welfare Act—specifically the Freedom to Work section—has passed the Senate and is in the House Appropriations Committee. The bill would expand enrollment and change the premium scale for all new and current members of the program. Under current law, the program includes any individual who meets Federal Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) disability standards, is between the ages of 16 and 64, has unearned income below the poverty level, is Medicaid eligible, and is employed. This program provides coverage for people who qualify, even if they generate income up to $75,000 or save for retirement. The coverage is free up to 250% of the federal poverty limit (FPL), and a sliding scale of premiums is in place from 250% FPL and $75,000 of income. Over $75,000, the recipient must pay the full cost of Medicaid.

SB 564 changes the enrollment pool by removing the requirement that a person be currently enrolled or eligible to be enrolled for Medicaid. The previous limitation on unearned income would be changed to a limit of a participant's countable income of 250% FPL of a family of one. The participant's asset limit would be equivalent to the Medicare Part D Low Income Subsidy and Medicare Savings program. Retirement savings would be excluded from eligibility consideration, and a ban on personal assistance services in the workplace would be lifted. (This ban was never enforced due to a conflict with federal law and is merely a technical rewrite which will have no impact.) There would also be a new scale for premiums. For participants under 138% FPL, there would continue to be no premium, but everyone from 138% FPL to $75,000 of income would pay 7.5% of gross income as a premium. Those over $75,000 would pay a premium equal to the average Freedom to Work Medicaid participant cost. The fiscal impact of this bill is unclear, as the potential costs and offset costs are both high. With a larger pool of participants, both the number receiving funding and those possibly paying premiums would increase. Exactly how many new enrollees sign up, as well as how the new FPL percentage falls among participants, will largely influence the fiscal impact.

Other Bills of Interest

- **HB 5089 Rep. Johnson (R-Clare)** Creates and establishes duties relating to the unused prescription drug repository and distribution program. Bill passed in the House, referred to the Senate Health Policy Committee where a hearing was held on September 13.

- **HB 5090 Rep. Ananich (D-Flint)** Requires acceptance and destruction or disposal of drugs or medications not eligible for distribution. Bill passed in the House, referred to the Senate Health Policy Committee where a hearing was held on September 13.
- **SB 884 Sen. Hansen (R-Hart)** Modifies the nursing home survey process. Bill passed the Senate and House, enrolled and sent to Governor on September 27.
- **HB 5903 Rep. Agema (R-Grandville)** Requires Department of Community Health to develop an assessment tool (akin to the Supports Intensity Scale) for payment of Medicaid funds to developmentally disabled individuals.
- **HB 5929 Rep. Meadows** (D-East Lansing) Gives power to personal representatives to control online social media accounts of deceased individuals.
- **SB 1333 Sen. Marleau** (R-Lake Orion) Creates brain injury law and establishes Brain Injury Services and Prevention Council.

New ELDRS Officers Named at Fall Conference

By Christine Caswell, Caswell Law PLLC

The ELDRS Council held its annual meeting on October 5 during the ELDRS Fall Conference at the Crystal Mountain Resort, naming its new officers for 2012-13:

- Chair—Bradley A. Vauter, Elder Law of Michigan, Inc.
- Chair-Elect—Rosemary H. Buhl, Law Office of Rosemary Howley Buhl, PC
- Secretary—Patrick Bond, Bond Estate Planning & Elder Law PC
- Treasurer—John Payne, Garrison Lawhouse PC
- Immediate Past Chair—Caroline Dellenbusch, Caroline Dellenbusch PLC

New members elected to the Council for a three-year term included:

- Jane A. Bassett, Bassett & Associates PLLC
- Christine Caswell, Caswell Law PLLC
- Erma S. Yarbrough-Thomas, Neighborhood Legal Services Michigan Elder Law & Advocacy Center

One current Council member was reelected to serve a second three-year term:

- William David Lucius, Paul A Sturgul Law Office

Approximately 150 people attended the Fall Conference, with 26 speakers and 22 separate sessions. Dates and locations for the 2013 ELDRS Spring and Fall Conferences should be in the next issue of the *ELDRS Update*.

Medicare Annual Enrollment Update

By Christopher W. Smith, Michigan Law Center, PLLC

Medicare's annual open enrollment began on October 15 and concludes on December 7. All Medicare beneficiaries who are enrolled in either a Medicare Advantage Plan or a Prescription Drug Plan need to review their plans during this time. Please remind your clients that the terms of their plan may have changed significantly for 2013, and they need to decide whether it is still the best plan. Not reviewing a plan and blindly continuing it is foolish.

Throughout the state of Michigan, MMAP, Inc. is holding enrollment events where a client can consult with an MMAP counselor to review his or her plan. Call 1-800-803-7174 or your local Area Agency on Aging to see where MMAP will hold enrollment events. (Please note that calls to the hotline are heavy during this period, and your client will likely get the quickest service by attending an enrollment event.) If clients are unable to work with an MMAP counselor, ICLE just released a How To Kit on "Using Medicare.gov to Select And Review Medicare Plans" that may be useful to them or you. ICLE also released a Top Tips in Ten Minutes on "Selecting a Medicare Prescription Drug Plan."
Courtesy of MMAP, Inc., here are the changes to be aware of this year:

- As of this newsletter's deadline, we still do not know what the Medicare Part B premiums will be. Preliminary projections suggest a Part B premium increase of about $7/month in 2013.
- For the first time, Prescription Drug Plans can cover benzodiazepines and certain barbiturates such as those used in the treatment of epilepsy, cancer, or chronic mental disorder. Note: Plans are not required to cover these prescriptions and may place restrictions on them.
- There are still no five-star Medicare Advantage plans in Michigan. Thus, an individual will not be able to switch Medicare Advantage plans after December 7.
- However, if an individual misses the December 7, 2013 deadline and is in a bad Medicare Advantage plan, he or she can return to Original Medicare between January 1 and February 14, 2013, and enroll in a prescription drug plan. Historically, this person may have been able to enroll in a Blue Cross Legacy plan, but the pending legislation *may* impact the ability to do this as discussed elsewhere in this newsletter. However, if the client is healthy, he or she might be able to enroll in a Medigap plan even if Blue Cross restricts the Legacy plans.
- Competitive bidding for Durable Medical Equipment (e.g., oxygen equipment, wheelchairs, and hospital beds) will take place in the Detroit, Flint, and Grand Rapids areas next year. These locations will also be a part of the mail-order diabetic testing demonstration. If you live in these areas, expect some limitations regarding where a client can get these supplies (but hopefully at better prices) beginning in mid-2013.
- Co-pays under Original Medicare for outpatient mental health services will be reduced from 40% in 2012 to 35% in 2013. Beginning in 2014, this co-pay will be reduced to 20%.

- Medicare beneficiaries will begin receiving a new Medicare Summary Notice beginning January 1. It will look like this.

Information Regarding Part D Prescription Drug Costs

- There are 34 Prescription Drug Plans in Michigan for 2013. **The Humana Walmart plan is no longer the cheapest Prescription Drug Plan at $18.50 in 2013. The cheapest plan is now an AARP United Healthcare plan at $15 month.**
- The national Part D base premium (i.e., the figure that the Part D penalty is calculated from) has increased a small amount to $31.17 in 2013, up from $31.08 in 2012.
- The basic structure for Part D plans will change as follows:
    - The annual deductible increases to $325 (up from $320 in 2012).
    - An individual will reach the "doughnut hole" when actual drug costs equal $2,970 (a $40 increase) and will escape the "doughnut hole" when his or her out-of-pocket prescription drug costs reach $4,750 (a $50 increase).
- Clients in the doughnut hole will pay 47.5% of brand name drug costs (down from 50% in 2012) and 79% of generic drug costs (down from 86%) in 2013.
- If your client never enrolled in Part D and did not have creditable prescription coverage, the maximum penalty is 79% ($24.62) if he or she enrolls this season.
- For those who receive low-income subsidies for prescription drugs (i.e., Part D LIS/"Extra Help"), the Michigan's Regional Benchmark premium is $34.18, and there are 10 plans with $0 premiums in 2013. There are very minimal increases in co-pays and deductibles for those in the LIS program.

How to Handle an Out-Of-State Home in a Medicaid Case

By Robert C. Anderson, Elder Law Firm of Anderson Assoc.

Assume that a new client who has a home outside of Michigan, e.g. Indiana, Wisconsin, Ohio, now enters a nursing home in Michigan, usually to be near Michigan children. The question is whether the BEM will allow the client's home to be treated as an exempt asset? It may appear that if the client maintains an "intent to return home"—that is to the client's former state—to secure the homestead exemption, the client will violate Michigan Medicaid's residence requirement under BEM 220 requiring an intent to permanently reside in the Michigan nursing home. In other words, your client certainly cannot maintain an intent to live in two different states at the same time.

However, there is a solution. First, BEM 400 (p. 26) contains these two alternative grounds for a LTC Medicaid recipient to maintain his/her home exemption while absent: (1) maintain an "intent to return home" or (2) the owner is in a LTC facility. Therefore, the client's actual intent to stay in LTC or to return home is irrelevant because all that is required is for the client to be in a skilled nursing facility.

However, in order to also satisfy BEM 220's residency requirement, the client cannot claim that he/she intends to return home to the other state. The coup de gras which saves the day is not actually found in the BEM but rather is a little known 2004 Program Policy Bulletin 2004-010, page 8, which states:

> PEM 400 An asset group's homestead can be excluded even though it is not located in Michigan.
> Reason: Policy clarification from DCH.
> Old Policy: An asset group's homestead was only excluded if it was in Michigan.

It is interesting to note that this Bulletin was never incorporated into the BEM but that should not make a difference.

Furlough from the Nursing Home

By John Payne, Garrison Lawhouse PC

Nursing home residents and rehabilitation patients are not imprisoned. They have the right to come and go, with proper safeguards. With the upcoming holidays, families need to make plans early to take their elderly and disabled family members to holiday get-togethers. Often, it only takes enough forethought that someone drive a big enough vehicle to accommodate a wheelchair or other assistive equipment.

Who wants to be stuck in a nursing home when the family is at Auntie Annie's house scarfing down pigs-in-a-blanket and eggnog? If your family does not have someone in a nursing home, go pick up an honorary great-grandparent to take to the family holiday bash. The person will be thrilled, and you can tell your siblings that you just found out you all were adopted and this is your real grandparent.

Additionally, many nursing home residents are spending down to get on Medicaid. Use some of that money to hire a medi-van or ambulance, if necessary. Paying for such services is permissible under Medicaid rules.

The Center for Medicare Advocacy has an excellent article by Toby Edelman that explains the nursing home resident's right to leave temporarily. It is called "You Can Leave the Nursing Home," http://www.medicareadvocacy.org/2012/05/17/you-can-leave-the-nursing-home/. Please suggest to your clients that they read it and consider taking their family member out of the nursing home for family outings. Then do the same yourself.

Upcoming Events

2012	TITLE	LOCATION	WEBSITE
November 8-10	2012 National Aging and Law Institute	Washington, D.C.	www.NAELA.org
November 8	Taxation Section: End of Year Tax Strategies	Webcast	www.michbar.org/tax
December 6	Real Property Law Section: Real Estate Joint Ventures	Plymouth, MI	www.michbar.org/realproperty
December 6	Probate & Estate Planning Section: Administration of Trusts Under the Michigan Trust Code	Plymouth, MI	www.icle.org
2013			
January 18-20	2013 NAELA Unprogram	Grapevine, TX	www.NAELA.org
January 24	Probate & Estate Planning Section: 22nd Annual Drafting Estate Planning Documents (Live)	Grand Rapids, MI	www.icle.org