Legal Matters®

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Be on the lookout for new Medicare cards (and new related scams)

The federal government is issuing new Medicare cards to all Medicare beneficiaries. To prevent fraud and fight identity theft, the new cards will no longer have beneficiaries' Social Security numbers on them.

The Centers for Medicare and Medicaid Services (CMS), the federal agency that oversees the Medicare program, is replacing each beneficiary's Social Security number with a unique identification number, called a Medicare Beneficiary Identifier (MBI). Each MBI will consist of a combination of 11 randomly generated numbers and upper-case letters. The characters are "non-intelligent," which means they don't have any hidden or special meaning. An MBI is confidential like a Social Security number and should be kept similarly private.

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CMS began mailing the cards in phases in April 2018 based on the state the beneficiary lives in. The new cards should be completely distributed by April 2019. If your mailing address is not up to date, call 800-772-1213, visit www.ssa.gov, or go to a local Social Security office to update it.

The changeover is attracting scammers who are using the introduction of the new cards as a fresh opportunity to separate Medicare beneficiaries from their money. According to Kaiser Health News, the scams to look out for include phone calls in which callers:

- claim to be from Medicare and request your direct deposit num-

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Proving a transfer was not made in order to qualify for Medicaid

Medicaid law imposes a penalty period if you transferred assets within five years of applying, but what if the transfers had nothing to do with Medicaid? It is difficult to do, but if you can prove you made the transfers for a purpose other than to qualify for Medicaid, you can avoid a penalty.

You are not supposed to move into a nursing home on Monday, give all your money away on Tuesday, and qualify for Medicaid on Wednesday. So the government looks back five years for any asset transfers, and levies a penalty on people who transferred assets without receiving fair value in return. This penalty is a period of time during which the person transferring the assets will be ineligible for Medicaid. The penalty period is determined by dividing the amount that was transferred by what Medicaid determines to be the average private pay cost of a nursing home in your state.

The penalty period can seem very unfair to someone who made gifts without thinking about the potential for needing Medicaid. For example, what if you made a gift to your daughter to help her through a rough time? If you unexpectedly fall ill and need Medicaid to pay for long-term care, the state will likely impose a penalty period based on the transfer to your daughter.

To avoid a penalty period, you will need to prove that you made the transfer for a reason other than qualifying for Medicaid. The burden of proof is on the Medicaid applicant and it can be difficult to meet. The following evidence can be used to prove the transfer was not for Medicaid planning purposes:

- The Medicaid applicant was in good health at the time of the transfer. It is important to show that the applicant did not anticipate needing long-term care at the time of the gift.
- The applicant has a pattern of giving. For example, the applicant has a history of helping his or her children when they are in need or giving annual gifts to family or charity.
- The applicant had plenty of other assets at the time of the gift. An applicant giving away all of his or her money would be evidence that the applicant was anticipating the need for Medicaid.
- The transfer was made for estate planning purposes or on the advice of an accountant.

Proving that a transfer was made for a purpose other than to qualify for Medicaid is not easy. If you innocently made transfers in the past and are now applying for Medicaid, consult with your elder law attorney.

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Long-term care insurance policyholder wins breach of contract suit over increased premiums

A long-term care policyholder has successfully sued her insurance company for breach of contract after the company raised her premiums.

At age 56, Margery Newman bought a long-term care insurance policy from Metropolitan Life Insurance Company. She chose an option called "Reduced-Pay at 65" in which she paid higher premiums until she reached age 65, after which the premium would drop to half the original amount. The long-term care insurance contract set out the terms of the reduced-pay option. It also stated that the company could increase premiums on policyholders in the same "class." When Newman was 67 years old, the company notified her that it was doubling her premium.

Newman sued MetLife for breach of contract and fraudulent and deceptive business practices, among other things. In its defense, the company argued that the increase was imposed on a class-wide basis and applied to all long-term care policyholders over the age of 65, including reduced-pay policyholders. A federal trial court dismissed the suit, ruling that the contract permitted MetLife to raise Newman's premium.

She appealed. A federal appeals court reversed the lower court's decision and held that MetLife breached its contract when it raised Newman's premium. According to the court, reasonable people would believe that signing up for the reduced-pay option meant that they were not at risk of having their premiums increased. The court also allowed Newman's fraudulent and deceptive business practices claim to proceed, ruling that she presented evidence that the company's marketing of the policy was deceptive and unfair.

How to appeal a Medicare prescription drug denial

If your Medicare drug (Part D) plan denies coverage for a drug you need, you don't have to simply accept it. There are several steps you can take to fight the decision.

The insurers offering Medicare drug plans choose both brand-name and generic medicines that they will include in a plan's "formulary." This is the roster of drugs the plan covers and will pay for, and it changes year-to-year. If a drug you need is not in the plan's formulary or has been dropped, the plan can deny coverage. Plans may also charge more for a drug than you think you should have to pay or deny you coverage for a drug in the formulary because the plan doesn't believe you need the drug. If any of these things happens, you can appeal.

Before you can start the formal appeals process, you need to file an exception request with your plan. The plan should provide instructions on how to request an exception. The plan must respond within 72 hours, or within 24 hours if your doctor says that waiting 72 hours would be detrimental to your health. If your exception is denied, the plan should send you a written denial-of-coverage notice and the five-step appeals process can begin.

1. The first step in appealing a coverage determination is to go back to the insurer and ask for a redetermination, following the instructions provided by your plan. You should submit a statement from your doctor or prescriber that explains why you need the drug you are requesting, along with any medical records to support your argument. If your doctor informs the plan that you need an expedited decision due to your health, the plan must respond within 72 hours. For a standard redetermination, the plan must respond within seven days.
2. If you disagree with the drug plan's decision, you have the right to reconsideration by an independent board. To request reconsideration, follow the instructions in the written redetermination notice you receive from the insurer. You have 60 days to make your request. An independent review entity will review the case and issue a decision either within 72 hours or seven days.

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3. If you receive a negative decision, you can keep appealing. The third level of appeal is to request a hearing with an administrative law judge (ALJ), which allows you to present your case either over the phone or in person. To request a hearing, the amount in controversy must be at least $160 (in 2018). The amount in controversy is calculated by subtracting any amount already covered under Part D and any applicable deductible, co-payments, and coinsurance amounts from the projected value of the benefits in dispute. Your request for a hearing must be sent in writing to the Office of Medicare Hearings and Appeals. The ALJ is supposed to issue an expedited decision within 10 days or a standard decision within 90 days.
4. If the ALJ does not rule in your favor, the next step is a review by the Medicare Appeals Council. The appeal form must be filed within 60 days after the ALJ's decision. You will need a statement explaining why you disagree with that decision. The appeals council will issue an expedited decision in 10 days or a standard decision within 90 days.
5. The final step is review by a federal trial court. To be able to request review, the amount in controversy must be $1,600 (in 2018). Follow the directions in the letter from the appeals council and file the request in writing within 60 calendar days.

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ber, using the new cards as an excuse;

- ask for your Social Security number to verify information;
- claim Medicare recipients need to pay money to receive a temporary card; or
- threaten to cancel your insurance if you don't give out your card number.

There is no cost for the new cards. It is important to know that Medicare will never call, email or visit you unless you ask them to, nor will they ask you for money or for your Medicare number. If you receive any calls that seem suspicious, don't give out any personal information and hang up. You should call 1-800-MEDICARE to report the activity or you can contact your local Senior Medicare Patrol (SMP). To contact your SMP, call 877-808-2468 or visit www.smpresource.org.

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Five rights that trust beneficiaries have

If you are the beneficiary of a trust, it may feel like you are at the mercy of the trustee. But depending on the type of trust, trust beneficiaries may have rights to ensure the trust is properly managed.

A trust is a legal arrangement through which one person, called a "settlor" or "grantor," gives assets to another person (or an institution, such as a bank or law firm), called a "trustee." The trustee holds legal title to the assets for another person, called a "beneficiary." The rights of a trust beneficiary depend on the type of trust and the type of beneficiary.

If the trust is a revocable trust — meaning the person who set up the trust can change it or revoke it at any time — trust beneficiaries other than the settlor have very few rights. Because the settlor can change the trust at any time, he or she can also change the beneficiaries at any time. Often a trust is revocable until the settlor dies and then it becomes irrevocable, meaning that it cannot be changed except in rare cases by court order.

Beneficiaries of an irrevocable trust have the right to some information about the trust. The scope of those rights depends on the type of beneficiary. Current beneficiaries are beneficiaries who are currently entitled to income from the trust. Remainder or contingent beneficiaries have an interest in the trust after the current beneficiaries' interest is over. For example, a wife may set up a trust that leaves income to her husband for life (the current beneficiary) and then the remainder of the property to her children (the remainder beneficiaries).

State law and the terms of the trust determine exactly what rights a beneficiary has, but there are five common rights given to beneficiaries of irrevocable trusts:

► **Payment**. Current beneficiaries have the right to distributions as set forth in the trust document.

► **Information**. Current and remainder beneficiaries have the right to be provided enough information about the trust and its administration to know how to enforce their rights.

► **An accounting**. Current beneficiaries are entitled to an accounting. An accounting is a detailed report of all income, expenses, and distributions from the trust. Typically, trustees are required to provide an accounting annually, but that may vary, depending on the terms of the trust. Beneficiaries may also be able to waive the accounting.

► **Removal of the trustee**. Current and remainder beneficiaries have the right to petition a court for the removal of the trustee if they believe the trustee isn't acting in their best interest. Trustees have an obligation to balance the needs of the current beneficiary with the needs of the remainder beneficiaries, which can be difficult to manage.

► **Ending the trust**. In some circumstances, if all the current and remainder beneficiaries agree, they can petition a court to end the trust. State laws vary on when this is allowed.