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# What to do if you have an Obamacare plan and become eligible for Medicare

If you or someone you know has a marketplace health care plan under the Affordable Care Act (an "Obamacare" plan), and you've reached the age of 65 or are close to it, it's important to look carefully at your options. Not making the right decision could be costly.

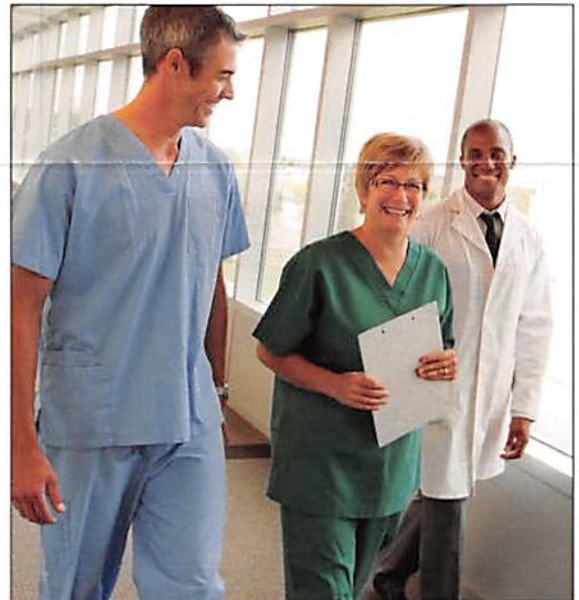
In the vast majority of cases, the smart approach is to terminate the Obamacare plan and sign up for Medicare.

But many people are unaware of this fact, because there's no warning given to such consumers that they have an important decision to make.

Most people who reach 65 become eligible for Part A, Medicare's hospitalization benefit, free of charge. Not only that, but if you become eligible for Medicare, you cease being eligible for Obamacare subsidies. So for most people, the choice is between a hospitalization plan that's free and a plan that's suddenly far more expensive than what they've been paying in the past.

In addition, if you don't sign up for Medicare when you're turning 65, and eventually change your mind and submit a Medicare application, there are often hefty penalties you have to pay.

For Part B, which covers outpatient and preventive care such as doctor's visits and tests, the current monthly base premium is $104.90. But late applicants must pay an additional 10 percent penalty for each year that enrollment was delayed. There's a similar penalty for Part D drug coverage if your other plan didn't meet certain requirements.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You should also know that you can't sign up for Medicare and keep your Obamacare plan as a supplement. You can buy a separate Medigap policy to cover what Medicare doesn't, but it's actually illegal for someone to sell you an Obamacare policy once you have Medicare.

So is it *ever* wise to keep an Obamacare plan and not sign up for Medicare?

There may be a few cases. For instance, people who haven't worked long enough to

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## Medicaid helps children who live with aging parents

In most states, if you give your house to your children (or to someone else) and then apply for Medicaid coverage of nursing home care, you can be disqualified for a long period of time. That's because you're supposed to spend down your assets on your own care before applying for Medicaid, not give them away.

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But there is an important exception that allows you to give your home to your children in certain circumstances.

Generally, you can give your house to a child if that child (1) lived with you in the house for at least two years before you entered a nursing home, and (2) provided care to you during that period that allowed you to avoid going to a nursing home.

This exception applies only to children – not to grandchildren or other relatives.

Each state Medicaid agency has its own rules for proving that your child lived with you and provided the necessary level of care, so it's important to consult with an attorney before you take advantage of this provision.

There are other exceptions, too. For instance, you can generally avoid a Medicaid penalty if you transfer your interest in your house to:

- Your spouse.
- A child who is under age 21 or who is blind or disabled.
- A trust for the sole benefit of a disabled person under age 65 (even if the disabled person is you, under certain circumstances).
- A sibling who lived in the home for the past year, so long as the sibling is already a part owner of the home.

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## *If you have an Obamacare plan and become eligible for Medicare*

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qualify for free coverage under Part A might prefer to keep their Obamacare coverage instead. And since Part B premiums are based on income, some wealthy people might find that their Obamacare premiums are cheaper than their Part B premiums.

But the problem is that if these people ever change their mind, they will face the Medicare late-enrollment penalties. (For people who don't qualify for free Part A, the penalty is a 10% increase in premiums for twice the number of years that they were eligible and didn't apply.)

There's one exception to the late penalties. If your employer has a Small Business Health Options plan – sometimes known as a SHOP plan – and the company employs more than 20 people, you can keep your plan and avoid the Part B penalty as long as you sign up for Part B within eight months after you cease being covered by the plan. You can also avoid the Part D penalty if the SHOP plan provides "creditable coverage" for drugs.

However, there are other problems with waiting to sign up for Medicare. For instance, people who don't apply for Medicare when they're turning 65 are sometimes limited in when they can apply, and the insurance doesn't always take effect immediately, so they might face a gap in coverage.

You should also consider that, even if they're cheaper, many Obamacare plans don't provide benefits that are as good as those under Medicare, in terms of co-pays, deductibles, hospital and doctor networks, annual limits on out-of-pocket expenses, and drug coverage.

If you decide to cancel your Obamacare plan, be careful not to do it before the date when your Medicare coverage actually begins. If your Obamacare plan covers other family members, be sure to remove only yourself from the plan, since canceling the plan altogether will cancel their coverage, too.

If you're listed on the plan as the "household contact," you should note that if you drop yourself from coverage but keep other family members on the plan, you'll remain as the household contact unless you affirmatively change this as well.

Also bear in mind that if you're currently receiving subsidies to reduce the cost of your Obamacare plan, it's up to you to tell the plan to cancel the subsidies as soon as you become eligible for Medicare, whether or not you actually sign up for Medicare. Otherwise, you'll have to repay the subsidies at tax time.

**We welcome your referrals.**
We value all our clients. And while we're a busy firm, we welcome all referrals. If you refer someone to us, we promise to answer their questions and provide them with first-rate, attentive service. And if you've already referred someone to our firm, thank you!

## New law warns seniors of Medicare nursing home loophole

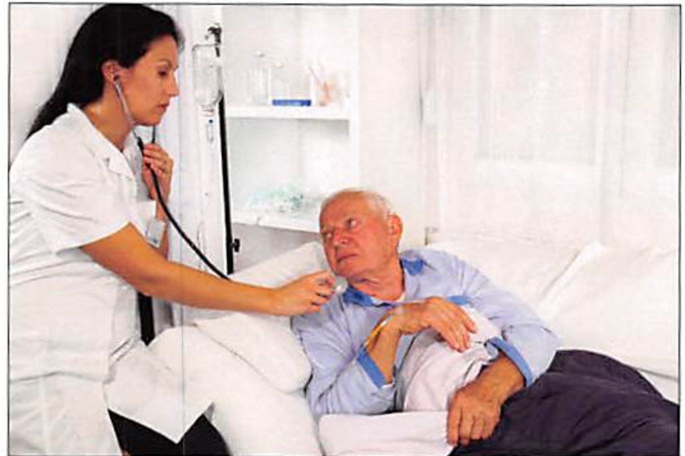
A new federal law will help many seniors with a costly Medicare loophole that often results in their not being covered for a stay in a nursing home. It won't make the stay covered, but it will at least put seniors on notice if a stay *isn't* covered, so they can plan accordingly and won't be hit with a nasty surprise.

Here's the problem: Medicare covers nursing home stays for the first 20 days, so long as the patient was first admitted to a hospital as an inpatient for at least three days. But a lot of people who spend three days in a hospital later discover that they were never actually "admitted." Rather, they were merely kept in the hospital "under observation." As a result, the nursing home stay afterward isn't covered.

Hospitals have increasingly been choosing not to admit patients and to place them under observation instead due in part to pressure from Medicare to reduce costs. As of 2011, some 1.6 million seniors per year were being treated under observation, a dramatic increase from past years.

Frequently, patients have no idea that they haven't actually been admitted. They're given a bed and a wristband, nurses and doctors come to see them, they get treatment and tests, and they fill out a meal chart just as if there had been a formal admission.

Patients who discover after the fact that they have been denied Medicare because of this problem usually have little recourse. As long as Medicare pays for the hospital stay – which it usually does on an outpatient basis – there's no way to appeal because there has been no denial of coverage. And the denial of coverage for the nursing home stay is technically proper if the patient wasn't admitted to the hospital for three days.



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The new federal law is called the NOTICE Act (which stands for Notice of Observation Treatment and Implication for Care Eligibility). It requires hospitals to notify patients who are under observation for more than 24 hours of their outpatient status within 36 hours, or upon discharge if that occurs sooner. The notification must explain that because the patient hasn't been admitted, their hospital stay won't count toward the three-day requirement, and so Medicare won't pay for a subsequent nursing home stay.

The NOTICE Act will go into effect on August 6, 2016.

In the meantime, if you're in the hospital and a nursing home stay is likely, it's a good idea to ask whether or not you've been formally admitted.

A lot of people who spend three days in a hospital later discover that they were never actually 'admitted.' Rather, they were merely kept 'under observation.' As a result, their nursing home stay afterward isn't covered by Medicare.

## Your IRA can have an effect on your Medicaid eligibility

When you're planning for Medicaid coverage of nursing home care, it's important to take any IRAs you own into account.

Medicaid applicants can retain only a small amount of assets ($2,000 in most states) in order to be eligible for benefits. Certain assets may be exempt from this rule. Whether your IRA is exempt often depends on whether it is in "payout status."

You can put your IRA into payout status starting at age 59½ if you elect to take regular, periodic distributions based on life expectancy tables. At age 70½, you're required to put your IRA into payout status.

The rules vary from state to state, but often, if an IRA is in payout status, it won't count as an asset for Medicaid purposes. The payments you receive from the IRA will count as income, though. Medicaid recipients are allowed to keep a tiny amount of income for personal use, and the rest will go to the nursing home.

If the IRA isn't in payout status, it will typically count as an asset – which means you'd have to cash it out and spend down the funds, or possibly transfer them to someone else (although this can be tricky).

Roth IRAs have their own rules. In many states, Roth IRAs always count as an asset because there are no required minimum distributions.

The rules regarding IRAs and Medicaid are complicated, which is yet another reason why it's good to consult an attorney whenever you're planning for nursing home care.

This newsletter is designed to keep you up-to-date with changes in the law. For help with these or any other legal issues, please call our firm today. The information in this newsletter is intended solely for your information. It does not constitute legal advice, and it should not be relied on without a discussion of your specific situation with an attorney.

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# Make sure your loved ones can get your medical information

If you're in the hospital, you probably want certain family members and trusted friends to be able to get information about your condition or prognosis. But to make sure this happens, you may need to plan ahead.

A federal law called HIPAA (the Health Insurance Portability and Accountability Act) is designed to protect your health care privacy, and says that medical personnel can't disclose your health care information to unauthorized people. Only a small number of people are authorized under HIPAA ... so if you want other people to know about your condition, you have to authorize them in advance.

You can do this by signing a "HIPAA release form" specifying who can receive information and what type of information each person can receive. For instance, you could allow certain people to receive general information about you, but nothing highly personal such as mental health records, addiction treatment, HIV status, etc. You can also limit the period of time during which the authorization will be in effect.

Surprisingly, there is no one general form for this purpose. Many health care providers have their own forms, so you may want to plan ahead and get a form from any doctors, hospitals, or clinics that will be involved in your care. Some providers offer printable forms on their websites.

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You can also find a generic form here: http://goo.gl/v1pqbq

It's also a good idea to make sure your power of attorney and health care proxy documents state that your agent is also your HIPAA personal representative and is thus entitled to all health care disclosures.