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BRENNAN & ROGERS PLLC
Informed and compassionate legal care

Elder law focus

ANNUAL CLIENT RELATIONSHIP SERVICE NEWSLETTER
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In This Issue

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Office Operations During the Pandemic

We remain open and have throughout the pandemic. We have been meeting with clients in person once again. Our office staff has been vaccinated. Zoom meetings are available to those who are continuing to practice social distancing precautions.

Business Developments

- **Brennan & Rogers, PLLC won in the "Best Law Firm" category in the 2021 Best of the Seacoast Community Choice Awards!**
  We are honored to have won in this category! We are filled with gratitude and humbled by this award made possible by all of those who took the time to vote for us. Thank you for making Brennan & Rogers, PLLC the Best of the Seacoast!

- **Welcome Attorney Michael C. Cahill, Esq.!**
  Before joining Brennan & Rogers, PLLC this past May, Michael's practice with a Maine-based legal aid clinic and, subsequently, a law firm focused on disabled and injured individuals. Michael has significant experience with Social Security disability and the Social Security Administration office. At Brennan & Rogers, PLLC, Michael's practice is focused on probate, Medicaid planning, Medicaid application assistance, and estate planning. To learn more about Michael, see our website.

- **Welcome Attorney Katherine (Katie) Audet, Esq.!**
  Before joining Brennan and Rogers, PLLC in October, Katie practiced at a regional law firm specializing in creditors' rights and regulatory compliance. At Brennan & Rogers, PLLC, Katie's practice is focused on probate, Medicaid planning, Medicaid application assistance, and estate planning. Katie is licensed to practice in licensed in Maine and Massachusetts. To learn more about Katie, see our website.

The Build Back Better Infrastructure Plan

Congress is considering a broad package of health, social, and environmental programs supported by President Biden, called the Build Back Better Act. The total cost of the original package had been pegged at $3.5 trillion (much of which would be offset by savings and new revenue), though the legislation has since changed in ways that will likely reduce the total. This brief summarizes major health provisions as of the bill reported to the House Rules Committee on November 3, 2021. Negotiations are ongoing and there may be future changes.

Here, we walk through 10 of the major health coverage and financing provisions of the Build Back Better Act, with discussion of the potential implications for people

and the federal budget. We summarize provisions relating to the following areas and provide data on the people most directly affected by each provision and the potential costs or savings to the federal government.

1. ACA Marketplace Subsidies
2. New Medicare Hearing Benefit
3. Lowering Prescription Drug Prices and Spending
4. Medicare Part D Benefit Redesign
5. Medicaid Coverage Gap
6. Maternal Care and Postpartum Coverage
7. Other Medicaid / Children's Health Insurance Changes CHIP Changes
8. Other Medicaid Financing and Benefit Changes
9. Medicaid Home and Community Based Services and the Direct Care Workforce
10. Paid Family and Medical Leave

A recent KFF poll found broad support for many of these provisions, though it did not probe on the costs or trade-offs associated with them. The poll also found that the vast majority of the public supports allowing the federal government to negotiate drug prices, after hearing arguments made by proponents and opponents.

Major Provisions of the Build Back Better Act and their Potential Costs and Impact

1. ACA Marketplace Subsidies

BACKGROUND

Under the Affordable Care Act, people purchasing Marketplace coverage could only qualify for subsidies if they met other eligibility requirements and had incomes between one and four times the federal poverty level. People eligible for subsidies would have to contribute a sliding-scale percentage of their income toward a benchmark premium, ranging from 2.07% to 9.83%. Once income passed 400% FPL, subsidies stopped and many individuals and families were unable to afford coverage.

In 2021, the American Rescue Plan Act (ARPA) temporarily expanded eligibility for subsidies by removing the upper income threshold. It also temporarily increased the dollar value of premium subsidies across the board, meaning nearly everyone on the Marketplace paid lower premiums, and the lowest income people pay ***zero*** premium for coverage with very low deductibles. The ARPA also made people who received unemployment insurance (UI) benefits during 2021 eligible for zero-premium, low-deductible plans.

However, the ARPA provisions removing the upper income threshold and increasing tax credit amounts are only in effect for 2021 and 2022. The unemployment provision is only in effect for 2021.

PROVISION DESCRIPTION

Section 137501 of The Build Back Better Act would extend the ARPA subsidy changes that eliminate the income eligibility cap and increase the amount of APTC for individuals across the board through the end of 2025.

Additionally, Section 137507 of The Build Back Better Act would extend the special Marketplace subsidy rule for individuals receiving UI benefits for an additional 4 years, through the end of 2025.

Section 137303 of the Act would, for purposes of determining eligibility for premium tax credits, disregard any lump sum Social Security benefit payments in a year. This provision would be permanent and effective starting in the 2022 tax year. Starting in 2026, people would have the option to have the lump sum benefit included in their income for purposes of determining tax credit eligibility.

Finally, Section 237502 modifies the affordability test for employer-sponsored health coverage. The ACA makes people ineligible for marketplace subsidies if they have an offer of affordable coverage from an employer, currently defined as requiring an employee contribution of no more than 9.61% of household income in 2022. The Build Back Better Act would reduce this affordability threshold to 8.5% of income, bringing it in line with the maximum contribution required to enroll in the benchmark marketplace plan. This provision would take effect for tax years starting in 2022 through 2025. Thereafter the affordability threshold would be set at 9.5% of household income with no indexing.

PEOPLE AFFECTED

CBO projects that, under Section 137051, subsidized ACA Marketplace enrollment would increase by 3.6 million people (relative to the number of people who would be enrolled in the absence of these provisions). CBO expects 1.4 million of these enrollees would otherwise be uninsured, while 600,000 would otherwise be covered by an unsubsidized individual market plan and 1.6 million would otherwise have employer coverage.

Additionally, CBO expects the enhanced subsidies for people receiving unemployment insurance (Section 137507) would result in 500,000 people newly enrolling, on average per year during the 2022-2025 period. Most of these new enrollees would otherwise be uninsured.

As of August 2021, 12.2 million people were actively enrolled in Marketplace plans – an 8% increase from 11.2 million people enrollees as of the close of Open

Enrollment for the 2021 plan year. HealthCare.gov and all state Marketplaces reopened for a special enrollment period of at least 6 months in 2021, enrolling 2.8 million people (not all of whom were necessarily previously uninsured). Of these, 44% selected plans with monthly premiums of $10 or less.

The US Department of Health and Human Services (HHS) reports that ARPA reduced Marketplace premiums for the 8 million existing Healthcare.gov enrollees by $67 per month, on average. If the ARPA subsidies are allowed to expire, these enrollees will likely see their premium payments double.

HHS also reports that between July 1 and August 15, more than 280,000 individuals received enhanced subsidies due to the ARPA UI provisions. Individuals eligible for these UI benefits can continue to enroll in 2021 coverage through the end of this year.

The ARPA changes made people with income at or below 150% FPL eligible for zero-premium silver plans with comprehensive cost sharing subsidies. 40% of new consumers who signed up during the SEP are in a plan that covers 94% of expected costs (with average deductibles below $200). As a result of the ARPA, HHS reports the median deductible for new consumers selecting plan during the COVID-SEP decreased by more than 90% (from $750 in 2020 to $50 in 2021).

With the ARPA and ACA subsidies, as well as Medicaid in states that expanded the program, we estimate that at least 46% of non-elderly uninsured people in the U.S. are eligible for free or nearly-free health plans, often with low or no deductibles.

2. New Medicare Hearing Benefit

BACKGROUND

Traditional Medicare currently does not cover hearing services, except under limited circumstances, such as cochlear implantation when beneficiaries meet certain eligibility criteria. Hearing services are typically offered by Medicare Advantage plans, and in 2021, 97% of Medicare Advantage enrollees in individual plans, or 17.1 million people, are offered some hearing benefits, but according to our analysis, the extent of that coverage and the value of these benefits varies. Some beneficiaries in traditional Medicare may have private coverage or coverage through Medicaid for these services, but many do not.

PROVISION DESCRIPTION

Section 30901 of the Build Back Better Act would add coverage of hearing services to Medicare Part B, beginning in 2023. Coverage for hearing care would include hearing rehabilitation and treatment services by qualified audiologists, and hearing aids. Hearing aids would be available once per ear, every 5 years, to individuals diagnosed with moderately severe, severe, or profound hearing loss. Hearing

services would be subject to the Medicare Part B deductible and 20% coinsurance. Hearing aids would be covered similar to other Medicare prosthetic devices, and would also be subject to the Part B deductible and 20% coinsurance. Payment for hearing aids would only be on an assignment-related basis. As with other Medicare-covered benefits, Medicare Advantage plans would be required to cover these hearing benefits.

Effective Date: The Medicare hearing benefit provision would take effect in 2023.

PEOPLE AFFECTED

Adding coverage of hearing services to traditional Medicare would benefit up to all 62 million people on Medicare, but particularly the roughly 36 million beneficiaries in traditional Medicare who currently lack coverage for these services. A new, defined Medicare Part B benefit could also lead to enhanced hearing benefits for Medicare Advantage enrollees. Because costs are often a barrier to care, adding this benefit to Medicare could increase use of these services, and contribute to better health outcomes.

Coverage of hearing services under traditional Medicare also would make these services more affordable relative to what beneficiaries who use these services currently pay out-of-pocket. Our analysis shows that beneficiaries who use hearing services can incur high out-of-pocket costs. Among beneficiaries who used hearing services in 2018, average spending was $914.

3. Lowering Prescription Drug Prices and Spending

BACKGROUND

Currently, under the Medicare Part D program, which covers retail prescription drugs, Medicare contracts with private plan sponsors to provide a prescription drug benefit. The law that established the Part D benefit includes a provision known as the "noninterference" clause, which stipulates that the HHS Secretary "may not interfere with the negotiations between drug manufacturers and pharmacies and PDP [prescription drug plan] sponsors, and may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs." For drugs administered by physicians that are covered under Medicare Part B, Medicare reimburses providers 106% of the Average Sales Price (ASP), which is the average price to all non-federal purchasers in the U.S, inclusive of rebates, A recent KFF Tracking Poll finds large majorities support allowing the federal government to negotiate and this support holds steady even after the public is provided the arguments being presented by parties on both sides of the legislative debate (83% total, 95% of Democrats, 82% of independents, and 71% of Republicans).

In addition to the inability to negotiate drug prices under Part D, Medicare lacks the ability to limit annual price increases for drugs covered under Part B (which includes

those administered by physicians) and Part D. In contrast, Medicaid has an inflationary rebate in place. Year-to-year drug price increases exceeding inflation are not uncommon and affect people with both Medicare and private insurance. Our analysis shows that half of all covered Part D drugs had list price increases that exceeded the rate of inflation between 2018 and 2019.

PROVISION DESCRIPTION

Negotiations. Sections 139001, 139002, and 139003 of the Build Back Better Act would amend the non-interference clause by adding an exception that would allow the federal government to negotiate prices with drug companies for a small number of high-cost drugs lacking generic or biosimilar competitors covered under Medicare Part B and Part D. The negotiation process would apply to no more than 10 (in 2025), 15 (in 2026 and 2027), and 20 (in 2028 and later years) single-source brand-name drugs lacking generic or biosimilar competitors, selected from among the 50 drugs with the highest total Medicare Part D spending and the 50 drugs with the highest total Medicare Part B spending (for 2027 and later years). The negotiation process would also apply to all insulin products.

The legislation exempts from negotiation drugs that are less than 9 years (for small-molecule drugs) or 13 years (for biological products, based on the Manager's Amendment) from their FDA-approval or licensure date. The legislation also exempts "small biotech drugs" from negotiation until 2028, defined as those which account for 1% or less of Part D or Part B spending and account for 80% or more of spending under each part on that manufacturer's drugs.

The proposal establishes an upper limit for the negotiated price (the "maximum fair price") equal to a percentage of the non-federal average manufacturer price: 75% for small-molecule drugs more than 9 years but less than 12 years beyond approval; 65% for drugs between 12 and 16 years beyond approval or licensure; and 40% for drugs more than 16 years beyond approval or licensure. Part D drugs with prices negotiated under this proposal would be required to be covered by all Part D plans. Medicare's payment to providers for Part B drugs with prices negotiated under this proposal would be 106% of the maximum fair price (rather than 106% of the average sales price under current law).

An excise tax would be levied on drug companies that do not comply with the negotiation process, and civil monetary penalties on companies that do not offer the agreed-upon negotiated price to eligible purchasers.

Effective Date: This provision would take effect in 2025, with the initial round of negotiated prices for drugs covered under Part D available that year. For drugs covered under Part B, negotiated prices would take effect in 2027.

Inflation Rebates. Sections 139101 and 139102 of the Build Back Better Act would require drug manufacturers to pay a rebate to the federal government if their prices for single-source drugs and biologicals covered under Medicare Part B and nearly all covered drugs under Part D increase faster than the rate of inflation (CPI-U). Under these provisions, price changes would be measured based on the average sales price (for Part B drugs) or the average manufacturer price (for Part D drugs). For price increase higher than inflation, manufacturers would be required to pay the difference in the form of a rebate to Medicare. The rebate amount is equal to the total number of units multiplied by the amount if any by which the manufacturer price exceeds the inflation-adjusted payment amount, including all units sold outside of Medicaid and therefore applying not only to use by Medicare beneficiaries but by privately insured individuals as well. Rebate dollars would be deposited in the Medicare Supplementary Medical Insurance (SMI) trust fund.

Manufacturers that do not pay the requisite rebate amount would be required to pay a penalty equal to at least 125% of the original rebate amount. The base year for measuring price changes is 2021.

Effective Date: These provisions would take effect in 2023.

Limits on Cost Sharing for Insulin Products. Sections 27001, 30604, and 139401, would require insurers, including Medicare Part D plans and private group or individual health plans, to charge no more than $35 for insulin products. Part D plans would be required to charge no more than $35 for whichever insulin products they cover for 2023 and 2024 and all insulin products beginning in 2025. Coverage of all insulin products would be required beginning in 2025 because the drug negotiation provision (described earlier) would require all Part D plans to cover all drugs that are selected for price negotiation, and all insulin products are subject to negotiation under that provision. Private group or individual plans do not have to cover all insulin products, just one of each dosage form (vial, pen) and insulin type (rapid-acting, short-acting, intermediate-acting, and long-acting) for no more than $35.

Effective Date: These provisions would take effect in 2023.

Vaccines. Section 139402 would require that adult vaccines covered under Medicare Part D that are recommended by the Advisory Committee on Immunization Practices (ACIP), such as for shingles, be covered at no cost. This would be consistent with coverage of vaccines under Medicare Part B, such as the flu and COVID-19 vaccines.

Effective Date: This provision would take effect in 2024.

Repealing Drug Rebate Rule. Section 139301 would prohibit implementation of the November 2020 final rule issued by the Trump Administration that would have

eliminated rebates negotiated between drug manufacturers and pharmacy benefit managers (PBMs) or health plan sponsors in Medicare Part D by removing the safe harbor protection currently extended to these rebate arrangements under the federal anti-kickback statute. This rule was slated to take effect on January 1, 2022, but the Biden Administration delayed implementation to 2023 and the infrastructure legislation passed by the House and Senate includes a further delay to 2026.

Effective Date: This provision would take effect in 2026.

PEOPLE AFFECTED

The number of Medicare beneficiaries and privately insured individuals who would see lower out-of-pocket drug costs in any given year under these provisions would depend on how many and which drugs were subject to the negotiation process, and how many and which drugs had lower price increases, and the magnitude of price reductions relative to current prices under each provision.

According to estimates from the CMS Office of the Actuary (OACT) of the drug price negotiation provision included in H.R.3 passed by the House of Representatives in 2019, allowing the federal government to negotiate drug prices would lower cost sharing for Part D enrollees by $102.6 billion in the aggregate (2020-2029) and Part D premiums for Medicare beneficiaries by $14.3 billion. Based on our analysis, premium savings for Medicare beneficiaries are projected to increase from an estimated 9% of the Part D base beneficiary premium in 2023 to 15% in 2029. The effects of the current legislation are likely to be more modest than this.

While it is expected that some people would face lower cost sharing under these provisions, it is also possible that drug manufacturers could respond to the inflation rebate by increasing launch prices for new drugs. In this case, some individuals could face higher out-of-pocket costs for new drugs that come to market, with potential spillover effects on total costs incurred by payers as well.

In terms of insulin costs, while formulary coverage and tier placement of insulin products vary across Medicare Part D plans, our analysis shows that in 2019, a large number of Part D plans placed insulin products on Tier 3, the preferred drug tier, which typically had a $47 copayment per prescription during the initial coverage phase. However, once enrollees reach the coverage gap phase, they face a 25% coinsurance rate, which equates to $100 or more per prescription in out-of-pocket costs for many insulin therapies, unless they qualify for low-income subsidies. Paying a flat $35 copayment rather than 25% coinsurance could translate to meaningful savings on many insulin products.

In terms of vaccines, providing for coverage of adult vaccines under Medicare Part D at no cost could help with vaccine uptake among older adults. Our analysis shows

that in 2018, Part D enrollees without low-income subsidies paid an average of $57 out-of-pocket for each dose of the shingles shot, which is free to most other people with private coverage.

4. Medicare Part D Benefit Redesign

BACKGROUND

Medicare Part D currently provides catastrophic coverage for high out-of-pocket drug costs, but there is no limit on the total amount that beneficiaries pay out-of-pocket each year. Medicare Part D enrollees with drug costs high enough to exceed the catastrophic coverage threshold are required to pay 5% of their total drug costs unless they qualify for Part D Low-Income Subsidies (LIS). Medicare pays 80% of total costs above the catastrophic threshold and plans pay 15%. Medicare's reinsurance payments to Part D plans now account for close to half of total Part D spending (45%), up from 14% in 2006.

Under the current structure of Part D, there are multiple phases, including a deductible, an initial coverage phase, a coverage gap phase, and the catastrophic phase. When enrollees reach the coverage gap benefit phase, they pay 25% of drug costs for both brand-name and generic drugs; plan sponsors pay 5% for brands and 75% for generics; and drug manufacturers provide a 70% price discount on brands (there is no discount on generics). Under the current benefit design, beneficiaries can face different cost sharing amounts for the same medication depending on which phase of the benefit they are in, and can face significant out-of-pocket costs for high-priced drugs because of coinsurance requirements and no hard out-of-pocket cap.

PROVISION DESCRIPTION

Sections 139201 and 139202 of the Build Back Better Act amend the design of the Part D benefit by adding a hard cap on out-of-pocket spending set at $2,000 in 2024, increasing each year based on the rate of increase in per capita Part D costs. It also lowers beneficiaries' share of total drug costs below the spending cap from 25% to 23%. It also lowers Medicare's share of total costs above the spending cap ("reinsurance") from 80% to 20% for brand-name drugs and to 40% for generic drugs; increases plans' share of costs from 15% to 60% for both brands and generics; and adds a 20% manufacturer price discount on brand-name drugs. Manufacturers would also be required to provide a 10% discount on brand-name drugs in the initial coverage phase (below the annual out-of-pocket spending threshold), instead of a 70% price discount.

The legislation also increases Medicare's premium subsidy for the cost of standard drug coverage to 76.5% (from 74.5% under current law) and reduces the beneficiary's share of the cost to 23.5% (from 25.5%). The legislation also allows beneficiaries the option of smoothing out their out-of-pocket costs over the year rather than face high out-of-pocket costs in any given month.

Effective Date: The Part D redesign and premium subsidy changes would take effect in 2024. The smoothing out-of-pocket costs provision would take effect in 2025.

PEOPLE AFFECTED

While most Part D enrollees have not had out-of-pocket costs high enough to exceed the catastrophic coverage threshold in a single year, the likelihood of a Medicare beneficiary incurring drug costs above the catastrophic threshold increases over a longer time span.

Our analysis shows that in 2019, nearly 1.5 million Medicare Part D enrollees had out-of-pocket spending above the catastrophic coverage threshold. Looking over a five-year period (2015-2019), the number of Part D enrollees with out-of-pocket spending above the catastrophic threshold in at least one year increases to 2.7 million, and over a 10-year period (2010-2019), the number of enrollees increases to 3.6 million.

We also find that in 2019, nearly 1 million more Part D enrollees incurred out-of-pocket costs for their medications above $2,000, the proposed out-of-pocket spending limit in the Build Back Better Act, than above $3,100, the proposed out-of-pocket spending limit in recent GOP drug legislation (H.R. 19) and a 2019 Senate Finance Committee bill (S. 2543). Overall, 1.2 million Part D enrollees in 2019 incurred annual out-of-pocket costs for their medications above $2,000, while 0.3 million spent more than $3,100 out-of-pocket.

Medicare Part D enrollees with higher-than-average out-of-pocket costs could save substantial amounts with an out-of-pocket spending cap, as our analysis shows. For example, the top 10% of beneficiaries (122,000 enrollees) with average out-of-pocket costs for their medications above $2,000 in 2019 – who spent at least $5,348 – would have saved $3,348 (63%) in out-of-pocket costs with a $2,000 cap and $2,248 (42%) with a $3,100 cap.

5. Medicaid Coverage Gap

BACKGROUND

There are currently 12 states that have not adopted the ACA provision to expand Medicaid to adults with incomes through 138% of poverty. The result is a coverage gap for individuals whose below-poverty-level income is too high to qualify for Medicaid in their state, but too low to be eligible for premium subsidies in the ACA Marketplace.

PROVISION DESCRIPTION

Section 137304 of the Build Back Better Act would allow people living in states that have not expanded Medicaid to purchase subsidized coverage on the ACA

Marketplace for 2022 through 2025. The federal government would fully subsidize the premium for a benchmark plan. People would also be eligible for cost sharing subsidies that would reduce their out-of-pocket costs to 1% of overall covered health expenses on average.

Section 30608 includes adjustments to uncompensated care (UCC) pools and disproportionate share hospital (DSH) payments for non-expansion states. These states would not be able draw down federal matching funds for UCC amounts for individuals who could otherwise qualify for Medicaid expansion, and their DSH allotments would be reduced by 12.5% starting in 2023.

Section 30609 would increase the federal match rate for states that have adopted the ACA Medicaid expansion from 90% to 93% from 2023 through 2025, designed to discourage states from dropping current expansion coverage.

PEOPLE AFFECTED

We estimate that 2.2 million uninsured people with incomes under poverty fall in the "coverage gap". Most in the coverage gap are concentrated in four states (TX, FL, GA and NC) where eligibility levels for parents in Medicaid are low, and there is no coverage pathway for adults without dependent children. Half of those in the coverage gap are working and six in 10 are people of color.

An earlier CBO estimate showed that extending Marketplace subsidies to people with income below 100% of poverty over the 2022-2024 period would increase enrollment in nongroup resulting in 1.7 million fewer uninsured people on average over the period.

6. Maternity Care and Postpartum Coverage

BACKGROUND

Medicaid currently covers almost half of births in the U.S. Federal law requires that pregnancy-related Medicaid coverage last through 60 days postpartum. After that period, some may qualify for Medicaid through another pathway, but others may not qualify, particularly in non-expansion states. In an effort to improve maternal health and coverage stability and to help address racial disparities in maternal health, a provision in the American Rescue Plan Act (ARPA) of 2021 gives states a new option to extend Medicaid postpartum coverage to 12 months. This new option takes effect on April 1, 2022 and is available to states for five years.

PROVISION DESCRIPTION

Section 30721 of the Build Back Better Act would require states to extend Medicaid postpartum coverage from 60 days to 12 months, ensuring continuity of Medicaid coverage for postpartum individuals in all states. This requirement would take effect

in the first fiscal quarter beginning one year after enactment and also applies to state CHIP programs that cover pregnant individuals.

Section 30722 would create a new option for states to coordinate care for Medicaid-enrolled pregnant and post-partum individuals through a maternal health home model. States that take up this option would receive a 15% increase in FMAP for care delivered through maternal health homes for the first two years. States that are interested in pursuing this new option can receive planning grants prior to implementation.

Sections 31031 through 31048 of the Build Back Better Act provide federal grants to bolster other aspects of maternal health care. The funds would be used to address a wide range of issues, such as addressing social determinants of maternal health; diversifying the perinatal nursing workforce, expanding care for maternal mental health and substance use, and supporting research and programs that promote maternal health equity.

PEOPLE AFFECTED

Largely in response to the new federal option, at least 26 states have taken steps to extend Medicaid postpartum coverage. Pregnant people in non-expansion states could see the biggest change as they are more likely than those in expansion states to become uninsured after the 60-day postpartum coverage period. For example, in Alabama, the Medicaid eligibility level for pregnant individuals is 146% FPL, but only 18% FPL (approximately $4,000/year for a family of three) for parents.

Some states have piloted maternal health homes and seen positive impacts on health outcomes. The federal grant provisions related to maternal health could affect care for all persons giving birth, but the focus of these proposals is on reducing racial and ethnic inequities. There were approximately 3.7 million births in 2019, and nearly half were to women of color. There are approximately 700-800 pregnancy-related deaths annually, with the rate 2-3 times higher among Black and American Indian and Alaska Native women compared to White women. Additionally, there are stark racial and ethnic disparities in other maternal and health outcomes, including preterm birth and infant mortality.

7. Other Medicaid and Children's Health Insurance (CHIP) Changes

BACKGROUND

Under current law, states have the option to provide 12-months of continuous coverage for children. Under this option, states allow a child to remain enrolled for a full year unless the child ages out of coverage, moves out of state, voluntarily withdraws, or does not make premium payments. As such, 12-month continuous eligibility eliminates coverage gaps due to fluctuations in income over the course of the year.

Under current law, Medicaid is the base of coverage for low-income children. CHIP complements Medicaid by covering uninsured children in families with incomes above Medicaid eligibility levels. Unlike Medicaid, federal funding for CHIP is capped and provided as annual allotments to states. CHIP funding is authorized through September 30, 2027. While CHIP generally has bipartisan support, during the last reauthorization funding lapsed before Congress reauthorized funding.

PROVISION DESCRIPTION
Section 30741 of the Build Back Better Act would require states to extend 12-month continuous coverage for children on Medicaid and CHIP.

Section 30801 of the Build Back Better Act would permanently extend the CHIP program.

PEOPLE AFFECTED
As of May 2021, there were 39 million children enrolled in Medicaid and CHIP (nearly half of all enrollees). As of January 2020, 34 states provide 12-month continuous eligibility to at least some children in either Medicaid or CHIP. A recent MACPAC report found that the overall mean length of coverage for children in 2018 was 11.7 months, and also that rates of churn (in which children dis-enroll and reenroll within a short period of time) were lower in states that had adopted the 12-month continuous coverage option and in states that did not conduct periodic data checks. Another recent report shows that children with gaps in coverage during a year are more likely to be children of color with lower incomes.

As of May 2021, there were 6.9 million people (mostly children) enrolled in CHIP.

8. Other Medicaid Financing and Benefit Changes

BACKGROUND
Unlike in the 50 states and D.C., annual federal funding for Medicaid in the U.S. Territories is subject to a statutory cap and fixed matching rate. The funding caps and match rates have been increased by Congress in response to emergencies over time.

To help support states and promote stability of coverage during the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) provides a 6.2 percentage point increase in the federal share of certain Medicaid spending, provided that states meet maintenance of eligibility (MOE) requirements that include ensuring continuous coverage for current enrollees.

Vaccines are an optional benefit for certain adult populations, including low-income parent/caretakers, pregnant women, and persons who are eligible based on old age

or a disability. For adults enrolled under the ACA's Medicaid expansion and other populations for whom the state elects to provide an "alternative benefit plan," their benefits are subject to certain requirements in the ACA, including coverage of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) with no cost sharing.

Under the Families First Coronavirus Response Act, coverage of testing and treatment for COVID-19, including vaccines, is required with no cost sharing in order for states to access temporary enhanced federal funding for Medicaid which is tied to the public health emergency. The American Rescue Plan Act (ARPA) clarified that coverage of COVID-19 vaccines and their administration, without cost sharing, is required for nearly all Medicaid enrollees, through the last day of the 1st calendar quarter beginning at least 1 year after the public health emergency ends. The ARPA also provides 100% federal financing for this coverage.

PROVISION DESCRIPTION

Section 30731 of the Build Back Better Act would increase the Medicaid cap amount and match rate for the territories. The FMAP would be permanently adjusted to 83% for the territories beginning in FY 2022, except that Puerto Rico's match rate would be 76% in FY 2022 before increasing to 83% in FY 2023 and subsequent years. The legislation would also require a payment floor for certain physician services in Puerto Rico with a penalty for failure to establish the floor.

Section 30741 of the Build Back Better Act would phase out the FFCRA enhanced federal funding to states. States would continue to receive the 6.2 percentage point increase through March 31, 2022, followed by a 3.0 percentage point increase from April 1, 2022 through June 30, 2022, and a 1.5 percentage point increase from July 1, 2022 through September 30, 2022.

Section 30741 also would modify the FFCRA MOE requirement for continuous coverage. From April 1 through September 30, 2022, states could continue receiving the enhanced federal matching funds if they terminate coverage for individuals who are determined no longer eligible for Medicaid and have been enrolled at least 12 consecutive months. The legislation includes other rules for states about conducting eligibility redeterminations and when states can terminate coverage.

Section 30751 of the Build Back Better Act would establish a 3.1 percentage point FMAP reduction from October 1, 2022 through December 31, 2025 for states that adopt eligibility standards, methodologies, or procedures that are more restrictive than those in place as of October 1, 2021 (except the penalty would not apply to coverage of non-pregnant, non-disabled adults with income above 133% FPL after December 31, 2022, if the state certifies that it has a budget deficit).

Section 139405 of the Build Back Better Act would require state Medicaid programs to cover all approved vaccines recommended by ACIP and vaccine administration, without cost sharing, for categorically and medically needy adults. States that provide adult vaccine coverage without cost sharing as of the date of enactment would receive a 1 percentage point FMAP increase for 8 quarters.

PEOPLE AFFECTED

In June 2019 there were approximately 1.3 million Medicaid enrollees in the territories (with 1.2 million in Puerto Rico).

From February 2020 through May 2021 Medicaid and CHIP enrollment has increased by 11.5 million or 16.2% due to the economic effects of the pandemic and MOE requirements.

All states provide some vaccine coverage for adults enrolled in Medicaid who are not covered as part of the ACA's Medicaid expansion, but as of 2019, only about half of states covered all ACIP-recommended vaccines.

9. Medicaid Home and Community Based Services and the Direct Care Workforce

BACKGROUND

Medicaid is currently the primary payer for long-term services and supports (LTSS), including home and community-based services (HCBS), that help seniors and people with disabilities with daily self-care and independent living needs. There is currently a great deal of state variation as most HCBS eligibility pathways and benefits are optional for states.

PROVISION DESCRIPTION

Sections 30711-30713 of the Build Back Better Act would create the HCBS Improvement Program, which would provide a permanent 6 percentage point increase in federal Medicaid matching funds for HCBS. To qualify for the enhanced funds, states would have to maintain existing HCBS eligibility, benefits, and payment rates and have an approved plan to expand HCBS access, strengthen the direct care workforce, and monitor HCBS quality. The bill includes some provisions to support family caregivers. In addition, the Act would include funding ($130 million) for state planning grants and enhanced funding for administrative costs for certain activities (80% instead of 50%).

Section 30714 of the Build Back Better Act would require states to report HCBS quality measures to HHS, beginning 2 years after the Secretary publishes HCBS quality measures as part of the Medicaid/CHIP core measures for children and adults. The bill provides states with an enhanced 80% federal matching rate for adopting and reporting these measures.

Sections 30715 and 30716 of the Build Back Better Act would make the ACA HCBS spousal impoverishment protections and the Money Follows the Person (MFP) program permanent.

Sections 22301 and 22302 of the Build Back Better Act would provide $1 billion in grants to states, community-based organizations, educational institutions, and other entities by the Department of Labor Secretary to develop and implement strategies for direct service workforce recruitment, retention, and/or education and training. Section 25005 of the Build Back Better Act would provide $20 million for HHS and the Administration on Community Living to establish a national technical assistance center for supporting the direct care workforce and family caregivers.

Section 25006 of the Build Back Better Act would provide $40 million for the HHS Secretary to award to states, nonprofits, educational institutions, and other entities to address the behavioral health needs of unpaid caregivers of older individuals and older relative caregivers.

PEOPLE AFFECTED

The majority of HCBS are provided by waivers, which served over 2.5 million enrollees in 2018. There is substantial unmet need for HCBS, which is expected to increase with the growth in the aging population in the coming years. Nearly 820,000 people in 41 states were on a Medicaid HCBS waiver waiting list in 2018. Though waiting lists alone are an incomplete measure, they are one proxy for unmet need for HCBS. Additionally, a shortage of direct care workers predated and has been intensified by the COVID-19 pandemic, characterized by low wages and limited opportunities for career advancement. The direct care workforce is disproportionately female and Black.

A KFF survey found that, as of 2018, 14 states expected that allowing the ACA spousal impoverishment provision to expire would affect Medicaid HCBS enrollees, for example by making fewer individuals eligible for waiver services.

Over 101,000 seniors and people with disabilities across 44 states and DC moved from nursing homes to the community using MFP funds from 2008-2019. A federal evaluation of MFP showed about 5,000 new participants in each six month period from December 2013 through December 2016, indicating a continuing need for the program.

10. Paid Family and Medical Leave

BACKGROUND

The U.S. is the only industrialized nation without a minimum standard of paid family or medical leave. Although six states and DC have paid family and medical leave laws in effect, and some employers voluntarily offer these benefits, this has

resulted in a patchwork of policies with varying degrees of generosity and leaves many workers without a financial safety net when they need to take time off work to care for themselves or their families.

PROVISION DESCRIPTION

Section 130001 of the Build Back Better Act would guarantee four weeks per year of paid family and medical leave to all workers in the U.S. who need time off work to welcome a new child, recover from a serious illness, or care for a seriously ill family member. Annual earnings up to $15,080 would be replaced at approximately 90% of average weekly earnings, plus about 73% of average weekly earnings for annual wages between $15,080 and $32,248, capping out at 53% of average weekly earnings for annual wages between $32,248 and $62,000. While all workers taking qualified leave would be eligible for at least some wage replacement, the progressive benefits formula means that the share of pay replaced while on qualified leave is highest for workers with lower wages. The original Act called for 12 weeks of paid leave for similar qualified reasons, plus three days of bereavement leave, and benefits began at 85% of average weekly earnings for annual wages up to $15,080 and were capped at 5% of average weekly earnings for annual wages up to $250,000.

PEOPLE AFFECTED

According to the Bureau of Labor Statistics (BLS), approximately one in four (23%) workers has access to paid family leave through their employer. Data on the share of workers with access to paid medical leave for their own longer, serious illness are limited, although BLS also reports that 40% of workers have access to short-term disability insurance.

It is estimated that 53 million adults are caregivers for a dependent child or adult and 61% of them are women. Sixty percent (60%) of caregivers reported having to take a leave of absence leave from work or cut their hours in order to care for a family member. Workers who take leave do so for different reasons: Half (51%) reported taking leave due to their own serious illness, one-quarter (25%) for reasons related to pregnancy, childbirth, or bonding with a new child, and one-fifth (19%) to care for a seriously ill family member. In total, four in ten (42%) reported receiving their full pay while on leave, one-quarter (24%) received partial pay, and one-third (34%) received no pay.

Social Security

In 2022, Social Security Beneficiaries Will See the Biggest Increase in 39 Years

The year was 1983: The U.S. invaded Granada. A gallon of gas cost 96 cents. Michael Jackson's 'Thriller' video premiered. That year was also the last time that Social Security recipients saw a cost-of-living increase steeper than the one just

announced for 2022. This year, Social Security benefits will rise 5.9 percent, the sharpest upsurge since 1983's 7.4 percent jump.

Cost-of-living increases are tied to the consumer price index, and rising inflation rates and gas prices caused by the ongoing coronavirus pandemic mean Social Security recipients will get a large boost in 2022. The 5.9 percent increase dwarfs last year's 1.3 percent rise, and over the past decade hikes have averaged just 1.65 percent. The average monthly benefit of $1,565 in 2021 will go up by $92 a month to $1,657 a month for an individual beneficiary, or $19,884 yearly.

The cost-of-living change also affects the maximum amount of earnings subject to the Social Security tax, which will grow from $142,800 to $147,000.

For 2022, the monthly federal Supplemental Security Income (SSI) payment standard will be $841 for an individual and $1,261 for a couple.

Part of the increase will be eaten up by higher Medicare Part B premiums, however. The standard monthly premium for Medicare Part B enrollees has not been announced yet, but it is projected to rise $10 a month to $158.30. And the 5.9 percent Social Security increase may not be enough for seniors to keep pace with rising health care and prescription drug costs.

"You're glad that you get a 5.9 percent increase, but it doesn't feel like you're getting 5.9 percent when all of your other costs are going up much higher," said Nancy Altman, president of the advocacy group Social Security Works.

Most beneficiaries will be able to find out their specific cost-of-living adjustment online by logging on to *my* Social Security in December 2021. While you can still receive your increase notice by mail, you have the option to get the notice online instead.

You May Be Overestimating Your Social Security Benefits

Studies have found that workers overestimate how much they will receive in Social Security benefits when they retire. Having a good understanding of the realities can help you plan for retirement.

Researchers from the University of Michigan studied the expectations of workers and found great uncertainty about future Social Security benefits as well as a tendency to overestimate the amount they think they will receive. Half of the workers surveyed in the study did not know their benefit amount. The average overestimation of the benefit was $307 a month, more than one-quarter of the average forecasted benefit. The study found that as workers got older, however, they were more likely to understand their benefits and less likely to overestimate benefit amounts.

Nationwide Retirement Institute's annual Social Security survey similarly found that future retirees over age 50 expect to receive a higher payment than what actual retirees receive. In this survey, respondents were off by nearly $200 a month. And almost 70 percent of Baby Boomers mistakenly believe that if they claim Social Security early, their benefit will go up automatically when they reach full retirement age. Not surprisingly, the Nationwide survey also found that more than half of workers are not confident in their understanding Social Security or how much money they will receive.

Not understanding how much you will get from Social Security could lead to you to save less money for retirement while you are working. Setting aside money in a retirement account early can lead to big dividends later. The University of Michigan study found that spending and saving choices based on incorrect expectations lead to less ability to spend in retirement.

Confusion about benefits could also cause you to start taking benefits before you should. Both the University of Michigan study and the Nationwide survey found that workers have misconceptions about claiming Social Security benefits early. Many people do not understand that if they take Social Security benefits early, it will permanently reduce their benefits.

Individuals who file for Social Security benefits at age 62 – before their full retirement age -- will receive around 72 percent of their full benefit. On the other hand, if you delay taking Social Security benefits beyond your full retirement age your benefit will increase by 8 percent for every year that you delay, in addition to any cost-of-living increases, up to age 70.

For those retiring in 2021 at their full retirement age, the average monthly Social Security benefit is $1,543 for an individual and $2,596 for a couple who both receive benefits, meaning that many will receive less than this amount based on their work and earnings history. The maximum monthly Social Security benefit that an individual can receive in 2021 is $3,895 if they wait until age 70 to collect. And keep in mind that many retirees have their Medicare Part B and Part D premiums deducted from their Social Security checks.

To gain a solid understanding of your expected Social Security benefits, you can create a *my* Social Security account. The account will give you retirement benefit estimates based on what you are currently earning.

Social Security Shortfalls Are Predicted to Begin a Year Earlier Due to the Pandemic

The Social Security trustees are projecting that due to the economic downturn caused by the pandemic the Social Security trust fund will be depleted in 2033 -- one year earlier than the previous estimates. Once the fund is depleted, Social Security benefits will be reduced unless Congress acts in the interim.

Social Security retirement benefits are financed primarily through dedicated payroll taxes paid by workers and their employers, with employees and employers splitting the tax equally. Employers pay 6.2 percent of an employee's income into the Social Security system, and the employee kicks in the same. Self-employed individuals pay the entire 12.4 percent Social Security payroll tax. This money is put into a trust fund that is used to pay retiree benefits.

The trustees of the Social Security trust fund now predict that if Congress doesn't take action, the fund's balance will reach zero in 2033. The coronavirus pandemic has caused job losses, lowered wages and interest rates, and a drop in gross domestic product, which means payroll taxes declined. Sadly, an increase in deaths of older Americans due to Covid helped to keep Social Security from losing as much money as some had feared. The impact of the pandemic over the longer term is still unclear, and the trustees said they are making no long-range assumptions "given the unprecedented level of uncertainty."

Once the fund runs out of money, it does not mean that benefits stop altogether. Instead, retirees' benefits would be cut. According to the trustees' projections, the fund's income from payroll taxes would be sufficient to pay retirees 76 percent of their total benefit (or 78 percent if the Disability Insurance fund is included).

The trustees recommend that Congress take immediate action to address the problem, but Social Security reform is not a top priority in Washington right now. Steps Congress could take to shore up Social Security include eliminating the cap on income subject to tax. Right now, workers pay Social Security tax only on the first $142,800 of income (in 2021). That amount can be increased, so that higher-earning workers pay more in taxes. The Social Security tax or the retirement age could also be increased.

Medicare

Medicare Open Enrollment 2022: Is Your Plan Still Working for You?

Every year Medicare gives beneficiaries a window of opportunity to shop around and determine if their current Medicare plan is still the best one for them. During

Medicare's Open Enrollment Period, which runs from October 15 to December 7, beneficiaries can freely enroll in or switch plans.

During this period, you may enroll in a Medicare Part D (prescription drug) plan or, if you currently have a plan, you may change plans. In addition, during the seven-week period you can return to traditional Medicare (Parts A and B) from a Medicare Advantage (Part C, managed care) plan, enroll in a Medicare Advantage plan, or change Advantage plans.

Beneficiaries can go to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to make changes in their Medicare prescription drug and health plan coverage. According to the *New York Times*, few Medicare beneficiaries take advantage of Open Enrollment, but of those who do, nearly half cut their premiums by at least 5 percent. Even beneficiaries who have been satisfied with their plans in 2021 should review their choices for 2022, as both premiums and plan coverage can fluctuate from year to year. For example:

- Are the doctors you use still part of your Medicare Advantage plan's provider network?
- Have any of the prescriptions you take been dropped from your prescription plan's list of covered drugs (the "formulary")?
- What are your total out-of-pocket costs?
- Could you save money with the same coverage by switching to a different plan?

For answers to questions like these, carefully look over the plan's "Annual Notice of Change" letter to you. Prescription drug plans can change their premiums, deductibles, the list of drugs they cover, and their plan rules for covered drugs, exceptions, and appeals. Medicare Advantage plans can change their benefit packages, as well as their provider networks.

Remember that fraud perpetrators will inevitably use the Open Enrollment Period to try to gain access to individuals' personal financial information. Medicare beneficiaries should never give their personal information out to anyone making unsolicited phone calls selling Medicare-related products or services or showing up on their doorstep uninvited. If you think you've been a victim of fraud or identity theft, contact Medicare.

Here are more resources for navigating the Open Enrollment Period:

- Medicare Plan Finder, which helps you find a plan to match your needs: www.medicare.gov/find-a-plan
- Medicare coverage options: www.medicare.gov/medicarecoverageoptions/

- The 2022 Medicare & You handbook, which all Medicare beneficiaries should have received. The handbook can also be downloaded online at: medicare.gov/forms-help-resources/medicare-you-handbook/download-medicare-you-in-different-formats
- The Medicare Rights Center: www.medicareinteractive.org
- Your State Health Insurance Assistance Program, which offers independent counseling: www.shiptacenter.org

Dual Eligibility: How Qualifying for Both Medicare and Medicaid Can Help With Costs

Qualifying for Medicare hardly means free health care -- there are still premiums and deductibles. However, people who qualify for both Medicare and Medicaid (called "dual eligibility") receive help paying their out-of-pocket costs.

Medicare is a federal program available to anyone 65 or older. It consists of four major parts, each of which have premiums and co-pays associated with them:

- Part A covers hospital stays and some limited nursing home stays
- Part B covers office visits, physician fees, medical equipment, home care, and preventative services
- Part C (called Medicare Advantage) permits Medicare beneficiaries to receive Part A and B benefits from private insurance companies
- Part D covers prescription medications

Medicaid is a joint federal and state program that provides health insurance to low-income adults, children, and people with disabilities. It is also the primary method of paying for nursing home care. To qualify for coverage, applicants must have limited assets and income.

To be considered dually eligible, beneficiaries can be enrolled in either Medicare and full Medicaid or in Medicare and one of Medicaid's Medicare Savings Programs. Medicare Savings Programs are state programs, run through Medicaid, that provide help paying for Medicare premiums. When Medicare and Medicaid coverage overlap, Medicare always pays for the services first. If Medicare doesn't cover the full cost, then Medicaid may cover the remaining cost. Medicaid may also cover some costs that Medicare does not cover, like long-term nursing home care.
The benefits available to dual eligible beneficiaries depend on which Medicaid program the beneficiary is enrolled in:

- **Full Medicaid**. Beneficiaries receive full Medicaid coverage. Because Medicaid is a state-run program, additional benefits can vary by state. Some states may pay Medicare's Part B premiums. In addition, beneficiaries do not

have to pay more than the amount allowed under the state's Medicaid program for services by Medicare providers.

- **Qualified Medicare Beneficiary (QMB) Program**. Beneficiaries receive help paying Part A and Part B premiums, deductibles, coinsurance, and copayments.
- **Specified Low-Income Medicare Beneficiary (SLMB) Program**: Beneficiaries receive help paying Part B premiums.
- **Qualifying Individual (QI) Program**: Beneficiaries receive help paying Part B premiums but help is limited on a first-come, first-served basis.
- **Qualified Disabled Working Individual (QDWI) Program**. Pays Part A premiums for certain disabled and working beneficiaries under 65 who meet certain income and resource limits set by their state.

Estate Planning

Estate Planning Demystified

What is Estate Planning?

While this designation is very recent, the concept of Estate Planning itself is not. "Estate planning is a process involving the counsel of professional advisors who are familiar with your goals and concerns, your assets and how they are owned, and your family structure. It can involve the services of a variety of professionals, including your lawyer, accountant, financial planner, life insurance advisor, banker, and a broker. Estate planning covers the transfer of property at death and a variety of other personal matters and may or may not involve tax planning. The core document most often associated with this process is your will. Estate planning also ensures that the estate will not be destroyed by taxes imposed on the transfer of assets at death."[1]

How Estate Planning and Federal Estate Tax are Intertwined

The United States' early beginnings of Estate Tax began when The Stamp Act of 1797 was enacted to fund the undeclared Naval "Quasi-War" with France between 1798-1800. "Most documents associated with an inheritance required an embossed revenue stamp, the cost of which was graduated according to the size of the inherited sum."[2] Over the years, it has evolved to more of what we know of today with the passage of The Revenue Act of 1916 to help fund WWI. The Revenue Act of 1924 added a gift tax with the same rate schedule as the estate tax. After another round of these Acts being repealed and reinstated, they were consolidated within the 1976 Tax Reform Act with more modifications to follow with the Revenue Act of 1978. Today, the federal estate tax exemption (the amount you can have and not pay a tax) is $11,700,000 per person. Few people have federal estate tax problems as a result. However, state estate tax exemptions are often lower, and they vary from state to state, which can be a tax for the unwary.

Moreover, the estate tax exemption, which has always been in flux, may change dramatically before the end of 2021 if Congress and the President sign into law a bill that the House has passed. That bill also makes many other significant changes to tactics used by lawyers to assist their clients in reducing estate tax bills. So if there was ever a time to speak with your attorney or financial advisor about estate tax planning, that time is now.

Why is Estate Planning Important?

"Estate planning is important for everyone, no matter their age or wealth. Estate planning avoids taxes and legal tie-ups and ensures funds are bequeathed as you wish. An estate plan elects the right people to take care of your kids and even you if you're incapacitated."[3] Estate planning often involves the creation of powers of attorney and healthcare-related documents that avoid costly conservators or guardianships. Every person over the age of 18 should, at a minimum, have a power of attorney and an Advance Health Care Directive/Proxy/Living Will. Estate planning is the process of planning for the transfer of everything you own to those persons you want it to go to after you die and so much more. Wills and trusts are some of the documents used in estate planning, and it is essential that all means by which assets transfer at death work together to achieve your desired result. It can also include planning for or dealing with a disability. That coordination is critical and frequently overlooked.

Estate Planning Documents

Many document solutions to common estate planning concerns include probate avoidance, asset preservation, legacy planning, estate tax planning, privacy planning, and charitable giving. Initially, the focus should be on the *goal* rather than the *means (the legal document)*.

- *Who* are you trying to benefit?
- *What* are you trying to achieve?
- *When*?
- *Why*?

These questions are often more critical than *how* (the document solution). Identifying your goals makes determining how to achieve them much less complicated. By taking the following steps, you will achieve your estate planning goals:

- Get the facts
- Make informed decisions
- Organize your thoughts
- Put them into motion

Be proactive and get your affairs in order. Clients often mention how relieved they feel once their planning documents are in place and that they have a relationship with an attorney that they, or their loved ones, can depend on in the future.

10 Reasons to Create an Estate Plan Now

Many people think that estate plans are for someone else, not them. They may rationalize that they are too young or don't have enough money to reap the tax benefits of a plan. But as the following list makes clear, estate planning is for everyone, regardless of age or net worth.

1. Loss of capacity. What if you become incompetent and unable to manage your own affairs? *Without a plan,* the courts will select the person to manage your affairs. *With a plan,* you pick that person through a power of attorney.

2. Minor children. Who will raise your children if you die? *Without a plan,* a court will make that decision. *With a plan,* you are able to nominate the guardian of your choice.

3. Dying without a will. Who will inherit your assets? *Without a plan*, your assets pass to your heirs according to your state's laws of intestacy (dying without a will). Your family members (and perhaps not the ones you would choose) will receive your assets without the benefit of your direction or of trust protection. *With a plan,* you decide who gets your assets, and when and how they receive them.

4. Blended families. What if your family is the result of multiple marriages? *Without a plan,* children from different marriages may not be treated as you would wish. *With a plan,* you determine what goes to your current spouse and to the children from a prior marriage or marriages.

5. Children with special needs. *Without a plan*, a child with special needs risks being disqualified from receiving Medicaid or SSI benefits and may have to use his or her inheritance to pay for care. *With a plan*, you can set up a supplemental needs trust that will allow the child to remain eligible for government benefits while using the trust assets to pay for non-covered expenses.

6. Keeping assets in the family. Would you prefer that your assets stay in your own family? *Without a plan*, your child's spouse may wind up with your money if your child passes away prematurely. If your child divorces his or her current spouse, half of your assets could go to the spouse. *With a plan,* you can set up a trust that ensures that your assets will stay in your family and, for example, pass to your grandchildren.

7. Financial security. Will your spouse and children be able to survive financially? *Without a plan* and the income replacement provided by life insurance,

your family may be unable to maintain its current living standard. *With a plan*, life insurance can mean that your family will enjoy financial security.

8. Retirement accounts. Do you have an IRA or similar retirement account? *Without a plan*, your designated beneficiary for the retirement account funds may not reflect your current wishes and may result in burdensome tax consequences for your heirs. *With a plan*, you can choose the optimal beneficiary.

9. Business ownership. Do you own a business? *Without a plan*, you don't name a successor, thus risking that your family could lose control of the business. *With a plan*, you choose who will own and control the business after you are gone.

10. Avoiding probate. *Without a plan*, your estate may be subject to delays and excess fees (depending on the state), and your assets will be a matter of public record. *With a plan*, you can structure things so that probate can be avoided entirely.

When Should You Update Your Estate Plan?

Once you've created an estate plan, it is important to keep it up to date. You will need to revisit your plan after certain key life events, including marriage, the birth of children, divorce or the death of a spouse, and a significant increase or decrease in assets. Here's why.

Marriage

Whether it is your first or a later marriage, you will need to update your estate plan after you get married. A spouse may not automatically become your sole heir once you get married. Depending on state law, your spouse may get one-third to one-half of your estate, and the rest will go to other relatives. You need a will to spell out how much you wish your spouse to get.

Your estate plan will get more complicated if your marriage is not your first. You and your new spouse need to figure out where each of you wants your assets to go when you die. If you have children from a previous marriage, this can be a difficult discussion. There is no guarantee that if you leave your assets to your new spouse, he or she will provide for your children after you are gone. There are a number of options to ensure your children are provided for, including creating a trust for your children, making your children beneficiaries of life insurance policies, or giving your children joint ownership of property.

Even if you don't have children, there may be family heirlooms or mementos that you want to keep in your family.

Children

Once you have children, it is important to name a guardian for your children in your will. If you don't name someone to act as guardian, the court will choose the guardian. Because the court doesn't know your kids like you do, the person they

choose may not be ideal. In addition to naming a guardian, you may also want to set up a trust for your children so that your assets are set aside for your children when they get older.

Similarly, when your children reach adulthood, you will want to update your plan to reflect the changes. They will no longer need a guardian, and they may not need a trust. You may even want your children to act as executors or hold a power of attorney.

Divorce or Death of a Spouse

If you get divorced or your spouse dies, you will need to revisit your entire estate plan. It is likely that your spouse is named in some capacity in your estate plan -- for example, as beneficiary, executor, or power of attorney. If you have a trust, you will need to make sure your spouse is no longer a trustee or beneficiary of the trust. You will also need to change the beneficiary on your retirement plans and insurance policies.

Increase or Decrease in Assets

For some, one part of estate planning is estate tax planning. When your estate is small, you don't usually have to worry about estate taxes because only estates over a certain amount, depending on current state and federal law, are subject to estate taxes. As your estate grows, you may want to create a plan that minimizes your estate taxes. If you have a plan that focuses on tax planning, but you experience a decrease in assets, you may want to change your plan to focus on other things.

Other

Other reasons to have your estate plan updated could include:

- You move to another state
- Federal or state estate tax laws have changed
- A guardian, executor, or trustee is no longer able to serve
- You wish to change your beneficiaries
- It has been more than 5 years since the plan has been reviewed by an attorney

Prescription Safety

It probably isn't news to you that our country is experiencing a prescription drug crisis. If you take prescription drugs or care for someone that does, make an effort to ensure that access to them is restricted and that unused drugs are correctly destroyed.

Financial Abuse and Scams (Yes, it can happen to you!)

By mail, email, and phone, scams continue to plague us, and the elderly are a prime target. People calling asking for you to send money, that you have won a prize, that

your computer is infected with a virus, and more, are all potential scammers. Review the Maine Attorney General's scam tips, and when in doubt, please call us to ask. https://www.maine.gov/ag/consumer/scams.shtml. If you think you have been a victim, ask for help quickly.

Online Survey Helps Older Adults Assess Their Financial Vulnerability

All older Americans are vulnerable to financial abuse, but there are certain circumstances that make someone more likely to be scammed. An online survey can help older adults (or their caregivers) assess their risk of being exploited based on how they make financial decisions.

It is hard to ascertain the exact number of people affected by financial exploitation because studies show that elder abuse is underreported. However, one study found that monetary loss from financial elder abuse could be close to $3 billion a year.

Experts have found that there are certain risk factors that can help indicate when someone is more likely to fall prey to a financial scam. Peter Lichtenberg, director of the Institute of Gerontology at Wayne State University, found that older adults' physical and mental health, along with their family and friend network, help predict their financial vulnerability.

Lichtenberg has created a website (www.olderadultnestegg.com) with resources for professionals, older adults, and family members to assess whether someone is at-risk. He provides trainings for caregivers on how to determine if a loved one is experiencing cognitive decline and how to spot financial mismanagement. The website also includes a financial vulnerability survey that assesses a person's risk of exploitation by asking 17 targeted questions. At the end of the survey, participants get a low, moderate, or high-risk assessment. There are also resources to direct older adults and caregivers on how to get help. .

10 Ways the Elderly Can Avoid Financial Abuse

Increased dependency due to illness, disability or cognitive impairments can make seniors susceptible to financial abuse. Nest eggs accumulated over decades also often make seniors attractive targets for financial predators, whether the predator is a bogus offshore sweepstakes or a care provider who sees an opportunity to be paid more than an hourly wage. Just as sunlight makes the best disinfectant, transparency provides the strongest abuse protection. If others are aware of the senior's finances, either would-be predators will see that no opportunity exists to take advantage of the senior, or the family members or professionals can step in to keep any fraud from

going too far. Here are some steps seniors or their loved ones can take to prevent financial abuse.

1. Use direct deposit
Set up direct deposit, so pension and benefit checks are deposited directly into the senior's account. That way checks cannot go missing in the mail or be taken by nefarious caregivers.

2. Arrange for account oversight
Make sure that someone close to the senior has access to his or her accounts to be able to see if anything unusual is going on, like big checks being written or larger-than-usual cash withdrawals from ATMs. The oversight can be through copies of monthly statements or online access to accounts. A joint account with someone gives them oversight as well as the ability to write checks, make investment decisions and take steps if necessary to protect the funds in the account. It also avoids probate, making the transition somewhat easier at the owner's death. But make sure you only add the name of someone you really trust to the account because it can also be an avenue for financial abuse if the joint owner becomes the perpetrator. And joint accounts can affect Medicaid planning.

3. Use a revocable trust
Revocable trusts can be useful for a number of reasons. They include all of the benefits of joint accounts, with few of the drawbacks. Your revocable trust gives someone you trust access to your accounts in trust and the ability to step in seamlessly if you become disabled. Unlike a joint account, it does not give the trustee any ownership interest in the account. If, for instance, you had four children but named one as a co-owner of your joint accounts, at your death she would have the legal right to keep the funds rather than share them with her siblings. That would not be the case with a revocable trust.

4. Build safeguards into a power of attorney
A power of attorney allows a person to appoint an agent to act in his or her place for financial purposes when and if the person ever becomes incapacitated. Unfortunately, unscrupulous agents can take advantage of this power. If this is a concern, the power of attorney document can build in safeguards. For example, the document could name co-agents or require the agent to periodically report to a third party.

5. Visit often
Nothing prevents financial abuse or stops it in its tracks better than frequent visits by loved ones. Either the potential perpetrator will see that the senior can't be isolated and taken advantage of or family members and friends will notice the abuse before it goes too far. If possible, offer to help sort bills and look at finances.

6. Talk about finances and scams
You should talk to your loved ones about their finances and stay up to date on the various scams going around. You can check with the AARP fraud website to monitor current scams in your area. Make sure seniors understand not to click on links in emails or give out personal information over the phone.

7. Simplify finances
Over the years, seniors may have opened a number of accounts and have several credit cards. You should streamline these down to a few essential accounts and cards in order to make things easier to monitor.

8. Use a limited credit card
Credit cards are now available that allow another person to monitor the activity of the cardholder and to limit both the amount spent and where it can be spent. One of these is the True Link card. You could also use a prepaid Visa card.

9. Limit calls
It is quite easy to register your telephone number with the Federal Trade Commission's Do Not Call Registry either online at www.donotcall.gov or by calling 888.382.1222. While this may not stop someone intent on defrauding a senior, it should help reduce calls from salespeople. You can also sign up for Nomorobo to block some robo calls.

10. Opt out of mail solicitations
At www.dmachoice.org the Direct Marketing Association permits you to limit the amount of catalogs, credit card offers and other direct mail pieces you or a loved one receives.

Your attorney can help set up a revocable trust and durable power of attorney to assist with financial management, advise on the best protective steps to take in your specific situation, and provide additional oversight to discourage financial abuse.
While there's no foolproof measure you can take that will both prevent financial fraud and leave you or your loved one with at least some independence and control over his or her finances, the steps described above can make the world a safer financial place. Just remember what was said at the beginning: isolation is a breeding ground for financial abuse (as well as depression and other illnesses). Social involvement is the best protection.

Stay Connected!

Follow us on social media!

- We manage an active Facebook presence at www.facebook.com/myestateplan. Its speed and cost-effectiveness allow us to pass on the savings to you!

- We recently created a Twitter account, which can be found by searching either @pllcrogers or https://twitter.com/PllcRogers.

- We also recently created an Instagram account, which can be found by searching either @brennanrogerspllc or https://www.instagram.com/brennanrogerspllc/.

- We are on LinkedIn at https://www.linkedin.com/company/law-office-of-smilie-g.-rogers-pllc/

- We also recently created a Pinterest account, which can be found by searching @brennanrogersme or https://www.pinterest.com/brennanrogersme/

Check out our Legal Blog!

We maintain an active blog titled **Planning for Life's Transitions** conveniently located on our newly redesigned website! It touches on a variety of topics that we come across every day. Please let us know if you have any questions.

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Happy Holidays!