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TSCL—Defending Your Earned Benefits For 23 Years

THE SOCIAL SECURITY & MEDICARE
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How Using the Chained CPI to Calculate COLAs Would Affect Your Benefits

The newly enacted tax legislation calls for adjusting tax brackets and the standard deduction using the more slowly growing Chained consumer price index (CPI). What would switching to the new index for calculating Social Security benefits mean for retired and disabled beneficiaries?

A new study released by The Senior Citizens League finds that the Chained CPI promises the worst of all worlds for tens of millions retirees and disabled Americans, lower benefits and higher taxes. The study found that had the government adopted the chained CPI to calculate COLAS since it first was launched in 2001, Social Security benefits would be about 5 percent lower today for people who have been retired since that date. Average benefits would be about $57 per month lower and total benefit income would be about $6,148 lower over the 17-year period. Even worse, if Congress were to adopt the chained CPI to calculate the COLA starting in 2017 (which it has NOT yet done), average benefits would be about $174 a month lower at the end of a typical 30-year retirement period, the report says.

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Retiree Expenses Up More Than $119 Month, COLA Up Less Than $45 Month

How well does the Social Security Cost-of-Living Adjustment (COLA) protect the buying power of Social Security benefits? Not very, according to early online results of TSCL's 2018 Senior Survey.

Retiree household spending rose by more than $119 per month in 2017 for a majority, 39 percent, of all

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No Limit to What Medicare Part D Enrollees Could Pay on Prescription Drugs

By Mary Johnson, editor

Your Part D drug plan would never tell you this, but the alarming fact is that there is no limit to what you might spend out-of-pocket for your prescriptions drugs in any given year. While this may not seem like much of a worry if you just take a few common generics, it becomes a far greater concern should you ever need high priced drugs—or have a medication bill of more than $600 per month. That could happen to any of us at any time.

While Part D costs are not capped, there is a "catastrophic level" of coverage that kicks in once Part D enrollees spend $5,000 of their own money out-of-pocket. Five thousand dollars is just the threshold in 2018. That threshold is forecast to rise to more than $9,000 per year in just eight years. Even worse, the $5,000 threshold is just for your covered drugs under Part D. It does not include other out-of-pocket spending for Medicare, such drugs you may receive through Medicare Part B (such as infusions received at a doctor's office), and all other out-of-pocket costs.

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Medicare Therapy Caps: A Long Battle for Patient Access

Madison West, Legislative Assistant

Mary Katherine was 90 when a stroke left her paralyzed on one side of her body and unable to speak. It was 1996 and at the time Medicare had a cap on physical and speech therapy services, which only allowed for a limited number of therapy sessions to help Mary Katherine regain the ability to walk, feed herself, and speak. The paltry coverage of therapy sessions from Medicare did not provide Mary Katherine with enough time or therapy to make much of an improvement in her physical health. Mary Katherine, who received a Social Security benefit of less than $250, couldn't afford more therapy and never recovered her speech. She remained paralyzed for the rest of her life, which she spent as a Medicaid patient in a nursing home.

Medicare's therapy cap on rehabilitation services, such as physical, occupational and speech therapy, has a long and sordid history in Washington D.C. The therapy cap sought to keep the Medicare budget under control but often hurt patients who need care after traumatic medical events. In practice, this cap limits access to Medicare-covered rehabilitation services. Patients are faced with either footing the bill for additional expensive care out of their own pocket or purchasing additional supplementary coverage if they can afford it.

Medicare first started covering rehabilitation services in 1972. Just seven years later in 1979, Congress enacted a cap of $500 on outpatient therapy due to concerns that rehabilitation outpatient services would take over the Medicare budget. The cap—which was indexed to medical inflation—remained in place until the passage of the "Balanced Budget Act of 1997," when a $1,500 cap was passed into law and set to take effect in 1999. However, President Clinton halted the implementation of the $1,500 cap, leaving services open to reimbursements by Medicare. Since 1999, several bills introduced in Congress sought to either repeal or keep the spending cap on rehabilitation services, with the cap drawing bipartisan criticism as being unfair to Medicare beneficiaries.

Only twice in the history of Medicare was the therapy cap actually implemented. In 2003, the cap was set at $1,500 until the cap was once again halted from being implemented that same year. Then earlier this year the cap briefly went into effect again. Congressman Erik Paulsen (MN-3) introduced the Medicare Access to Rehabilitation Services Act of 2017, a bill that would repeal the therapy cap permanently. This bill gained the bipartisan support of 240 cosponsors in the House of Representatives and TSCL was proud to endorse and build support for this piece of legislation.

In February of 2018, Congress took action and included a permanent repeal of the Medicare therapy cap in a two-year budget deal. The Senior Citizens League is proud to have endorsed the repeal of the therapy cap from the time such a repeal was proposed legislation in the Congress.

Madison West, Legislative Assistant

In order to learn more about what services you are eligible for under Medicare, call 1-800-MEDICARE (1-800-633-4227), a State Health Insurance Assistance Program counselor at your Area Agency on Aging, or your Member of Congress. ■

Sources: "History of Medicare Therapy Caps;" American Physical Therapy Association. January 2016.

How Do You Rate Your Member of the U.S. House of Representatives?

When we asked older voters to "rate your Representative" in the U.S. House on a scale of 0 to 5 on Medicare, survey participants rated their Member of the U.S. House 2.7 stars out of 5.

Here's how you voted:

★ ★ ★ ★ ★

5 stars	16%
4 stars	12%
3 stars	27%
2 stars	12%
1 stars	11%
0 stars	22%

Surprise! Recent Budget Law Accelerates Closing of Medicare Part D Doughnut Hole

By Jessie Gibbons, Legislative Director

Jessie Gibbons, Senior Policy Analyst

In February, after lawmakers allowed two government shutdowns to briefly take effect, Members of Congress finally passed the Bipartisan Budget Act of 2018. The massive budget deal set spending levels for two years and lifted the debt ceiling through March of next year. It came as a surprise to many in Washington—including The Senior Citizens League (TSCL)—and the agreement put an end to cycles of funding extensions that temporarily and irresponsibly funded the federal government for years.

Beyond funding the government and raising the debt ceiling, TSCL was pleased that the Bipartisan Budget Act included the following three improvements to the Medicare program:

1. **It eliminated the Independent Payment Advisory Board (IPAB).** This fifteen-member board of unelected officials was created by the Affordable Care Act in 2010 to keep Medicare spending down when it exceeded a certain level. While that level was never surpassed and no members were ever appointed to the board, TSCL felt that it could have threatened access to quality medical care for Medicare beneficiaries since it had the power to cut payments to doctors and limit networks of providers. TSCL has advocated for bipartisan legislation for years that would have eliminated the IPAB, and we were pleased that the Bipartisan Budget Act did just that.
2. **It accelerated the closing of the "doughnut hole."** Under prior law, the Medicare Part D coverage gap or "doughnut hole" was set to close in 2020. The Bipartisan Budget Act accelerated the closing of the gap so that it will occur one year earlier, in 2019. Instead of paying a coinsurance rate of 30% in the "doughnut hole," beneficiaries will pay 25%. And instead of brand-name drug manufacturers providing 50% discounts in the doughnut hole, they will begin providing 70% discounts. This means that more than one million Medicare Part D beneficiaries will pay less for their prescription drugs next year when they reach the gap in coverage.
3. **It closed the Medicare outpatient therapy cap.** Before the passage of the Bipartisan Budget Act, Medicare coverage for various forms of outpatient therapy—including physical therapy and speech therapy—was arbitrarily capped at $1,500 per year. For years, lawmakers sought to repeal this cap since it limited the care older Americans could receive under Medicare. TSCL advocated tirelessly for Congressman Erik Paulsen's (MN-3) bipartisan Medicare Access to Rehabilitation Services Act (H.R. 807), and we were thrilled that a similar provision was included in this year's bipartisan budget agreement, repealing the therapy cap once and for all.

TSCL believes these three Medicare improvements were long overdue, and we were pleased that lawmakers reached across the aisle earlier this year to address them once and for all. For more information about the Bipartisan Budget Act and the other Medicare improvements TSCL is advocating for on Capitol Hill, visit our website at www.SeniorsLeague.org. ■

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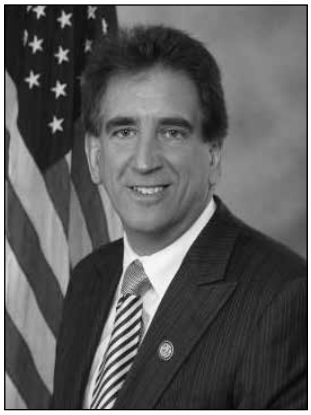
The Senior Citizens League is an organization of active seniors concerned about the protection of their earned Social Security, Medicare, military, and other retirement benefits. TSCL supporters participate in a number of grassroots lobbying and public education campaigns to help ensure governmental bodies live up to their commitments. Readers wishing to contact TSCL should address correspondence to The Senior Citizens League, 500 Montgomery Street, Suite 400, Alexandria, VA 22314. TSCL website: www.SeniorsLeague.org.

CONGRESSIONAL CORNER

Let's Reduce Barriers to Long-Term Care

By Congressman Jim Renacci (OH-16)



Congressman Jim Renacci (OH-16)

Over 2 million Ohioans are Medicare beneficiaries and rely not just on coverage for their health care services, but also access to the appropriate health care settings.

With nearly 1,000 skilled nursing facilities (SNFs) in our state, Ohio ranks third in the nation for offering these high-quality healthcare options to patients in need of post-acute and long-term care settings. Unfortunately, federal law limits Medicare's coverage of patients' stays in SNFs, which is why I introduced legislation to enhance access to quality care for Ohio's seniors.

As a former owner and operator of nursing facilities throughout Northeast Ohio, I understand the challenges families face when deciding upon the appropriate healthcare setting for their loved ones. From my experience, I also understand that, too often, our nation's seniors are being subjected to the wrong healthcare setting and are being denied the reimbursement they need.

Current law requires patients to first have an inpatient hospital stay of three or more consecutive days in order to meet Medicare criteria for reimbursement. Under this policy, even if physicians know that the proper care setting for a beneficiary is an SNF, the beneficiary must first have an inpatient hospital stay in order to qualify for Medicare coverage.

Regrettably, many seniors are often unaware of their patient status because they receive the same care whether they are admitted as inpatient or outpatient. When they seek to transition to a SNF, they are surprised to find they are not eligible for Medicare coverage.

The Office of the Inspector General reported that while over 617,000 beneficiaries had hospital stays lasting three or more nights, they did not qualify for SNF coverage under Medicare because their stays did not include three inpatient nights. Instead, they were left on the hook for their nursing care and other post-acute care services.

I find this policy unacceptable. Beneficiaries in need of skilled nursing care are among the frailest and oldest of the Medicare population, and they should not be shut out of these critical services because of nonsensical government policy.

To that end, I am introducing the Creating Access to Rehabilitation for Every Senior (CARES) Act. This commonsense legislation eliminates this three-day requirement to protect Medicare beneficiaries' access to skilled nursing care and to reduce barriers to healthcare services for Ohio's seniors. The CARES Act would allow SNFs that meet stringent criteria used by the Centers for Medicare and Medicaid Services to automatically waive the prior hospitalization requirement.

The CARES Act will better serve patients by providing access to quality care, at a reduced cost, and will make sure that Ohio's seniors—and all seniors nationwide—receive the treatment they need when they need it.

The opinions expressed in "Congressional Corner" reflect the views of the writer and are not necessarily those of TSCL.

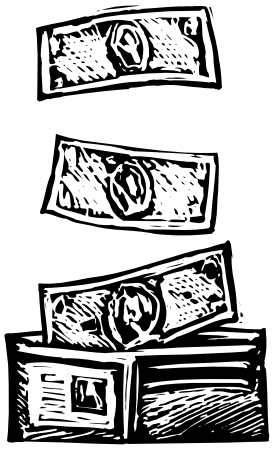
Your Opinion Counts!

We can strengthen Social Security, Medicare and Medicaid programs without the need for deep cuts and higher out-of-pocket costs. The Senior Citizens League needs your opinions and ideas to share with Members of Congress on the issues. Make sure they hear your concerns. Take a survey, sign a petition, read about the latest legislative action in Congress, or send us an email. Visit The Senior Citizens League's website at www.SeniorsLeague.org. ■

BEST WAYS TO SAVE

That Drug May Be Cheaper if You Pay Cash Instead of Using Your Drug Plan

By Mary Johnson



Before filling your next prescription, here's a tip. Call four pharmacies that you typically deal with and, without identifying yourself, ask their cash price for the drug, saying "you do not have insurance" if asked about your drug coverage. About one time out of four the price quoted may be lower than your drug plan's co-pay. If the price difference is large enough, it may be worth asking your doctor to send your prescription to the pharmacy with the lowest price and paying for it yourself out-of-pocket, rather than automatically sending your prescription to one of your drug plan's network pharmacies.

Calling in advance is important because you aren't likely to learn the real costs of the drug once you are actually at the pharmacy counter. "Gag clauses" are forcing pharmacists and their staff to keep quiet about cheaper cash prices that may be lower than your co-pay. For example, the common antibiotic, amoxicillin, is one of the cheapest and most widely-used drugs. The cost to the pharmacy is about $2.00 for 100 mg of liquid. A typical co-pay, however, could be $20, meaning the consumer would overpay $18. Pharmacies could save consumers money by giving them the information up front, but they risk their contracts with insurers and the big pharmaceutical benefit managers (PBM) that act as middlemen to negotiate prices with drug manufacturers. Most of the price difference is pocketed by insurers and the PBMs rather than returned to the consumer, currently.

Researchers from the University of Southern California Schaeffer Center For Health Policy & Economics launched a study that found that customers overpaid for their prescriptions 23 percent of the time, with an average overpayment of $7.69. Savings on brand drugs was higher than generics.

States across the country are moving to stop these gag clauses that prevent pharmacists from telling their customers when they could save money by paying cash instead of the co-pay charged by their insurance company. At least six states have adopted laws to make sure pharmacists can inform customers about the less expensive option to fill prescriptions. At least 26 other states are considering legislation to prohibit gag clauses according to the National Conference of State Legislatures.

TSCL believes that no PBM or insurer should be allowed to charge a co-payment that exceeds the actual cost of a medication and that Medicare law should be changed to ensure that beneficiaries receive the lowest price. TSCL supports two bills, the *Patient Right to Know Drug Prices Act, and the Know the Lowest Price Act* introduced by Senators Susan Collins (ME), Claire McCaskill (MO), and Debbie Stabenow (MI) that would prohibit health insurers and pharmacy benefit managers from using gag clauses, and would allow pharmacies to tell you when the retail cost is lower than your co-pay, a step forward in reducing

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SOCIAL SECURITY & MEDICARE QUESTIONS

Q: My dad passed away at 67 and my mother claimed a widow's benefit, at 65 based on his account. Now she's over age 70, and she's having trouble making ends meet. She worked for 30 years for a large company. Is there anything she can do to boost her benefit?

A: Maybe. Since your mom was entitled to both a widow's benefit, and her own retirement benefit, there may be a factor affecting her benefit that she needs to be aware of. A recent audit report from the Social Security Administration's Office of Inspector General found that the Social Security Administration (SSA) failed to tell 82% of widows or widowers, at the time when they applied for benefits, that they could switch to a higher retirement benefit later. The report said that 9,224 widows and widowers age 70 and above were *underpaid* approximately $131.8 billion, which works out to be an astonishing $14,288 per person, on average!

Normally when an individual files for Social Security benefits, the application includes all the benefits for which the claimant is entitled—in your mother's case, survivors and retirement benefits. SSA employees determine eligibility for the benefits, and should

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Best Ways To Save: That Drug May Be Cheaper if You Pay Cash Instead of Using Your Drug Plan; continued from page 5

drug costs for Medicare beneficiaries.

For more ways to save on prescription drugs, watch this video from *Consumer Reports:* "Don't Bother Paying More For Prescription Drugs;" you can find on their website: https://www.consumerreports.org. ■

Sources: "Why Your Pharmacist Can't Tell You That a $20 Prescription Could Cost Only $8," Robert Pear, The New York Times, *February 24, 2018. "Patients Overpay For Prescriptions 23% of the Time, Analysis Shows," Sydney Lupkin,* Kaiser Health News, *March 13, 2018. "Gag Clause Keeping Pharmacies from Revealing Lower-Cost Drug Options," Kiet Do, Sanfrancisco.cbs.com, February 28, 2018.*

Retiree Expenses Up More Than $119 Month, COLA Less Than $45 Month; continued from page 1

online participants. Yet despite receiving a 2% COLA in January—the highest in 5 years—94 percent of survey participants said their COLA raised monthly benefits by less than $45.

The survey question asked:

"Which of the following most closely represents the amount that your total monthly expenses increased or decreased during 2017?"

Expenses stayed the same or went down	*6%*
$.01–$39.00	*11%*
$39.01–$79.00	*24%*
$79.01–$119.00	*20%*
More than $119.00	*39%*

This trend has been consistent over the past five years. Since 2014, the majority has said that their household budgets grew by more than $119 per month over the prior 12-month period. In every year, however, the majority of survey participants also said that their actual COLA increase was far below this level of increased costs.

Tell others about this issue affecting retirees, by sharing these statistics in letters to the editor, or at your next town hall! ■

Source: The Senior Citizens League 2018 Senior Survey.

No Limit to What Medicare Part D Enrollees Could Pay on Prescription Drugs; continued from page 1

Even when you spend $5,000 out-of-pocket, there are still out-of-pocket costs. At the catastrophic level of coverage there are smaller co-pays or 5% coinsurance, which can further lead to substantial out-of-pocket spending. In 2015, for example, Part D enrollees with out-of-pocket costs above the catastrophic threshold comprised just 2 percent of all enrollees, but their spending totaled 20 percent ($3 billion) of enrollees' total out-of-pocket spending for the year, according to the Kaiser Family Foundation.

The White House budget released earlier this year proposes to establish an out-of-pocket limit to the Part D benefit by phasing down beneficiary co-insurance in the catastrophic coverage phase of the benefit from 5 percent to no-cost sharing over four years, beginning in 2019. While this is better than nothing, the proposals make other changes shifting significant costs to Part D plans which would likely be passed on to consumers in higher premium costs and higher drug costs for the sickest people who hit the pre-catastrophic Part D gap. One analyst has estimated those costs would average $1,000. In addition, there is no proposal at all that would allow Medicare to negotiate drug prices.

Medicare beneficiaries would still be on the hook for the $5,000 (and up) that would need to be spent out-of-pocket before the catastrophic coverage even starts. For the average beneficiary, that could take one-third or more of one's entire Social Security income for the year.

TSCL believes a cap of $3,000 to $5,000 out-of-pocket, particularly for people who don't receive any "Extra Help" to cover drug costs and out-of-pocket spending, would provide much needed protection that would significantly reduce the current impoverishing level of mandated out-of-pocket spending.

Would this proposal help you? We are interested in hearing what you think. Send us an email at www.SeniorsLeague.org.

Sources: "No Limit: Medicare Part D Enrollees Exposed to High Out-of-Pocket Drug Costs Without a Hard Cap On Spending," Kaiser Family Foundation, November 2017. "Summary of Recent and Proposed Changes to Medicare Prescription Drug Coverage and Reimbursement," Kaiser Family Foundation, February 2018.

ASK THE ADVISOR

Help! I've Been Told I Have to Return My Deceased Husband's Last Social Security Check. Is This Really True?

Q: My husband passed away on March 31st. I was told that I have to return his entire Social Security payment for the month of March. Can this be true? This is an unfair and callous policy. Bills were incurred during the days that he was alive. Returning the check creates a financial hardship since every bit of it was spent on his healthcare, not to mention the costs of his funeral!

A. Yes, unfortunately this is correct. Under current law Social Security benefits are not payable for the month in which a beneficiary dies. This is so even when the beneficiary, like your husband, passes away on the last day of the month. However, according to the Social Security Administration the check that an individual receives in a given month is the payment for the preceding month. That means the check that your husband received during the month of March was his benefit for February, which you would be entitled to keep. It is the March payment that you would have received in April, and any thereafter that must be returned.

This policy catches the vast majority of the public (who can't be expected to know the details of Social Security law) unawares. Understandably most people, like you, react with surprise, disgust, and upset when they learn the final payment must be returned.

TSCL believes this offensive policy is long overdue for a change. Social Security provides monthly income to retirees and we believe retirees are entitled to every last dime, including benefits for the month in which they die. Payment for the final month is especially important as you point out because medical and funeral expenses can be significant.

TSCL recently endorsed The BASIC ACT (S.1739) introduced by Senator Christopher Murphy that would pay the deceased beneficiary's Social Security benefits for each day a recipient lives. The bill would send the beneficiary's estate a check for the days lived in the final month. The legislation would also increase the size of the Social Security death payment from $255 to 50% of the deceased beneficiary's typical monthly Social Security income with $255 as the minimum payment. As currently structured, the legislation would cost an estimated $800 million each year.

To contact Social Security, you may call toll free at 1-800-772-1213 or visit the website at www.SocialSecurity.gov. ■

How Using the Chained CPI to Calculate COLAs Would Affect Your Benefits; *continued from page 1*

The CPI is used not only to adjust Social Security benefits for inflation, but also the benefits of many other federal programs, including military and federal worker retirement programs. It's also used to set the income thresholds that determine eligibility for safety net programs that include food stamps, Medicare Savings Programs and Medicaid. If income thresholds grow more slowly, fewer low-income people would qualify for benefits in future years.

The new tax legislation mandates using the chained CPI to adjust the tax code, including tax brackets and the standard deduction. That means the standard deduction will become less generous in coming years, and this would subject a greater portion of taxpayers' income to taxation.

With deficits rising rapidly since the enactment of tax legislation, switching to the chained CPI to index Social Security is once again a key option that lawmakers are eyeing to reduce the federal deficit. The Congressional Budget Office has estimated that using the chained CPI to index Social Security and other federal programs would reduce federal spending by $182 billion through 2026. It would also increase the amount people pay in taxes as tax brackets and the standard deduction grow more slowly in coming years.

The Senior Citizens League is opposed to the adoption of the chained CPI and supports using the Consumer Price Index for the Elderly (CPI-E) to index Social Security benefits for inflation, as well as the enactment of a minimum COLA guarantee. What do you think of the proposal to "Chain the COLA?" To take a survey about Social Security and Medicare proposals, visit www.SeniorsLeague.org. ■

Social Security & Medicare Questions; continued from page 5

have explained the benefit options that your mother had. They then must document the decision in the SSA system.

The SSA should have told your mother that she had the option to delay one of her benefits (usually the higher of the two) until age 70 to allow it to grow to its maximum. If she did not opt to "restrict" her benefit to one or the other, she may be getting a "combined" benefit. For example if she was entitled to a monthly $1,000 widow's benefit and an $800 monthly retirement benefit, the SSA would pay her $1,000, consisting of $800 for her own retirement benefit and $200 for the widow's benefit. While individuals cannot receive the full amount for both, beneficiaries are entitled to the amount of the higher of the two benefits, or $1,000.

However, had your mother opted for a "restricted" application in which she delayed her own retirement benefit, she could have received the $1,000 widow's benefit until age 70 and then switched to her own maximum retirement benefit if higher. According to the Inspector General's audit, when the 9,224 claimants applied for benefits, the SSA should have informed them of the option to delay their retirement application up to age 70. The Inspector General, however, did not find any evidence that SSA employees had informed the claimants or documented the filing decision in the Agency's automated system as required.

If you and your mother feel she may have been affected by the lack of correct advice, you should bring it up with the Social Security Administration. If you think something went wrong, ask to see what documentation the SSA has in its system regarding the advice she received on her options. If your mom was not advised correctly, or if you discover there is no documentation of your mother having declined the advice to allow her own retirement benefit to grow, ask an SSA customer service representative what recourse she has. Document your meetings with the SSA. If you and your mother are not satisfied, contact the constituent services staffer for your U.S. Representative. Every Member of Congress has staffers who help resolve problems concerning Social Security and Medicare benefits. ■

Sources: "Higher Benefits for Dually Entitled Widow(er)s Had They Delayed Applying for Retirement Benefits," Social Security Administration Office of Inspector General, February 2018, A-09-18-50559. "Social Security Underpaid 82% of Dually Entitled Widows and Widowers," Mary Beth Franklin, Investment News, *February 16, 2018.*

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