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TSCL—Defending Your Earned Benefits For 24 Years

THE SOCIAL SECURITY & MEDICARE
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Legislation to Lower Drug Costs Moving In House and Senate

Pharmaceutical companies and their allies are pouring millions of dollars into advertising fighting legislation in Congress that would lower U.S. drug costs. The ads portray legislative efforts in Congress as "foreign price controls," but the TSCL Senior Survey indicates that a wide swath of older Americans strongly support several of the proposals under consideration.

Legislation in the House would give Medicare the authority to negotiate by basing drug prices on those paid in other developed countries such as Canada, Austria, and Germany. One example is Humira, a brand name arthritis drug. In 2015 it cost $2,669 a month in the U.S. while the list price in the UK was $1,362. This approach to reducing drug costs has the support of 72% of TSCL Senior Survey participants.

The bipartisan Senate bill, The Prescription Drug Pricing Reduction Act of 2019, co-sponsored by Senators Chuck Grassley (IA) and Ron Wyden (OR), would also lower drug prices by requiring pharmaceutical companies to provide rebates to Medicare when list prices increase by more than the rate of inflation. In addition, for the first time, it would establish an annual limit on out-of-pocket drug costs for beneficiaries at

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Medicare Has a Tele-Scam Problem

Telephone scammers are bilking Medicare out of billions of dollars, and bombarding millions of older U.S. consumers with multiple daily automated phone calls for everything from "free" back braces to genetic tests. While Medicare scams have been with us for decades, what's new is the use of automated calling technology, and the massive international scale of the scams.

In September, federal agents announced the arrests of 35

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IN THIS ISSUE:

The CPI-E Would Pay a 1.9% COLA Versus the 1.6% You Are Actually Getting

By Mary Johnson, editor

How much would your Social Security Cost-of-Living Adjustment (COLA) be worth if it was more accurately based on your spending patterns as a retiree? Social Security legislation under debate in the U.S. House would tie the annual boost for inflation to the Consumer Price Index for the Elderly (CPI-E). Had that index been used to calculate the COLA for 2020, your annual boost would be 1.9%, versus the 1.6% that Social Security recipients are actually getting.

Research that I've conducted over more than 20 years indicates that retirees would receive a higher COLA in most years using a "seniors" CPI, rather than by using the current method of indexing which is based on the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). One of the bigger problems with using the CPI-W is the fact that retirees spend their money very differently than younger working adults. Retirees must spend more on healthcare and housing, and less on gasoline and consumer electronics.

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President Trump Signs Executive Order to Expand Private Medicare Plans

By Rick Delaney, Chairman of the Board

Rick Delaney, Chairman of the Board, TSCL

President Trump recently signed an executive order intended to change Medicare by expanding the role of Medicare Advantage—the private insurance alternative to Medicare. Medicare Advantage plans have been growing in popularity in recent years enrolling about one third of the nation's 61 million Medicare enrollees.

The executive order directs the Department of Health and Human Services to develop proposals that would expand plan options, encourage innovation in plan designs and payment models, and improve the enrollment process to make it easier to choose plans. It includes a variety of proposals that include combating waste, fraud and abuse in the program, and improving access to new treatments and medical devices.

Medicare Advantage plans are popular in many areas of the country for low, (or even no) monthly premiums, having an annual out-of-pocket maximum, and for offering supplemental benefits not currently covered by Medicare, such as dental and vision coverage. Most Medicare Advantage plans also provide prescription drug benefits.

The plans also reduce spending on premiums, because they eliminate the need for supplemental insurance. While the majority of Medicare beneficiaries still receive their Medicare benefits through traditional Medicare, many also purchase a Medicare supplement or "Medigap" policy to cover the considerable amount of out-of-pocket spending that Medicare alone does not cover, and a free-standing Part D drug plan.

There are important trade-offs to Medicare Advantage. Enrollees must use the network of hospitals and doctors who contract with the plan. In recent years as enrollment grows, more plan enrollees have been hit with surprise bills for out of network providers—often for thousands of dollars. While traditional Medicare is accepted by any willing doctor in every state, Medicare Advantage coverage tends to be accepted only in a specific geographic area. There are also more requirements for prior approval for certain procedures.

Access to the plans is highly variable. While some areas of the country have dozens of Medicare Advantage plans, rural counties often have very limited choices, or as little as just one insurer. Frequently, older and sicker enrollees discover that Medicare Advantage plan out-of-pocket spending due to chronic health conditions, or a hospitalization can be much higher than with a Medigap plan. Medigap supplements cover most, or even all, out of pocket costs.

Most troubling, in October we reported that Medicare Advantage plans have overcharged Medicare by almost $30 billion in recent years. Officials know that some Medicare Advantage plans exaggerate how sick their patients are by inflating the "risk scores" in order to collect higher payments from Medicare, yet the federal government has recovered only a tiny percentage of the overpayments to private insurers in the past.

Over the years, TSCL surveys indicate that older Americans overwhelmingly oppose totally replacing Medicare with a system of private insurance plans. On the other hand, the design of traditional Medicare alone has a considerably high level of out-of-pocket spending, and no annual out-of-pocket limit. That leaves an important role for private insurers to fill in the gap with Medigap supplements or Medicare Advantage plans.

While most retirees tend to want to hold onto their current supplement or health plan, concern about rising costs is universal. TSCL's 2019 Senior Survey found that more than 75% of survey respondents favor the establishment of a cap on the maximum percentage of profit that private insurers may earn.

TSCL is working with Members of Congress to enact legislation that would lower Medicare costs,

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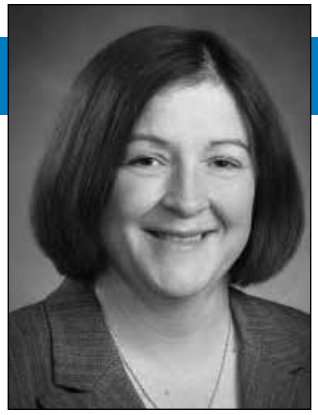
Payroll Taxes a Sticking Point in Social Security "Boost Bill"

By Shannon Benton, Executive Director



Shannon Benton, Executive Director

Legislation that would boost Social Security benefits and restore Social Security's solvency has been under debate this fall in the U.S. House. The Social Security 2100 Act (H.R. 860), introduced by Representative John Larson (CT-1) in the House, and (S. 269) introduced by Senator Richard Blumenthal, have strong grass roots support from older Americans. While the House bill is advancing—we are steeling for a tough challenge in the Senate.

Action from Congress is needed to address Social Security's looming shortfall. Without it, the Social Security Trust Fund is estimated to run short by 2035. Should that occur, benefits would be reduced by about 22% to match the level of payroll taxes coming in.

Representative Larson's bill addresses the growing problems of benefit adequacy and program finances by:

- Boosting Social Security benefits for everyone. The proposed boost would equal 2% of average benefits (about $30 per month).
- Tying the annual Cost-of-Living Adjustments (COLAs) to the Consumer Price Index for the Elderly (CPI-E). We expect this change would pay a COLA that's about .25 percentage point per year higher and would boost average benefits about $80 per month by the end of a 20-year period.
- Reducing the taxation of Social Security benefits by increasing the income thresholds that subject Social Security benefits, from $25,000 for single filers and $32,000 for joint returns, to $50,000 and $100,000 respectively.
- Addressing the Social Security Trust Fund shortfall by increasing both the amount of wages subject to taxation and, increasing the payroll tax rate. The bill would immediately tax wages above $400,000. That threshold would not be adjusted annually, and the current law maximum of $132,900 would continue to increase as scheduled, slowly closing the gap, until all covered earnings would be subject to payroll taxes by 2048. The bill would raise the payroll tax rate 0.1 percentage point per year until it reached 14.8%—2.4% higher than today. Currently employees and employers each pay 6.2% for a total of 12.4%.

While 211 Members have signed onto the House bill, critics of the legislation worry about increasing the payroll tax rate—especially on lower income workers. Lawmakers are continuing to discuss alternatives, and TSCL continues to meet with Members of Congress. TSCL's Senior Survey has found 74% of survey participants support completely lifting the taxable maximum and applying the payroll tax to *all earnings*. About 61% of survey participants support increasing the payroll tax rate by 1% each for workers and employers.

In the months ahead, The Senior Citizens League will continue to advocate for these and other policy solutions that would boost and strengthen Social Security benefits for current and future beneficiaries. For progress updates, follow The Senior Citizens League on Twitter. ■

***The Social Security & Medicare Advisor* © 2019** is published by The Senior Citizens League (TSCL). TSCL is an organization of active seniors concerned about the protection of their earned Social Security, Medicare, military, and other retirement benefits. TSCL's supporters participate in a number of grassroots lobbying and public education campaigns to help ensure governmental bodies live up to their commitments. Current active contributors to The Senior Citizens League are entitled to receive *The Social Security & Medicare Advisor* for no additional charge. Readers wishing to contact TSCL should address correspondence to The Senior Citizens League, 1800 Diagonal Road, Suite 600, Alexandria, VA 22314. TSCL website: www.SeniorsLeague.org. Editor: Mary Johnson.

CONGRESSIONAL CORNER

To Stay Healthy and Enjoy Retirement Means Protecting Earned Benefits and Cutting Drug Prices

By Representative Josh Harder, (CA-10)

Representative Josh Harder (CA-10)

My parents are entering retirement age just like thousands of people across the Valley. I care deeply about making sure they receive all of the benefits they've earned and that they get the support they need to stay healthy and enjoy their golden years. That means protecting people's earned benefits and cutting drug prices.

First things first: Social Security is not an entitlement. I'm sick and tired of hearing that.

My folks have worked their entire lives to get ahead and start saving for retirement. Now that I'm working for them—and for all our seniors in the Valley—my job is to protect these earned benefits. Folks who have worked hard and done everything right should not have to worry if they'll have their Social Security or Medicare cut when they need it most. We have to get federal spending in order—but we can't balance the budget on the backs of our seniors.

Recently I hosted a town hall for our seniors in the Valley, and retirement security is what I heard about most—but it wasn't the only thing. As Baby Boomers start to retire, we face all kinds of new challenges. A lot of older folks end up being alone after they retire. They encounter new health problems. And some struggle to afford the outrageous costs of health care and medicine, all on a fixed income.

We're working to tackle a lot of these problems. Just last month, I was proud to vote for the Older Americans Act. This sweeping bill takes aim at all of the issues our seniors face now and into the future.

When I was a kid growing up in Turlock, I joined my mom delivering Meals on Wheels to seniors here in the Valley. It was one of the most rewarding parts of my childhood—not only because it felt good to help someone out—but also because I got the chance to see the impact that such a seemingly small gesture had on people's lives.

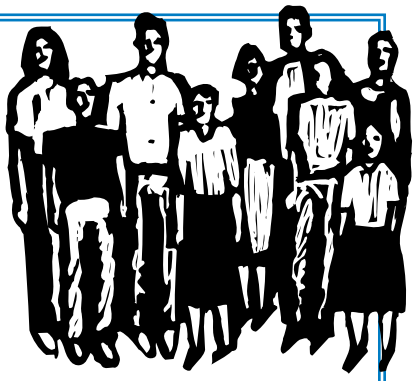
A lot of these folks lived alone, and for some, their Meals on Wheels visit was the only contact they had all week. This experience inspired my decision to focus on combating social isolation in the Older Americans Act. I worked to pass a provision that will do just that. Social isolation isn't just about feeling lonely—it can contribute to high blood pressure, heart disease, and depression. Giving folks a lifeline and a healthy meal is its own kind of health care.

But our work still isn't close to done. Drug prices are out of control, especially for our seniors. I am a huge advocate for allowing Medicare to negotiate drug costs. It will make medication cheaper for consumers—and save Medicare millions of dollars a year. We'd improve people's health while reducing costs.

I'm doing my part in Washington—but I always like to hear new ideas. Please feel free to stop by a town hall, office hours, or just drop me a line in Modesto. My job is to work for you. Please let me know if I can ever be of service. ■

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

Plan Ahead to Avoid this IRA Tax Trap

If you are close to age 70, and own one or more retirement accounts, start planning ahead to manage required minimum distributions (RMD). Even when you are taking a distribution by your deadline, you could be in for a surprise by the amount you must take out to comply with RMD rules, and this could cause problems if markets and the value of your retirement accounts go down right beforehand.

While you may have tapped your retirement savings for small amounts now and then, IRS rules mandate that you take your first RMD in the year in which you turn age 70½. The first payment can be delayed until April 1 of the year following the year you turn 70½, but you must take the RMD by December 31st of every subsequent year thereafter. Failure to withdraw the full amount of the RMD, or failing to withdraw it by the applicable deadline, can result in a tax penalty of 50% of the RMD amount that was not withdrawn.

Often, retirees approaching age 70½ put off the distribution as long as possible allowing funds to continue to grow. That strategy can backfire, because it only works when the market is steadily going up. If the market goes down right when you need to take a distribution from your account, you may be forced to sell depreciated assets when the stock market is down.

This is exactly what happened to retirees last year when stocks plunged in December. The surprise came because the amount of the minimum withdrawal in 2018 was determined on the account balance on December 31st of the prior year—2017, when the stock market was up.

Thus, to reduce your risk you may want to take your first RMD earlier and put it into your checking or savings account, or design your portfolio to ensure the required amount of cash will be on hand prior to the deadline.

RMD rules affect all employer-sponsored retirement accounts, including 401(k) plans, traditional IRAs and IRA based plans such as SEPs and SIMPLE IRAs. The rules also apply to Roth 401(k) accounts, but DO NOT apply to Roth IRAs while the owner is alive.

Although your IRA plan custodian or administrator may help you calculate your RMD, in the eyes of the IRS, you are the one responsible for calculating the amount of the RMD from all the plans that you own (that are affected by the rules). TSCL strongly recommends calling your plan administrator to discuss a plan to ensure your RMD cash will be available when you need it, should markets dip. ■

Source: "Here's the Trickiest IRA Tax Trap Retirees Need to Avoid," Steve Vernon, CBS News, *February 4, 2019.*

RESOURCE

To calculate a Required Minimum Distribution (RMD) you can find an IRS worksheet here:

https://www.irs.gov/pub/irs-tege/uniform_rmd_wksht.pdf

Legislation to Lower Drug Costs Moving In House and Senate; continued from page 1

$3,100. Seventy-eight percent of TSCL's Senior Survey participants support the idea of capping out-of-pocket spending on prescription drugs costs.

The affordability of prescription drugs is a major concern for older Americans. More than 51% of TSCL Senior Survey participants report spending at least $376 per month on healthcare costs and 20% say they spend more than $1,000. TSCL is delivering letters to the office of every Member of Congress sharing these results from our Senior Survey, and voicing support for passing prescription drug legislation NOW!

To learn more about recent proposals, and the impact on both Medicare and beneficiaries, here is a policy brief prepared by the nonpartisan Kaiser Family Foundation: files.kff.org/attachment/Issue-Brief-A-Look-at-Recent-Proposals-to-Control-Drug-Spending-by-Medicare-and-its-Beneficiaries.

What do you think? Send us an email at www.SeniorsLeague.org. ■

ASK THE ADVISOR

My Mom Is Applying for Assisted Living: Why Must She Agree to Mandatory Arbitration?

Q: I'm helping my mother shop for an assisted living facility. She's considering one within reasonable driving distance, but a clause in the paperwork stipulates that she must agree to mandatory arbitration to settle any disputes. Can you explain the pros and cons of this?

A: Clauses requiring mandatory arbitration have become exceedingly common in many types of contracts, but they can have serious implications for unsuspecting consumers. By signing such agreements, consumers give up their Seventh Amendment right to a trial by jury or their right to bring civil suit in court against the company no matter what the grievance. This can even include sexual abuse, medication errors, and negligence.

Often, consumers don't even know they signed such an agreement because the clauses are buried in the fine print.

The House recently passed legislation the FAIR Act (H.R. 1423, S.610) that would prohibit mandatory arbitration agreements in employment, consumer, and other contracts. Legal advocates who work on behalf of older adults estimate that as many as 90% of large nursing homes in the U.S. use arbitration agreements in their admission contracts. The federal government has been considering plans to expand the use of mandatory arbitration clauses to be included in contracts for every long-term care facility that accepts federal money as a condition of admission. Nursing homes receive funding from both Medicaid and Medicare for all residents.

Critics of mandatory arbitration say the agreements stack the deck against long term care residents and consumers. Unlike civil suits which go to court, arbitration is private, and there's no judge or jury. There are no rules of evidence that arbitrators have to follow under the law, and there's no oversight. Critics also contend that consumers are less likely to win their cases in private arbitration and, if they do win, they tend to get much less money than they would in court.

Companies requiring mandatory arbitration say it saves money and time for resolving complaints. But older consumers still may wind up with legal fees, and may wind up having to pay a share of the arbitration fees.

TSCL is interested in hearing your comments on this issue, and whether you have ever been forced to use mandatory arbitration to resolve a disagreement. If so, did the outcome satisfy you? Please send us an email. ■

Sources: "An 87 Year Old Nun Said She Was Raped In Her Nursing Home. Here's Why She Couldn't Sue," Haley Sweetland Edwards, Time, *November 16, 2017. "House Passes Ban on Forced Arbitration, Class Action Limits, Jaclyn Diaz,* Bloomberg Government, *September 20, 2019.*

Benefit Bulletin: President Trump Signs Executive Order to Expand Private Medicare Plans; *continued from page 2*

including the elimination of "surprise medical bills" from out-of-network providers, and is working to ensure that Medicare beneficiaries can continue to receive their Medicare benefits through the Medicare Advantage or Medigap plan of their choice.

What do you think about expanding the role of Medicare Advantage plans? Visit us at www.Seniors League.org and send us your comments. ■

Medicare Has a Tele-Scam Problem; continued from page 1

people linked to a huge genetic testing scam. Individuals charged are accused of billing Medicare for more than $2.1 billion worth of phony genetic tests. The crackdown included telemedicine companies, doctors, and labs which worked in an elaborate scheme that preyed on people's fears of having genetic markers for cancer.

Genetic testing is not routinely used by doctors to screen for cancer. Here's how the scam works—The "target" (that's anyone close to age 65 and up) might receive automated phone calls, often multiple times a week, or may be approached in-person by a "recruiter." The recruiter, who may present herself as a "certified Medicare counselor," convinces the target to take a genetic test promising that Medicare pays the full cost. The patient, however, often never receives a report, or the report may be incomprehensible.

The fraudsters enlist unscrupulous doctors to approve the test and the doctor receives a kick back from the recruiting company for each prescription. Medicare receives a bill that can range from $7,000 to $19,000. Victims have later reported that they did not even know the doctor who prescribed the test. Law officials warn that health fairs, senior centers and even church events are magnets for the scam, where recruiters take cheek swabs for genetic testing and collect Medicare numbers.

Not only does this put unwitting retirees' Medicare number in the hands of crooks who can then resell it to be used to file more false claims, but it can cause Medicare to deny future coverage for genetic testing when it's really needed, because the patient's record will show the test has already been performed.

According to Medicare, no single organization was behind the 35 people charged in the genetic testing scam, which included 9 doctors. All of this comes at a time when Medicare and Medicare Advantage are expanding the use of telemedicine, which allows doctors and nurses to connect with patients over the internet or by cell phone for consultations and to check symptoms remotely. ■

Sources: "Phone Scammers and 'Tele-doctors' Charged With Preying On Seniors in Fraud Case," Victoria Knight, NPR Health News, *October 7, 2019. "U.S. Thwarts Medicare Genetic Testing Scam,"* Associated Press, *September 29, 2019.*

Editor's note: Telephone etiquette has changed! Ask around, and you'll probably discover that many people are letting their voice mail or answering systems screen calls. This is no longer considered rude—but acting in self-defense. Protect yourself from scams (and your dinner from getting cold due to calls at meal time). Be defensive.

Screen your calls. Even if you have caller ID, experts suggest screening calls any way. More robo-callers are making their calls appear to be local by using phone numbers from your own local calling area. Unless you know the number of the caller is legit, don't pick up. Legitimate callers, such as your doctor's office calling to remind of an appointment, will leave a message. Tell your family and friends to leave a message and to keep talking at least long enough for you to get to the phone if your phone's speaker allows you to hear the caller's message.

Use call block technology. If you have a smart phone, you can block calls from unknown numbers. Some land line phones also have similar technology.

The CPI-E Would Pay a 1.9% COLA Versus the 1.6% You Are Actually Getting; continued from page 1

The CPI-E tends to grow more quickly than the CPI-W in most years, because it more accurately accounts for the percentage of income that retirees spend on healthcare and housing costs. Those two categories tend to increase several times faster than inflation, and tend to take a bigger share of retiree income. The CPI-E tends to give less weight to items like gasoline and consumer electronics which have fallen significantly in recent months and helped drag down the COLA for 2020.

Since the start of CPI-E in 1983, the average difference between it and the CPI-W is roughly .25 percentage point per year. Sounds tiny but, like interest, it compounds over time. Had the CPI-E been used to determine COLAs since 2015, your benefit would be about 2% higher today. An average benefit of $1,215 per month in 2015 will increase to $1,298 per month in 2020. But had the CPI-E been used to calculate the COLAs, that benefit would have been $26 per month more or $1,324 in 2020.

TSCL supports several bills in the House that would strengthen your Social Security benefits by indexing the COLA using the CPI-E. Visit us at www.SeniorsLeague to learn the latest on this legislation and what you can do to help move this legislation in Congress! ■

SOCIAL SECURITY & MEDICARE QUESTIONS

How Closing "The Doughnut Hole" in 2020 Might Affect Your Out-of Pocket Prescription Costs

Q: I take a brand name drug that cost more than $400 per month in 2019 and I have a co-pay of $47. In 2019, I hit the Part D coverage gap. Can you tell me how much I would have to pay in the Part D doughnut hole next year?

A: The Part D doughnut hole will be "closed" in 2020, but that doesn't mean that your out-of-pocket spending will stop. To the contrary, an unprecedented spike in Medicare's required out-of-pocket costs means you may pay more than you did in 2019. You will hit the former coverage gap around October or November, depending on whether the price of your prescription goes up.

Although Part D plans are given leeway to vary how they structure their plans here is a breakdown of the standard Medicare Part D plan cost sharing in 2020:

Deductible: During the initial deductible, the beneficiary pays 100% of the cost of the drug—up to $435 depending on the plan. Many plans provide immediate coverage on generics, and even preferred brand drugs "before the deductible." In this type of plan, you only pay the full price up to the deductible on higher tier drugs, and some plans don't charge a deductible at all.

Initial Coverage Period: During this stage of coverage you pay a co-pay or co-insurance of 25% of the cost of covered drugs, and the plan pays 75%, up to a total of $1,005 (beneficiary) and $3,015 (plan). This includes any applicable deductible. Your plan's full retail drug cost, not your co-pay, is what counts toward entering the coverage gap. Your co-pays or True Out-of-Pocket costs (TrOOP) count toward exiting the coverage gap and qualifying for catastrophic coverage.

Former doughnut hole coverage gap: After spending the initial coverage amount of $1,005, you are responsible for 25% co-insurance for both generic and brand name drugs, plus a portion of the pharmacy dispensing fee which is approximately $1–$3. Your drug plan pays 75% of the cost of generic drugs and 5% on brand-name drugs. The drug manufacturer provides a 70% discount on brand-name drugs. Your total costs in this stage could run as high as $5,345 between the end of the Initial Coverage Period and the Catastrophic stage of coverage begins. Altogether, beneficiaries could be responsible for as much as $6,350 in TrOOP, which includes the drug costs paid by the beneficiary and the 70% discount on brand-name drugs provided by the drug manufacturer. Payments made by the drug plan DO NOT count TrOOP costs.

Catastrophic Coverage Period: When your total out-of-pocket spending reaches $6,350, you hit the catastrophic stage of coverage. Your co-insurance drops to 5% coinsurance or co-pays of $3.60 generic, $8.95 brand, whichever is higher. You remain in the Catastrophic coverage period until December 31, 2020. ■

Resource: *The Medicare Rights Center has an online tool called "Medicare Interactive" that can answer more of your questions about prescription drug coverage. Try it at www.MedicareInteractive.org.*

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