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THE SOCIAL SECURITY & MEDICARE
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WHAT IT LOOKS LIKE TO LIVE ON JUST SOCIAL SECURITY

(It's Not Pretty)

Forty-three percent of respondents say they do not have *any* retirement savings according to a recent TSCL survey. This sobering finding is actually a slight improvement from a 2017 estimate by the U.S. Government Accountability Office that said 47% of older Americans don't have any retirement savings. What does trying to live on Social Security for all of your income look like? Here's a brief glimpse:

Michael H., a 70-year-old retiree who lives in rural central Virginia, still works odd jobs whenever he can find them. For years he worked as a welder but never made much more than $11 per hour as robotic automation took over welding plants during his working years.

Due to the intellectual disabilities that he was born with, Mike can't read, write, do math, or manage money. He never had a job that offered a pension, nor was he able to put money into a retirement account. But he never filed for disability. Mike, who could understand simple spoken explanations, retired with his own Social Security benefit at his full retirement age (66) after learning just how much money the government

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Part D Out-of-Pocket Costs Take Record Jump

Medicare Part D prescription drug coverage hit a new milestone this year. The highly-loathed "doughnut hole" or "coverage gap" closed this year. But that doesn't mean prescriptions will be free. The co-insurance in the former Part D doughnut hole dropped to 25% of all drug costs. That's the good news. But the out-of-pocket spending that's required to qualify for catastrophic drug coverage took a big jump, from $5,100 in 2019, to $6,350 an

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Should Social Security Benefits Be Adjusted Using a Locality-based Payment Rate?

Mary Johnson, editor

Should Social Security benefits be adjusted annually using a locality-based payment rate? Some of you, particularly those of you who are retired federal employees know far more about locality-based pay adjustments than I do. I hope you folks can set us straight on a new legislative proposal that would use locality-based pay adjustment rates to adjust Social Security benefits. My question to you—is this a good idea? Why or why not?

Under current law, Social Security benefits are adjusted annually based on changes in the consumer price index for Urban Wage Earners and Clerical Workers (CPI-W). According to the Social Security Administration, the intent of the annual Cost-of-Living Adjustment (COLA) is to help protect the buying power of benefits from increases in inflation. All beneficiaries receive the same percentage of increase, but the dollar

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What to Do When You Can't Afford Medicare Premiums

By Rick Delaney, Chairman of the Board

Rick Delaney, Chairman of the Board, TSCL

Medicare Part B premiums jumped $9.10 per month in 2020—one of the biggest increases in recent years. While the Social Security Cost-of-Living Adjustment (COLA) increased benefits by 1.6 percent in 2020, Medicare Part B premiums climbed 6.7 percent, more than four times faster. A jump of this size can put older household budgets into a bind, forcing retirees to go without essentials when they run short before their next Social Security check.

If you have limited income and savings, there are three Medicare Savings Programs that help pay Medicare costs. If you qualify, your Medicare Part B premium will no longer be deducted from your monthly Social Security check. Over the rest of the year, that could be worth an extra $144.60 per month in your Social Security check, and more than $1,300 in higher Social Security income through the end of the year (especially if you qualify for up to three months of retroactive payments). If you qualify, you will automatically get Extra Help, the Medicare program that helps with Part D prescription drug costs.

To qualify, you must meet your state's income and asset limits. The information listed at the left shows the 2019 baseline gross monthly income and asset limits but, even if your income or assets are slightly higher, you should still apply because these limits are somewhat higher for 2020, and some states have different guidelines.

To learn whether you or someone you care for qualifies, call your local Medicaid office, Family Social Services Department, or State Health Insurance Assistance Program (www.shiptacenter.org) to learn if you are eligible. ■

MEDICARE 2019 BASELINE GROSS MONTHLY INCOME AND ASSET LIMITS

	INCOME	
	Individual	**Couple**
Qualified Medicare Beneficiary (QMB) If you qualify you should not be billed for Medicare covered services when seeing Medicare providers or providers in your Medicare Advantage plan's network.	$1,061	$1,430
Specified Low-Income Medicare Beneficiary (SLMB)	$ 1,269	$1,711
Qualifying Individual (QI)	$1,426	$1,923
	ASSETS	
All of the above programs limit certain assets (such as savings, stocks or certificates of deposit).	$7,730	$11,600
In all states the following assets are not counted:	• Your primary home • One car • Household goods • Burial spaces • Burial funds up to $1,500 per person • Life insurance with a cash value of less than $1,500	

Legislative Update

Shannon Benton, Executive Director

Have You Ever Received a Surprise Medical Bill?

By Shannon Benton, Executive Director

It happens all too often. Out of the blue, you get a gut-wrenchingly high medical bill for services that you thought were covered by Medicare. Congress recently took the first step to deal with the practice. Legislation is advancing in the House that would protect patients from surprise medical bills and set up the process by which health plans and providers would settle disputed billing amounts.

Surprise medical bills often occur when a patient is treated by an "out-of-network" provider, which can sometimes happen even at an "in-network" facility. This problem occurs with the greatest frequency to enrollees of Medicare Advantage plans. The plans have contracts with a network of preferred doctors, hospitals and other providers to control costs for patients. Out-of-network providers mean patients get stuck with extra out-of-pocket costs. Sometimes a lot extra.

The problem can also affect beneficiaries who are covered by traditional fee-for-service Medicare and a Medicare supplement when the patient is seen by a provider who does not have a contract to provide services under Medicare. But since 90% of doctors do accept traditional Medicare, this is less likely.

Surprise medical bills are generally the difference between the amount that the provider charges, and the negotiated amount that the private insurer typically pays for the service(s). A large majority of Medicare beneficiaries (85%) think healthcare providers should be restricted from this billing practice. Surprise medical bills affect not only Medicare beneficiaries, but patients of all ages with private insurance. The patients who are most vulnerable to these unexpected bills include those who need ambulance or emergency room services. Often, the bills come from doctors the patient never remembers seeing.

Surprise medical bills are not only growing in the frequency with which they occur, but also in the cost of services provided, leaving unsuspecting patients responsible for bills in the hundreds, or even thousands, of dollars.

The bipartisan deal that was reached in the House last year would ban providers from sending surprise bills and would require insurers to pay them. Opponents argue this opens the door to "rate setting or federal "price controls." But the actual costs in question are currently those directly negotiated by healthcare providers and private insurers, and not by Medicare.

Medicare does not reimburse Medicare Advantage plans the same way it does for traditional Medicare. Plans receive a per-person payment to provide all Medicare covered services, rather than a fee for each service. Critics of Medicare Advantage point out that, due to this system of payment, private plans have an incentive to shift a bigger share of the cost to patients to boost profits.

TSCL strongly supports legislation to end surprise medical bills and is continuing to work for enactment of the bills in the House and Senate. We encourage you to email your Members of Congress and ask your lawmakers to support this legislation that would prohibit this practice and leave you stuck with the bills. ■

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CONGRESSIONAL CORNER

Lowering Prescription Drug Costs Should Never Be a Partisan Issue

By U.S. Representative Abigail Spanberger (VA-07)

Representative Abigail Spanberger (VA-07)

If you've been to a pharmacy in recent years, you've no doubt noticed how drug costs are soaring—and you've probably felt the immense financial pressure of rising prices. You've also probably thought about how it is that consumers are burdened with the pain of these higher costs while the drug industry simultaneously rakes in massive profits with little to no accountability.

At a prescription drug forum in Central Virginia in November 2019, I heard from seniors who share these feelings. They're tired of seeing their drug costs rising. They're tired of having no way to understand why these prices continue to spike, and they're tired of lawmakers who refuse to act on an issue that impacts millions of seniors and families across our country each day.

Right now, there are immediate steps we can take to help build a sustainable path toward cheaper drugs for all Americans—and I'd like to highlight two recent bills that could increase transparency and competition as a part of this strategy.

One of the first steps in bringing down prices is demanding transparency from the many players in the prescription drug supply chain. Many experts point to pharmacy benefit managers (PBMs) as potentially contributing to rising list prices and out-of-pocket costs. PBMs are the veritable middlemen of the drug industry—they serve as intermediaries between drug manufacturers, health insurers, and pharmacies. Some believe that, during this process, drug makers are forced to raise the list prices of their drugs just so they can offset the costs of rebates paid to these PBMs.

PBMs continue to leave American consumers and pharmacists in the dark about how their operations could be contributing to high prices. But to begin shedding light on the black box of prescription drug negotiations, I introduced the *Public Disclosure of Drug Discounts Act.* My legislation would require PBMs to publicly report their aggregate rebates, discounts, and other price concessions. Getting this information is a first step towards tackling the high cost of prescription drugs.

The issue of PBM transparency is not a hyper-partisan issue—and that was clear when the U.S. House passed our bill by an overwhelming margin of 403 to 0. That vote should signal just how common high drug prices are in districts across the country, and I'm encouraged by Democrats and Republicans both recognizing the pressing need for our legislation.

Another critical step toward lowering costs is giving Medicare the power to negotiate prescription drug prices. In December 2019, I helped pass the Lower Drug Costs Now Act with the support of both Democrats and Republicans. This commonsense bill would give Medicare Part D the power to negotiate directly with drug companies. Currently, Medicare is prohibited by law from negotiating for lower prices.

If enacted, this bill would address one of the key areas currently missing from our prescription drug market—competition. Just as the U.S. Department of Veterans Affairs is already able to negotiate lower drug prices for its patients, Medicare should be given the freedom to do the same.

The *Lower Drug Costs Now Act* contains additional provisions to combat relentless prices increases. For example, the bill would expand Medicare Part D benefits to include dental, vision, and hearing coverage. And it would establish a new $2,000 out-of-pocket limit on prescription drug costs. I'm proud to be a cosponsor of this bill, because American seniors shouldn't be subjected to unfair price hikes on lifesaving medications—especially when other industrialized countries are paying lower prices for identical drugs.

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Watch this video to learn more about prescription drug pricing.

Spanberger Bill Aims to Shed Light on Prescription Drug Pricing

https://www.youtube.com/watch?v=asPz7_d3MTg

Lowering Prescription Drug Costs Should Never Be a Partisan Issue; continued from page 4

American consumers have waited too long for Congress to finally make bipartisan progress on lowering prescription drug costs. At a time of rampant hyper-partisanship on Capitol Hill, I've seen glimmers of hope for how lawmakers from across the political spectrum can unite on this issue. We can't stop pushing for lower prices, because our nation's seniors deserve that level of respect, commitment, and urgency. ■

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

BEST WAYS TO SAVE

Should We Be Looking for a Live-In Nurse, or Nursing Home Care?

Q: A family member who lives alone told me that she had stage IV colon cancer. Recently, she had to go to the emergency room and was hospitalized for several days until it could be determined whether she was well enough to go home—or, to a nursing home. While she wrote a will, she never discussed a plan of care. Her brother is thinking about hiring a live-in nurse since the family lives a good distance away. What should we consider?

A: The idea of live-in caregiving is appealing to many families when round-the-clock care is needed, and increasingly hospitals are releasing terminally ill patients to receive late stage healthcare, hospice or palliative care in their homes. There are a number of factors that affect the decision. Here are some considerations:

Who is the primary caregiver? If there is no family member or friend who can provide live-in care for extended periods of the day, then a live-in caregiver may need to be hired. There may also be a need for additional home care aides to help part of the day or during the night. A main caregiver would expect to work between 4 and 5 days each week providing 24-hour care. The caregiver is given a bed and typically allowed an 8-hour period to sleep at night, although his or her sleep may be disrupted to care for the patient. In addition, the caregiver is given breaks during the daytime hours, often 4 hours or more. During the breaks, another caregiver may take over. Another option is to have three caregivers working 8 hour shifts. With this type of care the caregiver sleeps in their own home.

What are the costs? When paid caregiving is required for 40 hours or more per week, then a nursing home may be a better option. According to a national survey conducted in 2019 by Genworth a company that sells long-term care insurance, the national median monthly cost of a home health aide is $23.00 per hour ($552.00 per 24-hour period), but that varies considerably based on where you live. The Genworth survey found that the national median monthly cost of nursing home facilities was $8,517 for a private room in 2019.

What does Medicare cover? Medicare doesn't cover the cost of live-in caregivers, or long- term nursing home care. There are a number of conditions which must be met to qualify for short-term nursing home stays. If the patient has a three-day qualifying stay in the hospital as an *inpatient,* requires the assistance of skilled care workers, and has been admitted to a Medicare certified facility, Medicare covers stays for up to 100 days. Qualifying for Medicare coverage for short nursing home stays has become difficult, as more hospitals hold patients as *outpatients,* instead of inpatients. Medicaid does cover

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ASK THE ADVISOR

Do Healthcare Costs Grow Faster Under Medicare Than Under Private Insurance?

Q: Which type of insurance has been better at controlling healthcare costs? Medicare or Medicare Advantage? How does this affect my healthcare costs?

A: The cost of private health insurance is growing far more rapidly than Medicare. According to Drew Altman of the non-partisan Kaiser Family Foundation, per capita spending for private insurance has grown by 52.6% over the last decade while per capita spending for Medicare grew by 21.5% over the same period. Private insurance generally pays higher prices for care than does Medicare.

These trends are affecting private Medicare Advantage health plans and the federal government's reimbursements to the plans. Recent studies are finding that this program, which was originally intended to save taxpayers money, is actually costing the federal government more to provide the same benefits as traditional Medicare.

Medicare beneficiaries have the option of receiving their healthcare coverage through private Medicare Advantage plans as an alternative to federally administered traditional Medicare. While all enrollees pay a monthly Part B premium, many Medicare Advantage plans charge no or only a very low premium, saving enrollees premium costs for supplemental coverage. Many enrollees also save money on prescription drug plan premiums, because most Medicare Advantage plans include that coverage as well. The plans are popular for providing additional benefits that are not covered by traditional Medicare, such as vision services and dental care. Little wonder that federal spending on Medicare Advantage plans accounts for one-third of total federal spending on Medicare.

Studies indicate, however, that Medicare Advantage plans are spending less to provide care than traditional Medicare. Medicare Advantage plans receive capped payments from the federal government to provide all Medicare-covered services for each enrollee. Studies have found that Medicare Advantage enrollees are more likely to go home after a hospital visit rather than to receive care at a skilled nursing facility. Medicare Advantage patients see specialists less often, receive fewer inpatient operations, and more outpatient services, which cost less.

Because the plans cost more, this affects Medicare Part B premiums for everyone, even for people who aren't enrolled in a Medicare Advantage plan. Medicare Part B premiums are determined by the total estimated per-person cost of providing Part B

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Part D Out-of-Pocket Costs Take Record Jump; continued from page 1

increase of $1,250. That's the biggest jump in the out-of-pocket threshold since the start of Part D in 2006.

The costs don't stop at $6,350. Unlike other types of health insurance, there is no out-of-pocket annual maximum for beneficiaries enrolled in Part D. After spending the $6,350 in drug costs, Part D plan enrollees pay *the greater of* 5% co-insurance or copays of $3.60 for generics and $8.95 for brand or non-preferred brand drugs. For someone taking high cost specialty drugs, the 5% coinsurance could still be in the hundreds of dollars and, would continue for each refill until the end of the year.

Seventy-eight percent of participants in TSCL's 2019 Senior Survey think Congress should establish an out-of-pocket spending cap. In December of last year, prescription drug legislation, H.R.3, the Elijah Cummings Lower Drug Costs Now Act was passed by the House. In addition to allowing Medicare to negotiate drug costs, the House bill would cap Part D's annual out-of-pocket costs for prescription drugs, starting at $2,000 per year.

The Senate advanced its own bi-partisan prescription drug bill, that would establish a new out-of-pocket spending cap at about $3,100. While the Senate Finance Committee advanced the package to the floor, it remains on hold. Nevertheless these bills continue to be among TSCL's highest priorities for passage this year. ■

Should Social Security Benefits be Adjusted Using a Locality-based Payment Rate?
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amount varies based on the amount of benefits that one receives. In years in which inflation has gone down, there can be no COLA at all.

Locality pay adjustments are currently used to adjust the paychecks of federal workers. Federal employees receive a two-part pay adjustment that includes base pay (which is established by a specific formula set by law) and locality pay adjustments. The locality pay adjustment varies depending on where the employee works. The parameters aren't set by law but use metropolitan statistical areas to define locality pay areas.

While inflation varies significantly depending on the area of the country in which people live, locality-based payment rates *are not* calculated on living costs or specific price levels like the COLA. According to a story appearing on the Federal News Network's website, this is a common misconception about locality pay. In fact, consumer inflation is not even a factor when setting locality pay.

Instead, locality pay increases are intended to keep the salaries of current federal workers competitive with private sector jobs in the same locality pay area. The Bureau of Labor Statistics measures non-federal compensation in a particular market and compares it to federal pay for federal employees who perform similar work in the same region. The gap between the two helps determine the locality pay adjustment for a specific area in a given year.

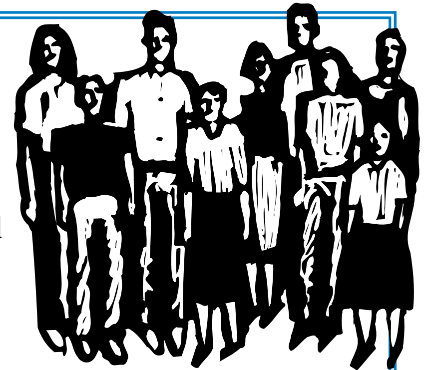
What would locality pay adjustments mean for your Social Security benefits? It's unclear, and likely difficult to estimate. Studies would have to be performed to compare locality-based pay adjustments to what future annual COLAs might be. Locality pay adjustments would be higher in areas where private sector pay scales are higher than those of federal workers, and lower in areas where pay scales are lower. The percentage of the annual locality pay increase would vary depending on where you live. Some retirees would receive a lower percentage of increase, or even no increase, while others a higher percentage.

The legislative proposal also does not specify whether the locality pay adjustment would be applied in addition to the COLA or used instead of a COLA. If the intention is to add a second adjustment in addition to the COLA my guess is that many retirees would welcome the additional boost. Should the proposal be intended to replace the COLA that brings a higher level of uncertainty to the annual adjustments than we already experience. For people who live in areas where private sector pay is on an even level with federal pay or lower, those retirees may wind up with little or no locality pay adjustment, perhaps over the course of many years.

Since people often move when they retire, under locality pay adjustment rates, the area they choose to live in during retirement could significantly impact the amount of Social Security they receive. Would retirees crowd into areas of the country with high locality pay adjustments?

Finally, locality pay is subject to the approval of the President, and thus subject to politics. In 2019, the average locality pay adjustment was 0.5%. The annual COLA was 2.8%. The calculation has also been challenged by economists and the nonpartisan CBO as not being accurate. What do you think about using locality pay adjustment rates to adjust Social Security? To send a comment or take a poll on this topic visit www.SeniorsLeague.org. ■

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.

What It Looks Like to Live on Just Social Security: (It's Not Pretty); continued from page 1

would "keep" (reduce his benefit) if he retired any sooner than 66!

Now, at age 70, his health and cognitive disabilities have worsened, and the jobs that he can still do are very limited. A recent doctor visit confirmed that he has lost most of the vision in one eye. Mike and his wife who is also mildly disabled, depend on Michael's Social Security check, which after deductions for his Medicare premiums is just $1,084 per month, for almost all of their income.

The couple routinely runs out of Social Security funds a week or two before the next check comes in. While they own a tiny four-room home, there's never enough money for maintenance, heating or electricity. The roof leaks. When they run out of their heating oil in winter, they use a wood stove. When the hot water heater broke down in July it was weeks before the couple was able to replace it. During that period, Mike's wife went to stay with her daughter. Mike stayed put and went without showers until he got the $550 together for a replacement water heater.

Located five miles out of town, transportation is a constant issue. Mike's 25-year-old truck recently stopped running. For more than two weeks after Christmas, Mike did not have the $16 copay he needed for his 6 generic prescription drugs, which include a blood thinner, and Glucophage for his diabetes. He couldn't call his sister to ask her for help because he had no phone service, the truck wasn't running, and his memory is so bad he couldn't remember his sister's phone number.

TSCL is working for families like Mike and *every retiree* to get legislation enacted that would provide a very modest boost in Social Security benefits and would strengthen the annual Cost-of-Living Adjustment (COLA). A bill that would boost Social Security benefits remains under consideration in the House and in the Senate. An estimate for TSCL projects that the legislation would boost an average benefit of $1,460 by an additional $70 per month, ($840 per year) by the end of the first ten years alone, and would continue to grow every year thereafter. In addition, legislation that would lower prescription drug, and out-of-pocket Medicare costs, recently passed in the House of Representatives, and the Senate is considering a similar bill.

You can help other older Americans when you, your friends and family, participate in TSCL's Senior Surveys and contact Members of Congress. Public opinion can help sway votes, strengthen Social Security benefits, and lower out-of-pocket health care costs. Please take our annual Senior Survey at SeniorsLeague.org/2020survey. ■

Do Healthcare Costs Grow Faster Under Medicare: Than Under Private Insurance?continued from page 6

services for the year, including the cost of all federal payments to Medicare Advantage plans. Higher than necessary payments to Medicare Advantage plans means higher Part B premiums.

A new study in 2019 by the Rand Corporation found that private health plans paid more than three times more than Medicare does for the same services. Some policy experts say that private plans have lost the ability to negotiate with health care providers on the same level as Medicare, in part because many hospital systems and doctors' practices have merged, giving healthcare providers greater leverage.

More than 75% of participants in TSCL's Senior Surveys think Congress should establish limits on the maximum amount of profit that Medicare private insurers may earn. What do you think? Send us your comments at www.SeniorsLeague.org ■

Sources: "Private Insurance's Costs are Skyrocketing," Drew Altman, Kaiser Family Foundation, December 16, 2019. "Market Muscle: Study Uncovers Differences Between Medicare and Private Insurers," Shefali Luthra, Kaiser Health News, *May 9, 2019. "Medicare Advantage Spends Less on Care, So Why Is It Costing So Much?" Austin Frakt,* The New York Times, *August 7, 2017.*

SOCIAL SECURITY & MEDICARE QUESTIONS

What is the Full Retirement Age for Social Security?

Q: I turn 61 this year and I'm still employed. I've read about waiting until my full retirement age before starting Social Security benefits. Is that 66? Do I enroll in Medicare at the same time I start Social Security?

A: Social Security's "full" retirement age is the age at which you qualify for *full, un-reduced* benefits. It's based on your date of birth, so it varies for everyone. In 1983, Congress enacted changes that very gradually raised the full retirement age to age 67 by the year 2027. The full retirement age for people born between 1943 and 1954 is 66. For those born in 1955 it is 66 and 2 months and it goes up 2 months per year for those born between 1956 and 1959. For people born in 1960 and thereafter, the full retirement age is 67.

Since you were born in 1959, your full retirement age is 66 and 10 months. Starting benefits prior to your full retirement age will lower your monthly payments. If you were to retire at age 62 instead of age 66 and 10 months, a $2,000 per month benefit would be permanently reduced to $1,416—a reduction of about 29.17%. The longer you delay starting your benefit, the more you will receive. But age 66 and 10 months is NOT your *maximum benefit age.* Your maximum benefit comes at age 70, no matter when you were born.

If you delay starting benefits, past your full retirement age, your benefit will grow by 8% of the full retirement benefit amount per year until age 70, at which point your benefit would be about $2,507. To learn more about your Social Security benefits, and to get estimates visit the Social Security Administration's website at www.SSA.gov.

The age at which you should start Medicare Part B is still 65. Failure to enroll on time can expose you to permanent delayed enrollment penalties, not only for Medicare Part B (doctors and outpatient services) but also for Part D (prescription drug coverage). These penalties which can add 10%–12% per year respectively to your Part B and Part D premiums for every year you miss enrollment deadlines, for the rest of the time you have Medicare.

To learn more about your enrollment deadlines for Medicare visit www.Medicare.gov. ■

Should We Be Looking for a Live-In Nurse, or Nursing Home Care?
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long-term care services for low-income patients who qualify.

Medicare covers hospice care. Medicare covers end-of-life hospice care for people who are terminally ill and who are not expected to live more than 6 months. The focus is on comfort (palliative care) because the patient is no longer responding to treatment. Services typically include physical care, counseling, drugs, equipment and supplies for the illness and related conditions. The care is generally given in the home, and family caregivers can also get support.

Both in home caregiving and nursing home care can be expensive, and costs continue to rise every year. TSCL strongly recommends that families contact local Agencies on Aging to learn about caregiving options and services in the area where your loved one is located. To find services call the Eldercare Locator at 1-800-677-1116. ■