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THE SOCIAL SECURITY & MEDICARE
ADVISOR©

November 2018, Volume 23, Number 7E

How the Medicare Part B Premium Increase Will Affect Benefits in 2019

The Social Security Administration recently announced that the annual Cost-of-Living Adjustment (COLA) will raise benefits by 2.8% for 2019. The average retirement benefit of $1,400 will increase by $39.20 per month, to $1,439.20. The Medicare Part B premium increase for 2019 will be $135.50 per month—just $1.50 per month more than the $134 in 2018. The COLA, the highest in 7 years, and a low Medicare Part B premium increase, should mean most retirees can finally expect a modest boost in net Social Security benefits.

But 2 million retirees receiving Social Security benefits of less than $600 per month in 2018 won't see an increase after the deduction for their Medicare Part B premiums. Part B premiums will increase by more than $1.50, for this group of retirees because they are paying less than the current Part B premium of $134 today. This is due to the effects of the Social Security "hold harmless" provision.

Recently we heard from Barbara B. of Indiana who was affected in a similar way last year, but who will finally catch up in 2019. Barbara's net

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MEDICARE PART D COVERAGE GAP CLOSES IN 2019

While little progress was made this year to lower overall drug costs, some changes made by the Bipartisan Budget Act (BBA) of 2018 are helping an estimated 5 million Medicare beneficiaries with the highest annual out-of-pocket drug costs. Provisions of the BBA reduced Part D enrollees' out-of-pocket co-insurance for brand-name drugs in the "doughnut hole" which is also called the coverage gap phase of coverage.

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Rx for Surprise Medical Bills

By Mary Johnson, editor

After 44-year-old Drew Calver had a heart attack last year, his health plan paid nearly $56,000 for a four-day emergency stay in a hospital that was not in his insurance plan's network. The hospital then charged Calver another $109,000—a bill for the balance, which is the difference between what the hospital and his insurer thought his care was worth. Calver's bill was reduced to $332, but only after Kaiser Health News and National Public Radio recently published his story.

Surprise bills like Calver's can occur almost any time to any of us—including Medicare beneficiaries. Often, the surprise bill is nothing more than a simple billing error when the provider doesn't have correct billing information, such as your Medicare number, Medicare Advantage or Medigap insurance info. (Stay calm and call your provider.)

Surprise balance billing, on the other hand, is no mistake. It happens after you've satisfied your deductible, co-insurance or co-payment, and your insurance company (such as a Medicare Advantage plan insurer) pays everything that it's obligated to pay. However, if there's still a balance owed, the bill gets sent to you.

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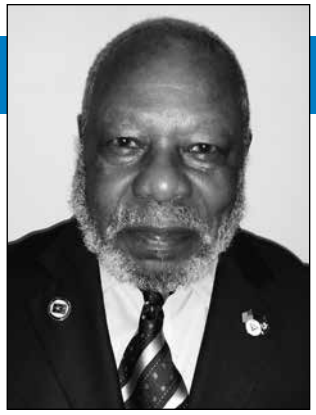
When You Can't Afford Your Prescription Drugs, Apply For "Extra Help"



Arthur "Coop" Cooper, Chairman, TSCL

We've heard stories about cutting back on prescriptions over the years, but recently I heard one about a diabetic who was forced to cut back on the amount of insulin that she needed to control blood sugar. She was going into debt to buy Lantus insulin. Cutting back, and not taking the recommended dosage to control her blood sugar, triggered severe nerve pain and sent the woman back to her doctor.

Nearly two-thirds of the spending on prescription drugs by older Americans is for out-of-pocket costs that include deductibles, co-pays and co-insurance. Since the start of Medicare Part D in 2006, out-of-pocket costs grew 188% or roughly 16% per year by the end of 2017, far exceeding the growth in Social Security benefits, that averaged just 1.9% per year over the same period.

If you find yourself in the situation where it's getting difficult to afford your prescriptions, Medicare has a program known as "Extra Help," that pays for some or even most of your out-of-pocket drug costs. You qualify if your monthly income is less than $1,538 for individuals or $2,078 for couples, and your assets are lower than the specified amount (see chart):

- Extra Help pays for your Part D plan premium, up to a specific amount, based on your state.
- Reduces the costs of your drugs.
- Gives you Special Enrollment Periods to enroll or change plans during the year outside of the fall Open Enrollment period.
- Eliminates the Part D late enrollment penalty if you delayed signing up for Part D when you first qualified.

The amount you receive depends on your income and assets. If your income is on the higher end you still might qualify for partial Extra Help. Keep in mind that to receive the assistance you must first enroll in a drug plan AND the drugs you take must be listed on the plan's formulary.

To learn more and to apply, visit the Social Security website at https://www.ssa.gov/benefits/medicare/prescriptionhelp/. Or call toll free at 1-800-772-1213 (TTY 1-800-325-0778).

You can also get one-on-one counseling and assistance in applying through your State Health Insurance Program (SHIP). Find the contact for your area online at: http://shiptacenter.org. ■

Source: "Extra Help Basics," Medicare Interactive, The Medicare Rights Center, accessed on June 19, 2018.

Do You Qualify For Medicare Part D Extra Help?

2018	Annual Income	Assets
Single	Less than $18,456	Less than $14,100
Married	Less than $24,936	Less than $28,150

SOCIAL SECURITY & MEDICARE QUESTIONS

What Can You Tell Me About Retroactive Social Security Benefits?

Q: I'm turning 65 soon, and I'm not employed since I was caring for my husband who recently passed away. I inherited our home and two retirement accounts, in addition to receiving a payout from life insurance when my husband died. Now my mother's dementia is worsening, and I need to take care of her, so I'm leaning toward starting Social Security. I've been told that I might qualify for widow's benefits and receive retroactive benefits. What can you tell me?

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Long Lines at Social Security Offices and What We Can do to Shorten Them

By Jessie Gibbons, Legislative Director

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If you've been to a Social Security field office in the past few years, you've noticed longer wait times, fewer staff members, unanswered phone calls, more visitors, and frustrated employees. You may have even seen your local Social Security field office shutter its doors.

Since 2010, the Social Security Administration's budget has declined by 9 percent, resulting in a loss of 10,000 employees and the closure of more than 10 percent of all field offices nationwide. At the same time, the number of Social Security beneficiaries has increased dramatically—by 15 percent.

Under current law, Social Security benefits are considered "mandatory spending" and they are required by law to be paid out directly to beneficiaries with no budget limits. However, the Social Security Administration's funding for administrative purposes is deemed "discretionary spending," and lawmakers, through the annual appropriations process, negotiate it to decide on funding. That means Congress must set the Administration's funding levels every year. Recently, lawmakers have been short-changing the program's administrative finances, at a time when 10,000 older Americans are becoming eligible for benefits every day.

As a result of the inadequate administrative funding for the Social Security Administration, both the Old-Age and Survivors Insurance (OASI) and the Disability Insurance (DI) programs are struggling to serve the public. More than 1 million applicants are currently waiting to hear whether they qualify for DI benefits, and those who have appealed recent rejections must wait 600 days or longer for their cases to be re-heard. In 2017 alone, 10,000 individuals died while waiting on their DI eligibility decisions. While waiting, they had no access to DI benefits or Medicare coverage, which recipients with long-term disabilities can receive after they are enrolled in the program for two years.

In an attempt to address these administrative funding challenges, Senator Bernie Sanders (VT)—Ranking Member of the Senate Budget Committee—and Congressman John Larson (CT-1)—Ranking Member of the Ways and Means Social Security Subcommittee—recently introduced the *Social Security Administration Fairness Act* (S. 3147, H.R. 6251) along with six Senate cosponsors and twenty House cosponsors. If adopted, their bill would accomplish the following:

- **Permanently set the Social Security Administration's administrative funding at 1.5 percent of overall benefit payments.** This would more than double the funding that the administration currently receives, and it would help reduce the growing DI backlog while ensuring that beneficiaries receive the service they have earned and deserve from the Social Security Administration.
- **Implement a moratorium on all field office and contact station closures.** Since 2010, one in ten field offices, and all rural contact stations run by the Social Security Administration, have closed due to inadequate funding. At a time when thousands of individuals are retiring every day, a moratorium would improve access to the essential services provided by these offices.
- **Eliminate two waiting periods for approved DI**

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The Social Security & Medicare Advisor © 2018 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

Congress Has an Obligation to Seniors

By Representative Debbie Lesko (AZ-8)

Representative Debbie Lesko (AZ-8)

Since 1935 and 1965, Social Security and Medicare have been, and continue to be, essential for senior citizens of the United States. More than 60 million Americans are currently enrolled in these programs, with 10,000 new eligible enrollees each day. Because many seniors rely on Social Security and Medicare to make ends meet, I introduced H. Res. 1026 in Congress, which recognizes these as important programs that must be protected for current enrollees and strengthened for future generations.

The federal government made a commitment to senior citizens with the Social Security and Medicare programs. Many seniors worked their whole lives paying into the system with the assurance that, later in life, the Social Security and Medicare programs would be there for them. Congress has an obligation to these seniors and must keep its promise.

According to the nonpartisan Medicare Board of Trustees, Medicare is set to become bankrupt by 2026. The nonpartisan Social Security Administration estimates that Social Security will be bankrupt by 2034. We must take action to preserve these programs, without diminishing any benefits for those currently relying on the programs. To be clear, I do not support any cuts to these programs.

A first step in preserving these programs is to increase oversight and accountability. The Government Accountability Office (GAO) estimates that $59.7 billion was misspent in 2016 due to improper payments in the Medicare Program. The Social Security Administration estimates that $7.6 billion will be lost this year in the Social Security program, also due to improper payments. We must take every effort to reduce waste, fraud, and abuse in these programs, in order for them to continue on a sustainable path.

My resolution, H. Res. 1026, affirms Congress's deep obligation to fulfill the promises made to senior citizens of the United States regarding access to Medicare and Social Security and rejects, in the strongest possible terms, any changes to Medicare or Social Security that diminish benefits for Americans currently enrolled, or citizens of the United States who are in or near the retirement age. It also expresses its firm commitment that Medicare and Social Security should be strengthened and preserved for future enrollees, and supports efforts to reduce waste, fraud, and abuse in these programs.

It is time for Congress to start the conversation on how to address the insolvency of the Social Security and Medicare programs, but we must do so without hurting those it is intended to help. There is a way for the government to keep its promise to seniors, and ensure these programs remain in place for future Americans. ■

Congresswoman Debbie Lesko represents Arizona's Eighth Congressional District in Congress, which is located north and west of Phoenix, including Sun City, Surprise, and Peoria. She serves on the House Homeland Security Committee and the House Science Space and Technology Committees.

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

Can You Help?

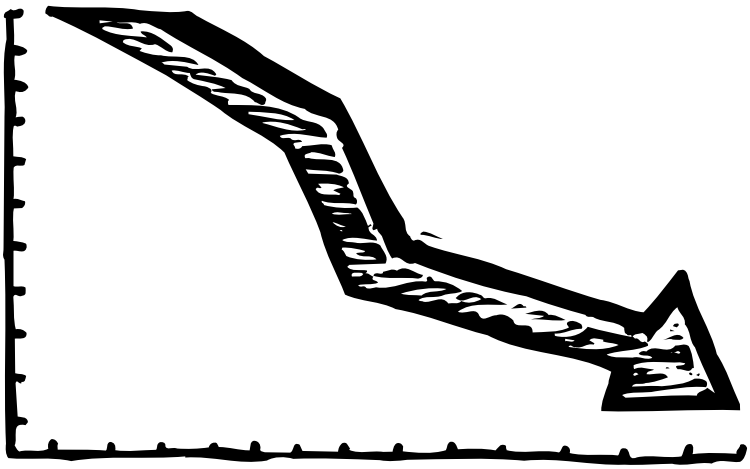
Social Security's financing imbalance threatens the long-term solvency of the program, and the benefits of more than 60 million beneficiaries. You can help us in the fight to protect Social Security from benefit and COLA cuts.

Help us help you with a donation.

☐ $10.00 ☐ $5.00

Send your donation to: The Senior Citizens League, PO Box 97173, Washington, DC 20090-7174

Tax Planning? Medical Expense Deduction Becomes Less Generous in 2019



Although there's a new higher standard deduction for U.S. taxpayers this year, tax professionals are cautioning taxpayers against automatically taking it. The 2017 tax legislation retains the deduction for medical expenses. This year, taxpayers can deduct medical expenses exceeding 7.5% of their Adjusted Gross Income (AGI), but that threshold will rise to 10% of the AGI in 2019, so taxpayers won't be able to deduct as much. It would be a good idea to crunch the numbers now, to learn if itemizing and the medical expense deduction would reduce your taxes.

The deduction is especially important to people age 65 and over, since spending on medical expenses increases with age, and healthcare costs can be considerable. About 23 percent of participants in The Senior Citizens League's 2018 Senior Survey said they routinely itemize medical expenses. A recent report from the non-partisan Kaiser Family Foundation says that Medicare households spent on average $5,355 in 2016 on healthcare costs that Medicare doesn't cover. That's equivalent to $5,700 in 2018 adjusting for inflation.

While you can count medical bills for you, your spouse and dependents listed on your tax return, you may also be able to count some medical expenses that you paid for a family member (such as a parent) who's not considered a dependent for tax purposes. This is the sort of question you should discuss with a tax professional.

In addition to expenses such as out-of-pocket drug costs, and co-pays for visits to the doctor, here are a few of the most common overlooked medical deductions:

- **Out-of-pocket costs** for dental, vision, audio, physical therapy and other services not covered by Medicare or other health insurance. This also includes equipment and supplies, like glasses, hearing aid batteries, dentures and implants. (Find a complete list in IRS publication 502.)
- **Medicare and other health insurance premiums,** including Medigap supplements, Part D or Medicare Advantage plans, and long term care insurance, as long as an employer did not pay the premiums.
- **Travel expenses to and from medical treatments.** In 2018, the standard mileage rate for tax purposes is .18 cents per mile for medical purposes. Keep a travel log for documentation.
- **Cost of alcohol or drug-abuse treatment.**
- **Medically necessary home remodeling.** This can include ramps, making doors and hallways wider, adjusting electrical outlets, even grading exterior landscape to provide access to the house.
- Some home healthcare can be deductible. In order for home healthcare expenses to be deductible, those who require the care must be unable to perform two or more of six activities of daily living (such as bathing, and feeding yourself) and have a plan of care from a physician that specifies help with these tasks.

To learn more about deducting medical expenses, see IRS publication 502, which can be downloaded at www.IRS.gov. ■

ASK THE ADVISOR

Can You Tell Me About Programs That Help Older Homeowners With Taxes?

Q: I've heard there are programs that allow older homeowners to get help with property taxes. Can you tell me anything about these?

A: For retirees living on fixed incomes, the ability to continue living in your own home often boils down to what you pay in property taxes. According to a story appearing in *USA TODAY,* owners of single-family homes paid an average of $3,296 in property taxes in 2016, roughly 1.15% of the appraised real estate value in 2016.

There are programs in almost every locality that could possibly lower your tax bill, but you will need to take time to research what is available, and file the necessary paperwork if you meet the guidelines. Some areas allow people living on fixed incomes to pay their real estate taxes in monthly installments rather than semi-annually. Here are details on two of the most common types of tax programs:

- ***Exemptions:*** An exemption waives some, or even all, of the tax you owe depending on your age, income, and where you live. (Don't automatically assume that you must be age 65 and older, some areas allow people younger than 62 to apply.) Some exemptions allow you to exclude a portion of your property from taxation. For example the Homestead exemption in the state of Colorado allows a 50% deduction for the first $200,000 in property (or a $100,000 exemption) for taxpayers over age 65, who have lived on their property for ten consecutive years. In many areas of the country, exemptions are more closely tied to age, disability, and income. For example in Orange County, Virginia, taxpayers must be age 65 or older, have a combined household income under $40,000 and a net worth no greater than $90,000 excluding the value of the dwelling and land (not exceeding two acres). The exemption must be applied for every year.
- ***Deferrals:*** Two-dozen states, including California and Texas, permit some form of tax deferrals for older taxpayers. These programs allow older homeowners to put off paying real estate taxes for as long as you remain in your home. When program participants do eventually sell or pass away, the state claims the balance of what you owe, including interest. Eligibility depends on age, residence and, in some instances, income and property value. Minnesota's deferral program, for example, allows homeowners 65 and older with household incomes of $60,000 or less to defer a portion of property taxes. Eligible taxpayers are still responsible for paying property taxes equivalent to 3% of household income. For example, if your income was $15,000 in the year prior to entering the program, you would be responsible for 3% or a tax of $450. That would be the maximum you would be responsible for paying each year you participate. If your tax is $1,450 you would pay $450 and the remaining $1,000 would be paid by the state of Minnesota, directly to your county. The interest on the loan changes annually, but is capped at 5%. Be sure to learn all the rules, and read the fine print. Tax deferrals are like a loan. The state attaches a lien on your property, meaning the state can take possession of the home as payment for the loan if you no longer qualify for the program and don't repay.

To learn more about programs in your area, contact your county or local government's tax office. ■

Sources: "Comparing Average Property Taxes For All 50 States And D.C.," Constance Brinkley-Badgett, Credit.com, USA TODAY, *April 16, 2017.*

Legislative Update: Long Lines at Social Security Offices and What We Can do to Shorten Them, continued from page 3

recipients. Under current law, approved DI beneficiaries must wait five months to begin receiving monthly benefits, and those with long-term disabilities must wait two years to begin receiving Medicare benefits. In a recent poll of The Senior Citizens League's supporters, 65 percent of respondents said they believe both waiting periods should be eliminated, while only 20 percent said they should be kept in place.

Upon introducing the comprehensive bill back in June, Congressman Larson said: "These are benefits that American workers have paid for and earned with every paycheck—they have earned the right to better service." The Senior Citizens League agrees, and we were proud to support the *Social Security Administration Fairness Act.* Since the legislation was introduced, we have been advocating for its passage on Capitol Hill, and we hope to see it signed into law in the coming months.

For more information about the *Social Security Administration Fairness Act,* visit the Bill Tracking section of our website. For progress updates on the bill's movement through Congress, follow TSCL on Twitter. ■

How the Medicare Part B Premium Increase Will Affect Benefits in 2019, continued from page 1

Social Security benefit, after the deduction for Part B premium, has remained exactly the same for the past three years. She hasn't seen an increase in her benefits since 2015, despite a 2% COLA in 2018.

The Social Security hold harmless provision prevents reductions in net Social Security benefits, when the dollar amount of an individual's Medicare Part B increase is greater than the dollar amount of their COLA. In 2019, Barbara may finally see a small boost of about $19 per month after deduction for her Part B premiums.

Here's how we got here:
The hold harmless provision was triggered nationally in 2016 when the Social Security Administration announced that there would be no COLA payable, due to a drop in inflation. Barbara's Medicare Part B premium stayed the same as it was the year before, at $104.90, even though Medicare Part B premiums in 2016 jumped to $121.80 for about 30% of beneficiaries, such as new enrollees who were not protected by the hold harmless provision.

In 2017, the COLA was almost zero again, just 0.3%. The Medicare Part B premium rose to $134 for people not protected by hold harmless. Again, the Part B premium of Barbara and the majority of Social Security recipients was adjusted. Barbara's monthly Medicare premium was adjusted to $108, taking every penny of her tiny COLA boost.

In 2018, the Part B premium remained $134 per month. To cover that premium, Barbara, whose Part B premium was $108.00, needed a COLA of at least $26.00. That was more than the 2% COLA boosted her Social Security benefits. Once again her Part B premium was adjusted and in 2018 she pays a Part B premium of $127.00 per month. In 2019 her COLA will be high enough to catch up to the Part B premium of $135.50 and still leave a small boost for her net Social Security benefits.

As much as the protection against reduction of Social Security benefits is appreciated, Barbara has been frustrated about high Medicare premium costs after years of low or no COLA growth. "It's been 36 months since I've had any raise in my net operating Social Security, but my actual household costs continue to go up," Barbara told us. "This isn't fair to retirees," she adds.

TSCL supports legislation that would strengthen the COLA three ways:

- Use a consumer price index that better reflects the costs of retirees—the Consumer Price Index for the Elderly (CPI-E).
- Provide a modest boost in monthly benefits to retirees to make up for years when no COLA, or only a negligible COLA, was payable.
- Guarantee a minimum COLA of no less than 3 percent.

To learn how you can get involved visit www.SeniorsLeague.org. ■

Medicare Part D Coverage Gap Closes In 2019, continued from page 1

In 2018, people who hit the Part D coverage gap pay a co-insurance of 35% for discounted brand-name drugs and 44% of the cost of generics. That will decline to 25% for brand name drugs and 37% for generics in 2019, a year sooner than scheduled under previous legislation.

In 2018, once drug plan enrollees enter the coverage gap phase, they remain there until they spend a total of $5,000 out-of-pocket. This out-of-pocket threshold is calculated entirely on drugs covered by the enrollee's drug plan formulary. If a drug isn't on the plan formulary, beneficiaries must pay 100% of the cost of drugs and those out-of-pocket costs do not count toward the out-of-pocket threshold for catastrophic coverage.

In 2019, that out-of-pocket threshold will increase to $5,100. Once that threshold is reached, the catastrophic phase of coverage begins, when beneficiaries pay 5% co-insurance, or $3.40 for generics and $8.50 for brand name drugs, whichever is greater.

The lower co-insurance in 2019, however, comes as the annual out-of-pocket threshold, the amount beneficiaries must spend before the coverage gap ends and catastrophic phase begins, is projected to take a stunning leap. The threshold is scheduled to increase by $1,250 in 2020, from $5,100 to $6,350. In fact, the catastrophic threshold is forecast to almost double over the next 9 years rising from $5,000 in 2018 to $9,450 in 2027.

According to TSCL's 2018 Senior Survey, 62% of survey participants support capping out-of-pocket spending on prescription drugs. Only 8% are opposed to the idea.

TSCL supports legislation that would eliminate beneficiary cost-sharing in excess of the Medicare prescription benefit's annual out-of-pocket threshold. In addition, TSCL supports legislation to allow Medicare to negotiate drug prices to benefit all beneficiaries. ■

Sources: Medicare Trustees 2018 Annual Report, June 5, 2018. Fact sheet: "Medicare Part D Prescription Drug Benefit in 2019," National Council on Aging, 2018.

Rx for Surprise Medical Bills. continued from page 1

Surprise balance billing is especially a problem for Medicare beneficiaries who unknowingly get care from a doctor that isn't part of their health insurance plan's provider network, or who doesn't accept Medicare's payment as payment in full. This happens all too frequently, even to people who have carefully selected in-network providers and hospitals for their care. Among the worst offenders are the doctors we don't tend to see or interact with, including anesthesiologists in surgery, pathologists, radiologists (who interpret X-rays and scans), and those providing ambulance services.

The problem is so common, and frustration over exorbitant prices for medical treatment so great, that a bipartisan group of Senators has proposed legislation to protect patients from surprise bills and high charges from hospitals or doctors who are not in their insurance networks: The proposal targets three top concerns:

- **Treatment for an emergency by a doctor who is not part of the patient's insurance network, at a hospital that is also outside the network.** Patients would be required to pay the out-of-pocket amount required by their insurance plan. The hospital or doctor could not bill the patient for the remainder.
- **Treatments by an out-of-network doctor or other provider at a hospital that is in the patient's insurance network.** Patients would pay only what is required by their plans.
- **Notification of emergency patients, once stabilized, that they are receiving out-of-network care and could run up excess charges.**

While legislation has not yet been introduced, TSCL supports this common-sense proposal, and plans to endorse legislation once introduced next year. Have you been affected by surprise medical bills? If so we want to hear from you! Send us your story or comments at: www.SeniorsLeague.org. ■

Sources: "Surprise Medical Bills May Lie in Stitching up Federal Law," Kaiser Health News, September 24, 2018. "Senators Unveil Legislation to Protect Patients Against Surprise Medical Bills," Rachel Bluth, Kaiser Health News, September 19, 2018.

Social Security & Medicare Questions, continued from page 2

A: Social Security pays up to six months of retroactive benefits to qualified beneficiaries who are *over* their full retirement age. While you potentially may qualify for widow's benefits now, any benefit you receive will be reduced because you are *under* your full retirement age. Because you would be retiring early, you wouldn't qualify for any retroactive Social Security benefits. If you were born before 1955, your full retirement age is 66.

When you retire after full retirement age, the Social Security Administration automatically calculates retroactive benefits back to the month when you turned your full retirement age, up to a maximum of six months. In other words if you retire at age 66 and 7 months, you would automatically receive 6 months of retroactive benefits unless you specifically decline the benefits. You may want to consider doing that instead.

Taking retroactive benefits can be a bad deal for you, because you would be trading a one-time retroactive payment for a lower monthly benefit for the rest of your life. For example, say you qualify for a benefit of $1,600 at age 66. At age 66 and 6 months your benefit has grown 4% to $1,664 by earning delayed retirement credits. If you opt for retroactive benefits, however, the Social Security Administration would start your benefits at $1,600 instead of $1,664. You would receive $9,600 in retroactive benefits, but if you lived longer than 12.5 years, you would potentially be leaving a considerable sum of money behind. Also keep in mind how much more you would have to pay in taxes by taking the lump sum early. If you are in reasonable health, it's quite possible these days to live another 25 years.

These are complicated decisions and we strongly recommend that you take your time and get professional financial counseling. Here's what you should definitely do right away when you are within 3 months of age 65—sign up for Medicare Part B. This is not automatic. You will need to sign up by Medicare's deadline to avoid getting hit with permanent late enrollment penalties. You sign up for Medicare on the Social Security Administration's website.

In addition to signing up for Medicare Part B, as soon as you receive your Medicare number, you will need to choose how you want to receive your coverage. Your choice is between a Medicare supplement with a stand-alone Part D prescription drug plan, or to enroll in a Medicare Advantage plan with Part D drug coverage. There is free one-on-one counseling available to help you with this decision at least, through State Health Insurance Assistance Programs (SHIP). Many of these programs operate through local Agencies on Aging, and senior centers. To get a counselor in your area visit: www.shiptacenter.org/. ■

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