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TURNING 65: NAVIGATING CRITICAL DECISIONS TO AGE WELL

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

SECOND SESSION

WASHINGTON, DC

JANUARY 24, 2018

Serial No. 115–13

Printed for the use of the Special Committee on Aging

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE
32–636 PDF WASHINGTON : 2019

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TURNING 65: NAVIGATING CRITICAL DECISIONS TO AGE WELL

WEDNESDAY, JANUARY 24, 2018

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairman of the Committee, presiding.

Present: Senators Collins, Fischer, Casey, Gillibrand, Blumenthal, Donnelly, Warren, Cortez Masto, and Jones.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order.

For the next 12 years, 10,000 Americans will turn 65 each day. Last month I officially joined that club.

By median age, Maine is the oldest state in the Nation and is aging the most rapidly. Mainers age 65 or older accounted for 19.4 percent of the population of the state in 2016. That is a twenty-two percent increase from the year 2010.

No matter where in the country you live, when Americans think of turning 65, we traditionally think of Medicare and Social Security—as well we should. Today, more than ever, there is also an opportunity to plan for a brand-new chapter of life as more Americans are living far longer.

More than one out of four Americans who live to age 65 can expect to live into their 90's. Americans age 85 and older are the fastest-growing segment of our population. For many seniors, this longevity means an additional three decades following what was once considered the time to retire. We need to plan to age successfully and achieve a new chapter of continued growth in our lives.

At the same time, we must make those all-important decisions regarding Medicare and Social Security. As I know from my own visit to the Social Security office in Bangor, Maine, where people were extraordinarily helpful, there are important decisions to make, and the programs can be very complex to navigate. So it is best to start considering options before that 65th birthday comes around.

For example, the enrollment window for Medicare is limited, and there are penalties for late enrollment. The clock to sign up begins 3 months before the 65th birthday and extends for 3 months afterward. Signing up late, particularly for Medicare Part B, can lead

to a hefty penalty that lasts for life. It can be confusing to navigate these hurdles and to choose the right package to suit individual health care needs.

Those who are collecting Social Security benefits when they turn 65 are automatically enrolled in Medicare. Increasingly, however, Americans who are healthy are choosing to work longer, as our Senate Aging Committee showed in its annual report issued last year when we chose to look at America's aging workforce. For many Americans, working longer wisely means delaying Social Security and then being able to collect much higher monthly benefits later.

How does one know which decision is best? What is the optimal time to claim Social Security benefits to ensure financial stability in the long run? When should you begin considering Medicare options to maximize care and reduce costs? Those are some of the questions we will be examining today.

We will also explore another issue: While we have formulas to help guide us through the best Medicare and Social Security decisions, there is no simple formula for healthy aging. If we were to create a checklist for healthy aging, what would it include?

There are proven choices that one can make to maximize health and well-being. While genetics determines about twenty percent of longevity, lifestyle and environment dictate the other eighty percent.

Staying physically active, eating well, conversing with friends, reading engaging books, doing something meaningful every day, and taking proactive steps to improve wellness all contribute to healthy aging. Most people know that physical, social, and cognitive engagement is good for you. Few people realize that it remains critical at every life stage, but especially in older adulthood. Even for those who face multiple chronic conditions and frailty, proactive actions can reverse a negative life course and lead to a healthier future, but that can be difficult in states like mine which are very rural and where people may feel isolated from one another.

I would like to share with you the story of "Sandy," a healthy 80-year-old woman. One icy winter morning, she stepped outside to take her dog out. She slipped and broke her right leg. Once an active woman, Sandy found herself unable to walk. Following surgery, rehab, and physical therapy, she was able to get around with a walker, but stayed home for days at a time. She felt down in the dumps. Her daughter convinced her to try a program called "A Matter of Balance" offered through MaineHealth, which is a hospital system based in Maine. This program reduces fear of falling and improves balance. For Sandy, the program literally changed her life. Each week she regained strength. She traded the walker for a cane, and soon afterward she shed the cane, too. Today Sandy is a coach for that program. She is able to walk miles on end and feels like she has her life back.

Sandy's story shows that even after falls, we have the capacity to get back up and age well. It also shows how important those programs can be in helping a senior regain his or her life.

Today more and more Americans have a chance to live to 100. The second fastest-growing age group in the United States is 100

and older. Turning 65 once meant that it was time to retire and slow down. Today it is an opportunity to prepare for a lifetime ahead—a lifetime of living, learning, and loving. A lifetime of financial security if the right decisions are made. As individuals and as a society, what do we need to do to get there? What choices should we make? How can we disseminate useful information to the senior population?

I look forward to our discussion on these important issues, and I am pleased now to turn to our Ranking Member, Senator Casey, for his opening statement.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., RANKING MEMBER

Senator CASEY. I want to thank Chairman Collins for this hearing and for her opening statement today, and I also want to thank her for the good work she has done in what has been a long week here in the Senate.

Every day 10,000 Americans turn age 65 in the United States of America. Ten thousand people every single day—that is a staggering number. And today we will hear that people turning age 65 face their own staggering number of decisions at that time in their life.

They must be thinking about a range of issues: claiming Social Security, about signing up for Medicare and about how to get what they need to stay healthy. These are not simple decisions. There is no one-size-fits-all choice for those individuals.

That is what I hear from my constituents in Pennsylvania, specifically through our constituent services team, and we hear about it day after day. Our office regularly works with Pennsylvanians who missed their window to sign up for Medicare, for example. They are people with a cancer diagnosis who have no way to pay for care simply because they did not know the right time to sign up. They are people who made an honest mistake, who did not know they needed to sign up for Medicare. It could happen to any one of us. Now they are paying higher premiums for the rest of their life.

Almost 26,000 Pennsylvanians—26,000—are paying a lifetime late enrollment penalty for Medicare Part B. Nationwide almost 700,000 Americans are on the hook for that lifetime penalty. The average penalty amounts to almost a thirty percent increase in a person's monthly Medicare premium. That is outrageous and unacceptable, especially considering that most retirees are already living on limited and often fixed incomes.

Medicare is one of America's great success stories, and it is our sacred responsibility to make sure that people can make the most of the Medicare benefits that they have earned.

So that is why I introduced the Medicare Beneficiary Enrollment Notification and Eligibility Simplification Act. Good news, we have an acronym, the BENES Act—B-E-N-E-S. And what that act does is to make sure that every American receives a notice before they turn 65 that explains when to sign up for Medicare and what can happen if you delay. That is the least that we can do for so many Americans. This bill would also make sure that fewer people experience a gap in health coverage.

In fact, this change would update parts of the Medicare law that have not been revisited since the program was created more than 50 years ago. I am proud of that legislation because it is bipartisan and it represents how Congress should work.

We should hear about what is not working and what is most challenging for our constituents.

We should design solutions to fix those problems—in a bipartisan way—and we should be able to pass these laws because they help the people we serve, the people that deserve that kind of law.

So I look forward to today's hearing, and I hope we can illuminate some of these problems—the same problems that Chairman Collins and I can work together on to fix.

Thank you, Madam Chair.

The CHAIRMAN. Thank you very much.

Before turning to the introduction of our witnesses, I do want to recognize and welcome our new Committee member, Senator Jones from Alabama. We have had the opportunity to work very closely together the last few days. In fact, you have probably seen way more of me than you would have liked. But I am delighted that you have joined the Aging Committee, and I think you will find it to be a great Committee. And you are sitting next to our Committee's most diligent member, and if you follow her lead, I am sure that you will have a great experience. So welcome.

Our first witness today is Jim Borland, the Acting Deputy Commissioner for Communications at the Social Security Administration. Mr. Borland will discuss the spectrum of tools and resources available to help Americans choose the right retirement benefits that are right for their individual needs and circumstances.

Next we will hear from Anna Maria Chávez. Ms. Chávez is the chief strategy officer and senior vice president of external affairs at the National Council on Aging. In her home State of Arizona, she launched the Governor's Aging 2020 Initiative and created the Arizona Division of Aging and Adult Services.

Next I would like to introduce Dr. Mehrdad Ayati, an adjunct clinical assistant professor of medicine at Stanford University. Dr. Ayati is a board-certified physician in geriatric and family medicine. He studies the physiology of aging and how to promote well-being through disease management and prevention.

And I will now turn to our Ranking Member to introduce our witness from Pennsylvania.

Senator CASEY. Thank you, Madam Chair. I am pleased to introduce Sharon Hill from Vanderbilt, Fayette County, Pennsylvania. And I also want to start by congratulating Ms. Hill. I am told that you have now your seventh grandchild?

Ms. HILL. Yes.

Senator CASEY. Congratulations. And it is a grandson, correct?

Ms. HILL. Yes.

Senator CASEY. That is good news. We need some of that around here.

Sharon is a volunteer with Pennsylvania's APPRISE program. For four years she has worked weekly to help counsel Pennsylvanians and their families, providing them with information to make the most of their Medicare benefits. Sharon will tell us how she came to this counseling work and why it is so important to help

people better understand Medicare. She will also tell us about the common questions that she helps people with and the missteps that families make when they lack key information.

I also want to recognize her granddaughter, August, who is here with us at the hearing. August, thank you for being here today and for supporting your grandmother. You must be very proud of her, and I hope we will see you back here providing your own testimony before Congress someday.

Thank you, Sharon. We are grateful you are here.

The CHAIRMAN. Thank you very much.

We will now start with Mr. Borland.

STATEMENT OF JIM BORLAND, ACTING DEPUTY COMMISSIONER FOR COMMUNICATIONS, SOCIAL SECURITY ADMINISTRATION, WASHINGTON, DC

Mr. BORLAND. Thank you. Chairman Collins, Ranking Member Casey, and members of the Special Committee, I am Jim Borland, Acting Deputy Commissioner for Communications at the Social Security Administration. Thank you for inviting me to discuss how we provide information to help workers and their family members decide when to claim Social Security retirement benefits and when to enroll in Medicare. These decisions are important, and we are mindful of our responsibility to provide information to help our claimants make informed choices. We believe that workers need to be thinking about their claiming decisions before they arrive at the field office. This is why our outreach and education efforts are crucial. The decisions workers make about starting retirement benefits are very important, as they will affect payment amounts for the rest of their lives.

For this reason, even before individuals apply for Social Security benefits or enroll in Medicare, we provide objective information that they may use to plan for retirement. We do this in a variety of ways, including our Web site, publications, outreach, and the Social Security Statement. The Social Security Statement in particular shows information on lifetime earnings as well as estimates of future benefits workers and their families may receive based on those earnings. Individuals may access their Statement at any time through a personal, online My Social Security Account.

We also currently mail statements to individuals aged 60 and older who are not receiving Social Security benefits and do not have a My Social Security Account. In fiscal year 2017, 15.6 million My Social Security users accessed their Social Security Statements nearly 46 million times, and we mailed around 13.5 million statements.

In addition to basic benefit information, the Statement includes information on how work affects benefits, how a worker's claiming decision affects survivor benefits, how to avoid Medicare late enrollment penalties, and information on average life expectancy.

Another valuable resource is our Web site. Each month nearly 15 million people visit us online to get the information they need to make informed decisions about their benefits. Our Web site includes our Retirement Estimator, which is a powerful, popular, and accurate tool. It uses an individual's actual earnings information from our records and allows him or her to input a few pieces of in-

formation to receive an estimate of benefits. It returns benefit estimates at age 62, at full retirement age, and age 70, or at any age in between. According to independent surveys of customer satisfaction, our Retirement Estimator is one of government's highest-rated Web sites.

We recognize, though, that not everyone chooses to use the Internet. Our committed employees assist the public in a variety of ways: through face-to-face interaction in our field offices; by telephone, including over our national 800 number; in response to online applications; and through the mail.

We also have over 100 public affairs specialists who, along with our field office managers, participated in more than 6,000 outreach events last fiscal year. With an estimated audience of more than 3.7 million people, these events range from small rural get-togethers in public libraries, senior centers, churches, and veterans organizations, to large gatherings like county fairs, state fairs, senior expos, and employer meetings. Whether the attendance is in the tens or in the thousands, SSA employees are there to help Americans better understand their benefits.

We also play a key role in signing people up for Medicare. Although the Centers for Medicare & Medicaid Services administers the Medicare program, Social Security is responsible for enrollment. We provide information and Medicare enrollment options for those who become eligible whether or not they are already receiving Social Security benefits.

We continue to strengthen our partnership with CMS to improve our communications with those nearing the Medicare eligibility age of 65. We have updated the statement insert for older individuals to strengthen the message about when to apply for Medicare and to make information more prominent. We have also clarified language about late enrollment penalties in many of our publications.

By establishing the Social Security and Medicare programs, Congress took action to provide seniors with benefits based on their earnings to sustain them throughout their retirement. As stewards of these programs, our job is to help workers make well-informed decisions that are best for their individual circumstances.

I thank you for the invitation to be here today, and I look forward to answering any questions you may have.

The CHAIRMAN. Thank you very much.

Ms. Chávez.

STATEMENT OF ANNA MARIA CHÁVEZ, J.D., CHIEF STRATEGY OFFICER AND SENIOR VICE PRESIDENT, EXTERNAL AFFAIRS, NATIONAL COUNCIL ON AGING, ARLINGTON, VIRGINIA

Ms. CHÁVEZ. Chairwoman Collins, Ranking Member Casey, and members of the Committee, thank you for the opportunity to speak with you today on behalf of the National Council on Aging. I am their chief strategy officer and senior vice president for external affairs at NCOA. We are the Nation's oldest aging advocacy organization.

Life after 65 has changed dramatically since NCOA started in 1950. Where retirement once meant a few years of leisure buoyed by a secure pension, today's older Americans have both the gift and

challenge of planning for a bonus 20 to 30 years of life. Yet few are prepared.

Traditional defined benefit retirement plans have mostly disappeared, and Americans' individual savings for retirement have not caught up. And longer life also brings new health challenges.

Women face unique hurdles. They begin retirement with the challenge that has followed many throughout their lives: the pay gap. Lower pay means less money saved. Women who choose to leave the workforce to be a parent or a caregiver have fewer Social Security benefits built up, and women of color face an even deeper disparity. Over seventy percent of older Hispanic women and over sixty-four percent of older African American women are economically vulnerable.

At NCOA we know there are proven, cost-effective ways to help Americans navigate life after 65. With the help of thousands of partners, our programs address two essential pillars of life past 65: health and economic security.

Health is essential to independence, but older adults are disproportionately affected by chronic conditions such as diabetes, arthritis, and heart disease. The good news is that chronic conditions can be prevented and managed. One example is the Chronic Disease Self-Management program available both in the community and online. It improves health and saves money. With help from Congress, NCOA hopes to bring this program to thousands of older adults.

Falls are another significant health concern, and the facts are alarming. Every 11 seconds an older adult is treated in the emergency room for a fall, and every 19 minutes an older adult dies from a fall. These falls cost Medicare $31 billion a year. But falls are preventable. Programs offered in communities such as A Matter of Balance, as you mentioned, Senator Collins, and tai chi can reduce falls by as much as fifty-five percent. NCOA leads two national initiatives to combat falls, and every September we sponsor Falls Prevention Awareness Day to spotlight the issue. Thank you to Senator Collins and Senator Casey for sponsoring the 2017 Senate resolution. We really appreciate it.

Social isolation and loneliness are a problem for millions as well. Older adults without adequate social interaction have a mortality risk comparable to smoking 15 cigarettes a day. In the community, senior centers are a beacon for older adults seeking social connections. They are a gateway to the Nation's aging network, connecting seniors to support as well as fun and friendships. NCOA runs the National Institute of Senior Centers to promote excellence and best practices.

When it comes to health, we believe prevention should be a national priority. Investing in programs like these improves seniors' quality of life and saves money.

Economic security is just as critical. Today half of older adults living alone struggle to meet their monthly expenses. I want to share just two ways that NCOA is working to change this statistic.

First is benefits access. Less than half of eligible seniors are enrolled in public benefits programs. We support local benefits counselors, and we offer BenefitsCheckUp, a free, online benefits screening tool that has helped nearly 6.5 million people.

Second is improving Medicare. Anyone who has turned 65 can tell you how overwhelming it can be to understand and enroll, and making poor decisions can hurt you, through higher costs, coverage gaps, and even lifetime penalties. And we support the bipartisan BENES Act introduced by Senator Casey, which aims to simplify enrollment. Thank you for your leadership.

Continued funding for low-income benefits, outreach, enrollment, and full funding for the Medicare State Health Insurance Assistance Program are critical. SHIPs provide local, in-depth counseling to Medicare beneficiaries, their families, and caregivers.

Americans want help navigating life after 65. That is why NCOA developed our own innovative approach called the "Aging Mastery Program," which we fondly call "AMP." AMP brings together our best knowledge into a fun, engaging program that gives seniors a pathway to age well. More than 10,000 seniors have graduated so far.

So, in conclusion, aging well means making informed, deliberate choices. At NCOA we offer tools and solutions to help seniors do just that. We look forward to working with the Committee to develop even more resources to help people navigate life after 65.

The CHAIRMAN. Thank you.

Dr. Ayati.

STATEMENT OF MEHRDAD AYATI, M.D., ADJUNCT CLINICAL ASSISTANT PROFESSOR, GERIATRIC MEDICINE, STANFORD UNIVERSITY, STANFORD, CALIFORNIA

Dr. AYATI. Madam Chair, Ranking Member, and distinguished members of the Aging Committee, thank you for inviting and giving me this opportunity to discuss the challenges regarding the aging population in the United States. My name is Mehrdad Ayati. I am a board-certified geriatrician and educator. I am presenting myself as a physician who has treated and managed and continues to treat thousands of senior Americans.

As well said at the beginning, today the number of Americans ages 65 and older is approximately 49 million. Currently, there are about 7,000 geriatricians in practice in the United States. We need about 20,000 geriatricians to staff up for the need we have right now.

This aging population is faced with multiple challenges on the path to healthy aging, and I am giving my opinion as a geriatrician about these challenges.

Number one, lack of experts in the field of geriatric medicine and gerontology. Unfortunately, our health care and education systems have not been designed to train enough senior care providers who can specifically manage seniors. As we age, our physiology changes. And, therefore, it is crucial to be managed by health care providers who have been educated and trained in this field.

In the U.S., eighty percent of seniors have at least one chronic condition; forty percent of the seniors take at least five medications, not taking into account over-the-counter supplements and herbal remedies. They see many different specialists and are prescribed a number of different medications through each, which can result in polypharmacy or overmedication and drug cascade syndrome.

The next challenge is lack of scientific and research-backed medical information regarding healthy aging. Despite the fact that we live in an era of advanced technology, with massive amounts of information on the subject of aging available, the validity of much of such information is highly questionable. For example, misleading marketing campaigns in every corner are enticing our seniors to take drastic measures such as taking unregulated vitamins and supplements or undergo harmful diets to live longer and healthier. This is regardless of the fact that the scientific data collected over many years indicates such over-the-counter supplements and drastic diets are not contributing to better health and could even be detrimental to our health.

The next challenge, the elderly are becoming more racially and ethnically diverse. In 2014, about fifteen percent of people age 65 and older lived in a home where a language other than English was spoken. Currently, we lack the resources to address the challenges of these growing ethnic and racial groups.

The next challenge, which is most important one, we live in an anti-aging society. In traditional society, the elderly hold an exceptional status in their community. They are considered very sage, are highly respected, and have a central position in the family and their community. In the U.S. that is not true. Older adults are often forced out of the workforce and replaced by cheaper and unskilled labor. They usually retire to the solitude of their houses. They become isolated and lonely, and as a consequence, they develop depression and cognitive impairment. Later they may be institutionalized and set aside by the society they built and the children they raised. They can even be easily mistreated, cheated, and taken advantage of.

The next challenge, lack of infrastructure and resources. Our seniors face a lack of appropriate resources in the areas of transportation, affordable housing, senior centers, organized and affordable social activities, and qualified health care centers.

And the next, financial difficulties. A large number of seniors are living in poverty. Often they are faced with a hard choice between paying their rent or mortgage, buying the many medications they cannot survive without, or purchasing food. Too often they become not only financially but also physically dependent on their children, which are known as the "sandwich generation."

Next is robotic mentality. We live in a modern society where more is considered better. This kind of mentality tells us that for every single problem, there should exist a quick fix—even if there is no logic behind it. "Modern medicine" dictates that things should be fixed with either medications or interventions or procedures. But in reality, the statistics do not support this.

And the last challenge is Medicare expenditures. As the Medicare system is set up today, it does not pay for the medically necessary services, which can have tremendous impact toward a better physical and mental quality of life for older adults.

Thank you again for this opportunity, and I will be happy to answer any questions and discuss about how we can fix that.

The CHAIRMAN. Thank you very much, doctor.

Mrs. Hill, welcome.

STATEMENT OF SHARON HILL, APPRISE VOLUNTEER, STATE HEALTH INSURANCE ASSISTANCE PROGRAM, VANDERBILT, PENNSYLVANIA

Ms. HILL. Thank you, Chairman Collins, Ranking Member Casey, and members of the Committee. Thank you so much for this opportunity to testify today. It is a real honor to be here.

My name is Sharon Hill. I am 63 years old and a resident of Vanderbilt, Pennsylvania. I have two sons and seven grandchildren and my youngest grandchild, Logan, was born Tuesday. My granddaughter August has joined me here today. She volunteers with me at many of the senior centers that I go to. I am a volunteer with the Pennsylvania APPRISE program. Nationally, APPRISE is also known as the State Health Insurance Assistance Program—SHIP.

In addition to volunteering with the APPRISE program, I work cleaning my church. I also care for my 89-year-old father and help care for my 92-year-old neighbor, who is blind. I have a disability myself and rely on the support of state and federal programs to remain active and engaged in my community.

I have been an APPRISE volunteer for four years. I initially saw an ad in our local Senior Times newspaper, asking for volunteers to help people with Medicare issues. At that time I was on Medicare due to a disability and had recently been left with $67,000 in medical bills after a cancer diagnosis. I also recalled the difficult decisions my parents had to make about their Medicare coverage. Both events were behind my interest in volunteering for the APPRISE program.

To be an APPRISE volunteer, I had to attend many training sessions. At these sessions I learned about the different parts of Medicare, including Medicare Parts A, B, C, and D, as well as Medigap. I also learned about the programs that can help low-income seniors and people with disabilities. This would be like Medicare Extra Help and even Pennsylvania-specific programs that help individuals who have high medical expenses. I was trained on how to use the computer system and enter information into the Medicare Plan Finder. Each year we receive refresher training to provide volunteers with any updated information that the insurance companies are offering.

However, the more I learned, the more I realized I did not know. People have a lot to consider when signing up for Medicare, and the decisions can be daunting. I wish I would have known about the resources sooner, because if I had known the program that I am on now, MAWD, I would not have had the intense medical expenses that I had earlier.

It is because of my own experiences that I am passionate about the APPRISE program. APPRISE is the only place that older adults can go, in person, to get unbiased information. This helps them with their Medicare decisions. As a volunteer, I give speeches at local senior centers and provide in-person counseling sessions. Each counseling session is 60 to 90 minutes long, and during Medicare open enrollment season, we are very busy.

Sometimes people come in with specific questions about their coverage, and other times we are starting with the basics. It is common for people to make Medicare coverage decisions based on the well-intentioned advice of friends, family, or other places. What

I have learned during my time as an APPRISE volunteer is that people do not have all the information they need to make the best decisions for their health care or financial needs.

Making a bad decision when signing up for Medicare can have unintended, lifelong consequences. When I see people with gaps in their coverage or seniors paying lifelong penalties, it is often because of misinformation. Knowledge is important in helping beneficiaries maximize their benefits and avoid the pitfalls of lifelong penalties.

Thankfully, as an APPRISE volunteer, I am trained to help those that are having trouble with their Medicare due to misinformation. We can liaison with organizations to appeal a decision or screen people for programs that help cover the cost of their medications. APPRISE counselors not only provide information, they help beneficiaries navigate a complex system and serve as advocates. We also find that once people come to APPRISE for help, they come back each year to be sure that their coverage is right.

People's lives are changing, and they need to be educated or they will fall through the cracks. It is because of this that I tell everyone I meet about the program. APPRISE counselors do not make Medicare decisions for beneficiaries. We instead provide them with information so that they are able to make the best choices for themselves.

Again, I thank you for the opportunity to testify before the Committee, and I look forward to answering any of your questions.

The CHAIRMAN. Thank you very much, Mrs. Hill. I think you just gave a compelling case for why it would be a mistake to implement the administration's proposal to eliminate altogether the SHIP program. And I am pleased to say that that has been rejected by the Appropriations Committee on which I serve. And if anyone needs further proof, I am quoting your testimony.

[Laughter.]

The CHAIRMAN. Dr. Ayati, I want to start with you. You gave a very compelling statistic about the number of seniors, more than forty percent, who take at least five prescription medications plus over-the-counter supplements and herbal remedies. And this obviously can lead to overmedication, but also something that I understand is called "drug cascade syndrome," in which the side effects result in yet another prescription for the senior.

I met last year with a physician in Maine who is doing house calls on seniors, and the first thing he has them do is bring out all the prescription drugs and over-the-counter remedies that they are taking. And in every case he has been able to reduce the number. It really was extraordinary. He did before and after pictures of the number of bottles of pills, and it was incredible.

So elaborate a little bit more for me on why this problem exists and why there is not better coordination among all of the specialists that a patient may be seeing.

Dr. AYATI. That is a great point. Thank you so much.

I believe the biggest problem for older adults these days is exactly as you said—polypharmacy/overmedication. The first reason, which I think is just all of that, when we come to the conclusion for everyone turning 65, I like to decide if the package about their benefit of Medicare, we should give them some basic information

to be careful about polypharmacy in the future, because as we age, the risk of chronic disease is going to be higher, and then there is going to be more chance that we get medication.

One of the reasons is because of the way that we train our students, the way we train our doctors. We actually have 16,000 physicians that have been trained in our medical schools in the U.S., and the way we train them—which I also have been trained in the same way—we wanted to not disappoint our patients. We want to, when the patients come to our office and they have a problem—that is what I said about robotic mentality. Quick fix means that there should be a medication to fix the problem.

We forget sometimes to discuss pros and cons of treatment intervention, talk about side effects and adverse drug events that can happen. As we discussed, the physiology is changing, and as we age—and this is not happening when we are 60. It is happening when we are even 20, 30. Every decade our physiology is changing, and we become more susceptible to adverse drug reactions.

One thing that has happened is that, again, the patient and doctor, they are expecting. The reason patients go to the doctor's office is because, "Finally I am going to get a medication." And then when they come out from the doctor's office with that medication, they take it, there is no follow-up, because one of the big problems is that we do not explain therapeutic endpoint for medication. I give you this medication because I wanted to reach this therapeutic endpoint, and if you do not, we need to stop that. I cannot tell you how many times I have been in the public places and just discuss about this topic, and a lot of people, when I ask them, said, "I take 18 kinds of medication, and I do not know why. I do not know why I am taking this medication because the doctor just prescribed it for me, and I just keep asking pharmacy to refill it for me."

Now, patients do not know, and the physicians also, they do not follow that. We have some of the programs encouraging the doctors and hospitals to do medication reconciliation, which is going through the list and making sure that they are taking all these medications or not. But I think we should have another conversation. We should really go at one point and tell the patients that you have to, every visit when you get your annual wellness with your Medicare with your doctor, review all the medication. And if you are not really a candidate to continue this medication, do not.

Many times I have 90-year-old patients that is only bone and skin on the bed, not able to eat, and they give a high-dose cholesterol medication. When I am calculating, the cholesterol medication is for preventing a stroke in 5 and 10 years. I am calculating myself, what am I treating for? Why am I giving cholesterol medication to somebody that is not even able to take a sip of water? And we just keep refilling this medication.

I am glad that I have this opportunity. Many times I have a hospice patient that has a prognosis of less than six months or maybe two weeks. They are crushing vitamins and supplements in applesauce, and the person is not able to swallow, and we are force-feeding with a spoon to the mouth of these people. Why? This needs to be changed. We need to bring first public education, asking all the people when they start turning to Medicare to have this information. You need to discuss about your medication. And the next

thing, go to a medical school and train the doctors that it is OK if you tell your patient that maybe a strategy of watch and wait is the best strategy rather than jumping to prescribe another medication for that.

The CHAIRMAN. Thank you very much for that thorough answer. I have many more questions, but I will save them for the next round.

Senator Casey?

Senator CASEY. Thank you, Madam Chair.

Sharon, I will start with you, and I am using your first name. I hope you do not mind.

Ms. HILL. Fine.

Senator CASEY. We are pretty formal around here, but if you are from Pennsylvania, I think it can be informal. But I want to thank you for being here and for your testimony. You can tell—this is probably the first time you have ever testified. You not only did it well, but you already got action. Senator Collins is already working on something based upon what you said. It is a great country, right?

Ms. HILL. Yes, it is.

Senator CASEY. But thanks so much, and I was talking before about the legislation I have, the BENES Act, and I was struck by a lot of what you said, but in particular, one line jumped out at me. You said in your testimony, "People have a lot to consider when signing up for Medicare, and the decisions can be daunting." And that is a pretty good summation of one of the points we are trying to make today. These are difficult decisions. We are hoping we can pass the BENES Act so we can prevent common Medicare enrollment mistakes.

Maybe if you can elaborate a little bit more on your experience with engaging with people that are trying to make these decisions and the need for clear and easily accessible information to make those decisions. Can you tell us a little bit more about that?

Ms. HILL. I think one of the funniest things that we run into are when couples come in to do their Medicare, and they think that they have to agree on a plan for each of them. And when they find out they can each get their own plan, they think you have given them, you know, another piece of candy, because they are really happy about that so that they do not have to limit somebody's medical information because somebody else needs more pharmaceutical. And a lot of the things when you come in, sometimes they do not think they want any pharmaceutical or Part D insurance because they do not take any medicine. And, you know, you try to explain to them that you have got to put something in there because if not, down the line if you ever do get medication, you are going to pay a lifelong penalty on top of your medication.

And then there are decisions. In western Pennsylvania, we have got the two factions going on. We have the UPMC and Highmark, and you have got to walk people through that distinction, too. Do you want this or do you want that? And this doctor or this hospital that you used to go to does not handle this company anymore, so we need to get you—you know, which do you want to choose? And, you know, make that decision.

So it is not as simple as going in and saying, "I am 65, just give me something to use," because a year of the wrong program can leave you in a lot of medical distress and bills.

Senator CASEY. That word "navigate" that you and others have been using is an apt description, I think, of what some are up against.

In the remaining time I have in this round, Sharon, I wanted to ask you as well, where you said in your testimony knowledge is important to avoid the pitfalls of lifelong penalties. The reality for a lot of people is they are paying penalties. I said before our constituent service people hear about this all the time across Pennsylvania, and I know you have seen it up close.

Can you share with us why it is important for seniors to have access to not just information but unbiased information provided by an APPRISE counselor?

Ms. HILL. Certainly. If someone comes in to one of our training sessions and they say, "I got this letter, and it says I have a penalty," well, your heart just sinks because you know there is going to be a problem. And, you know, they end up being in a pickle, more like somebody in a canoe without a paddle, because sometimes when people say "penalty," they think, "Oh, OK, I owe my $10, and then I am done." What they find out is it is a lot more than $10, and it is every day for the rest of their life. So I do not think that part of it is emphasized enough in the information that we have right now. It is just listed as a penalty. I think it definitely needs to say "long term" so that they would know.

Also, the problem with the prescription penalties is that if they are not taking medication, they do not see a need for a prescription plan. But then all of a sudden, 10 years later they are taking a heart medication. Now they have got heart medication medicine, which is expensive, and then lifelong penalties on top of it. So it becomes very frustrating.

The best that we can do when we have someone like that come to us is to try to backtrack to see if we can find, you know, did Social Security, did Medicare, did the people's H.R. department—where was there a breakdown in the information? So that sometimes we can go back and see if we can get maybe a lower penalty or on rare occasions no penalty. But it is a long process and a difficult one that people find themselves in. And it is very sad.

Senator CASEY. Well, thank you very much for that. That is the real life of it. Thank you.

The CHAIRMAN. Thank you.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you. Welcome, all of you. Thank you so much for being here. And I am going to start with you, Mr. Borland. I noticed you were taking notes, and that was my first question because I think Mrs. Hill is really—it is important to get her feedback because she is on the front lines interacting with seniors and talking with them. And to me, the first step in all of this, obviously, is the awareness and education. But if what we are providing to them is not enough information for them to make an intelligent decision, then we are missing out on providing that educational piece.

So my first question is to you. A couple of things. One, thank you so much for having the online My Social Security Account that people can access and gather that information. I noticed you also talk about doing outreach through telephone, face-to-face, field office, community gatherings where you are going out into the community to talk with individuals, libraries in rural communities, everywhere. But to what extent do you coordinate with the states? I know in the State of Nevada we have a Division of Aging Services, and they do a lot of outreach and education. They work with people like Mrs. Hill. In my state, how do you coordinate with them to make sure that we are leveraging those additional resources to get the educational information out, at the same time getting feedback on what we should be putting out there to make sure that our seniors have the most important information they need?

Mr. BORLAND. Thank you for that question, Senator. I was listening to Mrs. Hill speak and thinking how fortunate we are to have people like her who are dedicating a portion of their lives to helping the Social Security Administration be more effective in ensuring that seniors have access to health care. I can tell you from personal experience that our claims specialists do many, many, many referrals to the State Health Insurance Assistance Programs because at Social Security, while we are responsible for enrolling people in Medicare, for explaining the consequences of not taking Part D, not enrolling in a prescription drug plan, we can only go so far. We are not in a position to assist folks with selecting a plan. What plan is best for them, what medications, that is not part of our conversation. We can explain why you should coordinate Part B if you have an employer-provided health insurance plan. But our role is not to help you choose a plan.

We do, I will say, thousands of referrals to the State Health Insurance Programs every single week, and I can talk a little bit later about some of the work we are doing with NCOA and CMS to improve access.

Senator CORTEZ MASTO. Are there additional resources that we can help you obtain that can make sure you are doing a better job or more interaction at the state level with individuals on the front line? Is there more that we can help you with what you could be doing?

Mr. BORLAND. So I think that we have strong coalitions. For example, with the National Council on Aging, every year when we send our low-income subsidy notices out to those who may be eligible for a subsidy in paying their Part D premiums, we provide that information broken down by Zip code to NCOA who provides it to the SHIPs so that they can do specific outreach. They know where folks are. They know what their service demand volume is going to be. We have strong partnerships. We can always strengthen those partnerships.

Senator CORTEZ MASTO. Yeah, I guess my concern is—and I am running out of time, so I will wait until the next round, but, Ms. Chávez, I am going to ask you to weigh in on this. That first contact is so important, and I think if we lose people by passing them off, we should probably figure out how we stop that opportunity where we lose people in that gap. That first contact to me is the key, and how do we keep them involved instead of passing them

to the next—I do not know—state agency or whoever. And, Ms. Chávez, do you have any comments on that?

Ms. CHÁVEZ. Sure. I think, again, that is why it is so important that the Senate bill that Senator Casey has introduced is all about consumer education, really alerting people that this deadline is coming. Although turning 65 is a great opportunity, there is also some responsibility an individual has to take.

What I have also noticed is that it is critical—and we have done this for decades—is not only working with the federal agencies but also working with other community-based organizations across the country who are in communities and know these individuals who may need extra help. So, for example, we run benefit enrollment centers where, again, we train volunteers, staff members at local organizations to actually walk people through sometimes very complicated federal programs. And what we have found is there is a need for both. There is a need for education from the federal agencies directly into their mailbox, or Facebook, because a majority of seniors are on Facebook every day. And so how are you communicating to seniors in a way that they want to be communicated to through the federal agency avenues, but also funding and supporting local community-based organizations to do the one-on-one training.

The CHAIRMAN. Senator Warren.

Senator WARREN. Thank you, Madam Chairman, and thank you for holding this hearing. Very important. You and the Ranking Member come up with good things for us to talk about.

Now, two days ago, Congress passed a short-term budget that will keep the Government open for another three weeks. I believe, though, we need to look beyond the bare minimum and to stop lurching from crisis to crisis just to try to keep the lights on.

This is a moment for us to be able to focus on our core values and to choose carefully about what we invest in. And I, along with members of this Committee, believe that government should invest in our seniors. And that starts with making sure that the Social Security Administration offices are fully funded so that seniors can get their hard-earned Social Security checks when they turn 65 and when they enroll in Medicare.

So, Mr. Borland, you are the Acting Deputy Commissioner for Communications for the Social Security Administration. SSA has a budget for staff and other resources. Can you just say a word about what the Social Security Administration does with that money?

Mr. BORLAND. Thank you, Senator Warren. I would be happy to. We have over 1,200 field offices across the country. We dedicate over fifty-six percent of our entire budget to staff, that is, folks who work in field offices, hearing offices——

Senator WARREN. But could you say a word about what they do for seniors?

Mr. BORLAND. Sure, I would be happy to. So on any given day, someone walking into our field office may be coming in to file a retirement claim or a combination retirement and Medicare claim. They may be coming in to file for disability benefits, to get a replacement Social Security card. If they are already receiving benefits, disability benefits, they may be reporting their wages, which can impact their benefit amounts.

We are doing program integrity reviews to ensure that people are still eligible for benefits on a continuing basis so that we do not create overpayments.

But we are also—and I think this is something that is less understood—we are providing a tremendous amount of information and counseling in a way. People have lots of questions about Social Security, and our front-line staff are very knowledgeable, very well trained, and they interact with the public every day to ensure they are making informed decisions.

Senator WARREN. So that is powerfully important. People have rights, and you make sure that they get what they are entitled to. It is clear to me that the Social Security Administration's work is very important and that the field offices are critical to making sure that Americans get the benefits that they are entitled to. But cuts to the Social Security Administration budget in recent years have resulted in staff shortages, field office closures, and longer wait times.

So, Mr. Borland, despite years of underfunding, Senate appropriators have proposed a more than $400 million cut to the Social Security Administration budget for this year. Now, that is nearly four percent of your budget. Can you just say a brief word about how those cuts would affect seniors who are applying for benefits?

Mr. BORLAND. So, first of all, I would like to say that at the Social Security Administration we believe that if we receive the President's fiscal year 2018 budget request, we will be able to address the agency's priorities. But to give you a couple of examples, how does budget impact the service that we provide? For every $100 million, that will buy you 826,000 retirement and survivor claims. That is taking the claim, adjudicating the claim, and making the payment. It will buy you 51,000 disability hearings.

Senator WARREN. So let me just multiply that by four, since those are the numbers we have got here. We are looking at around 200,000 hearings for Americans trying to get their disability benefits and more than 3 million claims processed for retirement benefits for seniors. Is that right on the numbers?

Mr. BORLAND. That sounds exactly right.

Senator WARREN. Well, thank you, Mr. Borland. You know, here is how I see it: Social Security and Medicare are contracts that we make with each other. Americans have paid into Social Security and Medicare on the understanding that the government would be a good steward of their money and that they would have the protection available when they need it. The government cannot be a good steward of Social Security and Medicare if it does not have the money to run the Social Security offices.

You know, this one should be easy. I believe we should increase the funding for the Social Security Administration so that you have the resources that you need to make sure that our seniors get the benefits that they have earned. Thank you.

Thank you, Madam Chair.

The CHAIRMAN. Thank you.

Senator Jones?

Senator JONES. Thank you, Chairman Collins.

I have a couple of things just to go briefly. Ms. Chávez, I was especially struck by testimony giving the statistics about the chal-

lenges of women of color and Hispanic women, seventy percent, sixty percent. Obviously, that is because of the pay gap, which, if it had been worked on years ago, that would not be a problem. But the fact is we are where we are.

And I know that we have to be concerned with the budgets for Medicare and Social Security and other things, but is there something that can be done from the federal policies, knowing that these women have often no choice—or I would say very little choice, they are either caregivers, they drop out to raise their children, all of which contribute to society in so many other ways. Is there anything that you can suggest from a federal policy standpoint that might help level the playing field for those who are taking on significant important jobs—and they are jobs. You can ask any one of them. They are probably more challenging than anybody sitting up here right now. Anything we can do to help level that playing field so that those people cannot be punished for doing their duties?

Ms. CHÁVEZ. So, Senator Jones, I wish we could have another hearing just on this subject because the data is overwhelming. It is actually bigger than the pay gap. It is a wealth disparity issue. It impacts girls and women throughout their lifetime.

I think from a federal policy level, it goes to how we educate women, how we ensure that employment rules and regulations are followed. But I also want to say that by reinforcing the aging sector, by looking at all the human services that impact seniors, you are actually going to impact women in a very terrific way. Interestingly enough, as we were looking at our data around the programs that we administer—for example, we run the National Institute of Senior Centers, and we looked at thousands of senior centers across the country and daily activities, and we found out that more than seventy-five percent of people who go to senior centers on a daily basis are women. We looked at our BenefitsCheckUp. It is a free, online system where you simply go on and put a few data entries about your Zip code, female/male, and we found that of the millions of people we serve, the majority of the people on the system are women. Either they are checking their benefits or they are caregiving their spouse or their children.

So, again, I think that because aging disproportionately impacts women, anything we can do to reinforce these systems is incredible. I will say—perhaps the gentleman to my right could not say it, but I think any federal funding cuts to the Social Security Administration, for the Administration on Community Living, will have a disproportionate impact on women and children in families living with seniors across this country because, again, as I hear from my partners across the country that are running non profits, who are running state units on aging, their systems are overwhelmed and overburdened. And as we know, although we appreciate the federal laws that were put in place 50 years ago, they have not really been reformed in decades.

So I welcome the opportunity to work with this Committee to figure out a way how we would leverage the experience that we have gained over these few decades, but also how we reinforce those connections between the federal, state, and local community organizations that are doing great work.

Senator JONES. All right. Well, thank you for that.

Senator Collins, Madam Chairman, I would respectfully suggest that might be a pretty good topic for this Committee at some point in the future. So thank you so much for that.

Dr. Ayati, just briefly in the time that I have got left, I understand and can relate to the challenges faced. Over the last year or so, I have faced many of those with my aging parents, and we are fortunate in Birmingham to have a fair amount of resources available, but it was still a challenge. But Alabama in particular also has a very rural population, and rural health care delivery in Alabama is challenged in and of itself, much less to the aging population.

Do you have any suggestions of what we can do that might address the challenges specifically to our rural segments of this country?

Dr. AYATI. Thank you so much. It is a great question. It actually is one of the biggest challenges that we always discuss, especially in our area.

One of the models that has been suggested is that we actually utilize the resources that we have right now for rural areas. For example, we are having a lot of things in technology today. We can use telemedicine, which actually Medicare even approved for reimbursement for telemedicine for rural areas. But one of the suggestions is we expand geriatric consultation for these areas. We have wonderful primary care physicians that work in rural areas, but the problem is that the patients need a second opinion because they are frail, they have a lot of geriatric syndrome, but there is not any expert to help them.

Definitely some sort of satellite program, telemedicine, virtual care, these kinds of models which, again, in a lot of areas they are using right now have been very helpful. And I think that the more we invest in that, we are able to have one physician that is taking care of the patient but always have a backup. One of the issues that we have here, which I think just goes more toward Government, is reimbursement for this model. The fees that we are currently paying for geriatric consultation in telemedicine does not make it satisfactory for the health care system to invest more money on it. If we have a better solution for that, definitely there is going to be a lot of encouragement for medical centers to expand this program, which is going to be very, very crucial. It is going to be a huge benefit for all the—because as you mentioned very well, many of the aging population, actually they live in rural areas in the United States. It is not only about Alabama. And that is why we can have this service and expertise for them to have the second opinion and, again, help them through that.

Senator JONES. Well, great. Thank you. I also would like to mention—and I know my time is up—the telemedicine leads to another issue that we have in rural America, and that is access to broadband. So that is something we are going to be working on as well.

Thank you, Madam Chairman. I appreciate the opportunity.

The CHAIRMAN. Thank you very much, and that is a great lead-in to my next question for Mr. Borland.

It is wonderful that the Social Security Administration has developed so many online tools that can help our seniors, but the fact is, in a state like mine, there are large sections of the state that do not have access to broadband services on the Internet. And there are also seniors who simply do not have computers in their homes and are not familiar with it.

Finally, I would suggest that there are seniors who are much more comfortable with a face-to-face interaction than they are going down to their local library and trying to figure out how to access Social Security information online.

We had an office closed in Rumford, Maine, which created real hardship for a lot of the people living in that community because the nearest Social Security office was in Lewiston. And in the winter that is quite a drive for seniors to have to make, and they were just uncomfortable.

So what can you tell us about how Social Security is trying to reach rural seniors who may not have computers at all? Again, I think your online services are excellent, but they do not reach everybody.

Mr. BORLAND. Thank you, Senator Collins, and you are right. We have to make sure that we have the services that we can deliver to all Americans, whether they live in urban areas or live in rural areas, whether they have Internet access, broadband access, or not. We have a commitment, a longstanding commitment to our field office structure. We have 1,200 offices around the country, including many in rural areas, small cities and towns across America. We have our 800 number. Certainly that is a lifeline for many people in rural America that have service delivery needs or have questions for Social Security.

But we do not stop there. The part of the agency that I represent, we are responsible for outreach. We are responsible for communicating with the public. I think any of you who live in rural areas or have lived in rural areas know that weekly and monthly newspapers are a lifeline, that radio is a lifeline in rural communities. Our public affairs specialists work with local media. Many of our public affairs specialists have weekly radio shows where they talk about services and benefits; they talk about when to claim benefits. They talk about Medicare enrollment and the importance of enrolling in Medicare before you are 65.

So we are using some of the more traditional means of communications to ensure that we reach rural America, but we are not stopping there. Also, you mentioned libraries. Not all seniors are comfortable using a computer at the library, but many are. That is why we have the SSA Express program where we partner with libraries to provide one-click access to our online information and services.

The CHAIRMAN. Thank you.

My next question is for both Dr. Ayati and for Ms. Chávez. Doctor, I was so intrigued in your written testimony by your phrase that, "We live in an anti-aging society," because I think this is a key issue in addressing isolation, in addressing how we treat our seniors, in keeping them engaged. And I would like both of you to address that issue.

What advice do you have for older Americans and their families so that we can counter this pervasive anti-aging feeling in our society that sometimes leads to our seniors being devalued or pushed aside? And, Doctor, I am going to start with you because you have lived in two different countries. You were trained in Iran, and you now live in the United States. So I would be interested if you see differences in those societies. But, in general, please comment, and then, Ms. Chávez, I would like to hear from you, too.

Dr. AYATI. Thank you, Chairman Collins. I am always asking this question for myself as a physician being in a Third World country and traditional society and then practicing here, why older adults in this countries, even there are—they do not have access to medical field. They do not have access to nutrition supplements, all vitamins that we have here, why they are physically and mentally doing better, but very interesting observation. These people, when they migrate to United States, they actually are going to get worse. They are starting to have depression or cognitive impairment. And I see it every day. Especially I practice in the State of California with a lot of immigrants actually living there, why this going to be changed?

And, again, as you well mention, it is mentality. We are very obsessed about youth, and this culture is going from—from the beginning, I am always criticizing—or maybe I am doing as well, this is the wrong thing, that we teach our children that there is something wrong with aging, or aging is the microbe or the germ that we have to avoid that.

When I go to every place shopping, I see the sign of anti-aging supplements. It makes me very nervous because I just tell my son, who is 4 years old, if I show it to him, that now your Dad is aging, it means something wrong with him.

We should just the word of fighting with aging. I see a lot of time when they are trying to do public education, it says we have a seminar about fighting with aging. There is no fighting with aging. Fighting with aging, we are likely fighting with nature, with the solar system. We cannot fight with it. We need to adapt to aging. It is a process, starting from beginning of life. If you start this culture, which has changed the dialog in the community, in the society about aging, then we can accept the aging. That is why I have a very educated Ph.D. patient that, when he comes to me and asks me for depression treatment, he said, "Every time when I apply for a job, I have to dye my hair, and I do not reveal my age, because I have more experience and they are not going to pay me, and they actually"—"and they tell me that because I am aged, I am not innovative." Who said aging people are not innovative?

We actually have many studies that show as we age, our social skills improve, or why they are actually doing better, and we have many a study—not in United States, in Germany, BMW or Benz company, they actually had the study about older laborers versus younger laborers. The older laborers in the line of the production of the BMW, they actually do better, more productive, less mistakes.

We need to change this dialog. When we change this dialog, older adult people do not feel frustrated, fear of aging. When we have this dialog change, then we can help this aging population to not

focus on negative things; stay on positive. And then we can have these things going to be changed.

Just one comment. I have the same problem with my students and nurses to encourage them to work in aging field, because when we look at the media, the picture of the doctors or nurses, our heroes in the TV series, they are in scrubs, they have ten pagers, they are all body builders, and they are just——

[Laughter.]

Dr. AYATI. This is the picture that my students see, and when I ask them to come work in nursing home, they say, "I do not like to come here. It just smells very bad. I have to take care of many old people there." And the same with the young nurses. But this is not medicine. The people went into medicine because they have a passion to help these people. That is the philosophy of medicine.

But we are changing. I think we need to definitely change for public education media, and then we will start from—I am sorry I have been a little bit over time.

The CHAIRMAN. Thank you.

Ms. Chávez?

Ms. CHÁVEZ. I enjoy sitting next to the doctor who is clearly passionate about this subject. It is wonderful.

I have the same philosophy, actually. When I was running the state unit on aging in Arizona a few decades ago, people would look at me and they would say, "You are too young to be running a state agency on aging issues." So I used to wear this button. It said: "Aging: If it is not your issue, it will be."

[Laughter.]

Ms. CHÁVEZ. Because for me it is a rite of passage, and in my culture as a Latina, seniors are the epicenter of our universe, so for me it is just something you do. But I would say three major things at NCOA we tell people to think about.

The first is really think about your financial plan. For women, again, even more important. Start thinking about it now. Even for women and young men in college, start putting away for that longer retirement you are going to have, that bonus 20 or 30 years you are going to have at the end of life. Also, understand the benefits that are coming to you at that point in time, because there are ways of really leveraging those benefits.

The second is engage in healthy behaviors. Doctors and scientists will tell you that the things you do in your 20's and 30's actually can have a great impact on what you will be able to do in your 60's and 70's. And if you look at my father, who is 89 years old and doing 200 push-ups a day, nobody can tell him that aging is a bad thing. It is a great thing. And so start doing great things now with your body, both mentally and physically.

And, third, stay active and engaged in your community. Find a passion, something you are truly, truly excited about that gets you up every day. You know, having been in the field working on these issues for decades, I will tell you the number one reason seniors are able to get over a fall, or are able to get through chronic disease, is they have something other than disease that they are focused on every day. And so I encourage everybody to always think through, just as we say in our Aging Mastery Program, what are you grateful for? Because every day is a gift. And how are you

going to use that gift of time, not only wisely but for the better things in life?

The CHAIRMAN. Thank you very much.

Senator Casey, feel free to take some additional time, as I did.

Senator CASEY. Madam Chair, thank you very much.

I want to start with just something for the record. I would ask consent on two matters—two letters, I should say. The first letter was organized by the Medicare Rights Center. It is from more than 75 national and state organizations urging Congress to pass the BENES Act. That is one. And the second is from former administrators of the Medicare program from both Democratic and Republican administrations who also support the bill. So I would ask consent, Madam Chair, to submit both letters to the record, one dated December 19, 2017, and the other dated August 22, 2016.

The CHAIRMAN. Without objection.

Senator CASEY. Thank you, Madam Chair.

I also want to express support for two statements made here today, the first by our Chair with regard to the cuts the administration would propose or have proposed with regard to the so-called SHIPs program that allows us to have programs like the APPRISE program that Sharon has done such good work on. So, Madam Chair, I appreciate your saying that here today, and I certainly support that.

And Senator Warren's call for the Social Security Administration, we want to make sure that those kinds of cuts do not become the norm and do everything we can to prevent those cuts.

I will go there with Mr. Borland. You have been asked a couple times today about the work that your team does, and we can, as you have, and we should cite efforts you have already undertaken and will continue to undertake, all of the outreach that you do, and we appreciate that.

I hope, though, that when—maybe I will ask two questions. One is—I will make a statement and ask a question. The first is I hope if you think you need more resources, you or someone in your agency would tell us. I know that in every administration—I am not saying this just focused on this administration. Every administration instructs people sometimes not to say much, not to advocate for more resources. I do not know if that is the case here, and I do not want to make that charge. But I hope—I hope—that if you need more resources, you would come to the Congress and express that.

I know what it is like to criticize agencies. I was for two terms Pennsylvania's auditor general. I kicked the hell out of a lot of state agencies with tough investigations that really were critical of people and their work in the agencies. I did a lot of audits that criticized how state government agencies work. They never wanted to hear from me.

But I also tried to couple that criticism and critique our investigation or audit with recommendations for how to improve, how to improve the work that you do, and sometimes that comes down to money. Sometimes you cannot fix a problem without the resources. You can be efficient, you can be effective and all that. I get that. I do not need anyone to tell me about that. But sometimes you need to ask for more dollars. I am not asking you to do that today.

I do not want to get you in trouble. But I hope that you would come to us, and not just to appropriators, but maybe especially to appropriators when you need more resources.

So I guess, Mr. Borland, here is the question: How does the Social Security Administration make sure that people are prepared to sign up for Medicare? And if you want to reiterate some of what you have already said, I think it bears repeating. But maybe the more important question is: What initiatives or partnerships are underway right now at the Social Security Administration to strengthen the communications that you undertake and to prevent the misinformation that sometimes leads people to make decisions or fail to make a decision that can hurt them down the road?

Mr. BORLAND. Thank you, Senator Casey. Let me talk first about some of the efforts that we are currently making. I have certainly talked and made a pitch for My Social Security Accounts. For Americans who do not have a My Social Security Account, they are missing out on an opportunity to learn an awful lot about the benefits that they may become entitled to in the future, including, yes, retirement benefits but obviously also survivor's benefits for their family, disability benefits, but also Medicare. And as I mentioned earlier, we mail a Social Security Statement with an insert to everyone 60 years and older every year, until they claim Social Security benefits.

In that insert very prominently displayed—the insert is entitled, "Thinking of Retiring," but very prominently displayed is a note, a reminder: "Make sure you sign up for Medicare three months before your 65th birthday." That notice goes out at age 60, at age 61, at age 62. It is certainly a message that bears repeating, and we certainly repeat it. That is a primary way that we communicate to individuals who are not receiving Social Security benefits that they need to sign up for Medicare at 65.

But I want, I think more importantly, to talk about some things that we are working on. Literally just three weeks ago, I sat down along with my counterparts from Social Security, from Policy, Communications, the folks that run our 800 number, across the table with the folks from CMS. We think there are great opportunities for strengthening the partnership between the agencies to prevent unnecessary hand-offs and to increasingly serve the public at the first point of contact.

Senator CASEY. Well, I appreciate that. I know I am over time. I will just wrap up with this. The point that has been made here about even if you are making all of those efforts, there is a gap because of lack of broadband access and high-speed Internet, that is one of the many reasons why we have got to get to an infrastructure bill around here or something that would focus on broadband. Many people in the Senate, including Senator Gillibrand, who is here, have worked on these issues for years, but we have not gotten to the point where rural America has the kind of connectivity it deserves. Something on the order of thirty-nine percent of the people—not the places, the people—who live in rural America have no high-speed Internet. Thirty-nine percent of all the people living in rural America. So if there was ever a time to push for it, now is the time.

Thanks very much.

The CHAIRMAN. Thank you.

Senator Gillibrand, welcome.

Senator GILLIBRAND. Thank you. I did not expect to——

The CHAIRMAN. If you would prefer that——

Senator GILLIBRAND. No, I am ready. I just did not want to bump her. I thought she had not gone yet.

As the number of individuals eligible to claim Social Security benefits is rapidly rising, it is more important than ever that we ensure the Social Security Administration is fully funded and capable of providing the essential services older Americans need. SSA sites are being forced to close across my State of New York, making it inaccessible for seniors to get the benefits that they have earned and worked hard to pay into.

Mr. Borland, can you tell us what steps SSA is taking to keep up with the growing demand for its services and how SSA will ensure that the quality of its services will not decline as it serves so many individuals?

And, second, the Social Security Administration provides critical information to millions of individuals figuring out when to claim Social Security every year. Can you tell us a little bit about some of the issues surrounding claiming benefits that seem to confuse people the most and what topics it is most apparent people could use more information?

Mr. BORLAND. Thank you, Senator. I would be happy to. Let me first talk about some of the areas where people have a lot of questions when they come into our offices. Probably the most important information that we provide folks is the basic fact that the longer you wait to claim benefits, the higher your benefits will be for the rest of your life. There is some confusion around early retirement age, full retirement age, and the impact of delayed retirement credits at age 70.

But the basic message that we deliver to every person that asks us, whether it is over the Internet or via the 800 number or in a field office, is the longer you wait, the higher your benefit amount will be for the rest of your life. And that is a point of confusion.

Others include that your benefits are based on your 35 highest years of earnings. Many people think that it may be your highest three or your highest five. It is your highest 35 years of earnings. Why is that important? Well, if you have 30 years of earnings or 33 years of earnings, you are going to have zeroes instead of an earning amount in those years. It may encourage people to work a few more years, to fill in those zeroes and potentially boost their benefit amounts, again, for the rest of their life.

Senator GILLIBRAND. Medicare beneficiaries rely on SHIP counselors for unbiased, one-on-one Medicare counseling. In New York we call the SHIP the Health Insurance Information Counseling and Assistance Program, or HIICAP. In 2007, SHIP counselors provided one-on-one counseling to nearly 130,000 individuals and held more than 3,000 educational presentations in enrollment events across New York. Many say that 1–800-Medicare is a sufficient source of information for beneficiaries, but I have heard from many New Yorkers that SHIP is essential for them to get access to benefits.

Ms. Chávez, could you share with us the importance of SHIP counselors as a source of unbiased information beyond the 1–800 number?

Ms. CHÁVEZ. Thank you, Senator, for that question. Absolutely, we are a very big supporter of the SHIP program. We clearly know that it is going to take many different points of contact with the senior to ensure they really understand their benefits. We administer the Center for Benefits Access through a grant from the Federal Government, and so we physically put benefits counselors in the field to assist seniors.

But we also know that there are other volunteers through other programs that we need to work with. So we are very glad on a daily basis to work with individuals like Mrs. Hill who are doing those community interventions and interviews and one-on-one discussions with seniors. And we also work very closely with other federal and state agencies to ensure that we are getting the latest, greatest information.

One of the things that we have also gotten feedback on is because we run one of the largest online benefit access tools, which is free to the public, and we update that consistently to ensure that both the SHIP counselors and other benefits counselors across the country have access at their computer, not only to the federal benefits that those seniors may be eligible for but also at the state level, and sometimes even sort of municipality level.

So, again, I think what you will see here today is that this ecosystem that we have built between federal partners, state agencies, volunteers such as the SHIP volunteers, and national nonprofits who are serving these seniors, this ecosystem is critical and would not be doing this great work without the support of Congress and the appropriations they provide.

Senator GILLIBRAND. For the record, would you guys please submit an analysis of the impact of enrollment errors? Because I know that there is a percentage or a number of people who make mistakes enrolling, and almost 700,000 Americans paid Part B late enrollment penalties because it was late. Can you at least submit for the record so I can understand, when people make mistakes, how do we fix them? What is the burden? And what are your best recommendations on how to limit that?

Thank you, Madam Chairwoman.

The CHAIRMAN. Thank you very much.

Senator Cortez Masto?

Senator CORTEZ MASTO. Thank you, Madam Chair, and thank you for this second round because this is part of the discussion I wanted to get into. I echo my colleagues on the concerns with cuts to Social Security, and the reason why I wanted to go down this path—and I so appreciate, Ms. Chávez, your comments on this. You know, I was fortunate enough to be raised by not only incredible parents but also grandparents and great-grandparents. Not only were they in our every day lives, I saw what happened to them as they aged. And I have a Mexican-American grandmother who worked her entire life as a sales clerk, and her retirement was Social Security. And I will tell you that pay gap had an impact on the type of retirement she had later on in life, and that is why I know, looking at the statistics, when it comes to Social Security

and the beneficiaries of that retirement or that the money they count on and they worked so hard for, are women and children like my grandmother.

And so I do not support any cuts to Social Security, and, Mr. Borland, I appreciate the position that you are in, but I also know talking with some of your employees that live in my state and the interaction that I have seen in my state and the benefits of having those offices open and the interaction with state and local, which you are right, there is that interaction, and that working together there are so many beneficiaries of Social Security that are out there that are aging, that are going to need that interaction and those offices open. So I do not support cuts and will never support cuts to Social Security. There are ways that we can address this issue, but it does not start with harming all of those people out there that rely—that have worked so hard in their lives and they are relying on that type of retirement. So I thank you for that.

The other thing, I appreciate the conversation today as well. I also have Italian-American grandparents, and, Doctor, I can tell you are a very good doctor. I have an Italian grandfather who loved to smoke cigars, play golf, and believe it or not, likes Christian Brothers brandy with orange juice, which I am not sure most people would. But as he aged and he got older, he became very familiar with his doctor, and he was always in the doctor's office with an ache or pain or, "I cannot walk," or, "I am dizzy." And finally the doctor looked at him and said, "Lawrence, you are just getting old. I do not have a magic pill for you. This is about lifestyle. This is about healthiness, and this is about how you eat."

And so would you please—and we have not touched on this—I think part of this though, is this education that somehow not just nutritional food, but healthy food has an impact on your health. I think we need to learn at an early age, but at the same time, as you age, this has an impact on your health. And, Doctor, if you do not mind talking a little bit about that?

Dr. AYATI. Thank you so much. I appreciate it. Before I started, whenever I talk about healthy lifestyle, I always admire Italian culture because they talk, and this is the best exercise for the brain. And that is why whenever I have an elderly person that complains about isolation, I say, "Live like Italians. Talk, talk, and talk. This is the best way to go."

[Laughter.]

Dr. AYATI. It is a very, very important thing that you brought up. It is about nutrition. One thing about that, one of the biggest challenges we have for a lot of our patients, they are always looking for a magic formula. They say, "What are the best vitamins and supplements I can take?" The problem is that this is exactly part of the education that we should provide for them, that nutrition is part of exactly at the beginning, as Chairman Collins started, of the healthy lifestyle, which is eighty percent—or longevity depends on it, and only twenty percent on genetics. And nutrition should be a balanced diet.

When we talk about balanced diet, a lot of people—again, we go back again to the conversation that I started, that we sometimes obsess about the diets. Sometimes the people recommend you have to take lots of fiber, you have to take lots of vegetables. I wrote

years ago in the San Francisco Chronicle, the local newspaper, that too much fiber actually can be harmful for the elderly. We should have only a balanced diet which has protein, carbohydrates, and fat. Even fat, fat can be helpful for the elderly, but only in moderation, not in exaggeration.

That is why it is important for all the older people to know, first of all, they do not need to take extra supplements. If they eat just a healthy, balanced diet, that is going to be enough for them. Definitely more focus on healthy parts of the diet. But, again, one of the things is that we do not educate them, because in a majority of our health centers, we do not have educated nutritionists in senior care that they come and talk to them, review their diet. A lot of seniors are living on some of the programs that they actually deliver the food for them.

But it is very interesting because one thing is only that they do not eat. The other thing is a social problem, lack of companionship. A majority of my patients, they have the program like Meals on Wheels, and when I do a house visit, I see all the foods in the refrigerator and nobody touched that because they do not have this feeling to eat. And there are a lot of other things related to nutrition, like good dental hygiene, and dental issues are one of the biggest problems. A lot of things happen for us because we prescribe too much medication, and they change the taste buds of the older adult people, and that is why they do not feel that they are eating food.

One of my advice to senior centers is to make a good presentation for your food. Make them motivated and engaged that actually they are feeling that it is only not a piece of bread and a piece of meat. I mean, this art can make them to become motivated. But definitely nutrition is one of the biggest factors for healthy aging that we need to emphasize, and more public education.

Senator CORTEZ MASTO. Thank you. Thank you very much. And, again, to the Chair and Ranking Member, thank you for this great panel and this great discussion today. I so appreciate it.

The CHAIRMAN. Thank you very much.

I want to thank all of our great witnesses for your testimony today and, more important, for your work that you are doing to assist older Americans who are navigating what can often be a confusing maze of information, to help our society recognize and value our seniors, and to assist older Americans in living healthier lives.

Dr. Ayati, we really need you in Maine.

[Laughter.]

The CHAIRMAN. California has plenty of specialists. And we are the oldest state in the Nation by median age, and we have a real shortage of physicians who are trained in geriatrics. So I am serious about this. If you really, really want to make a difference, I am positive that I can get you a good job in the State of Maine.

Dr. AYATI. I will prepare my resume today.

[Laughter.]

The CHAIRMAN. So it is a real problem. In states with aging populations, there are not people who have the kind of training that you have and that you discussed. And this problem is only going to become more severe as our population continues to age. When the fastest-growing cohort of our population are those 85 and older

and the second fastest-growing are those 100 and older, the future is staring at us. And I am really concerned about having the workforce that is trained and experts to help us adjust and ensure good, healthy lives for people as long as possible.

When you think about how much our world has changed in the last 65 years since 1953, that is the year that color television first started appearing. Gas back then cost 20 cents a gallon. Nobody ever heard of iPhones or computers being widely available. In fact, when you were talking about the need for people to talk more face-to-face, this is a major obstacle to people having conversations. I could not live without it, but it is a major obstacle. And you cannot probably see from there, but my 92-year-old father in his World War II uniform is my screen saver on it.

But we need to do so much more to adjust to the new reality that we are in, and that has been one of the purposes of this hearing today. So I thank you all so much for helping us to better understand the world that we are living in. And I also want to thank our staff for their hard work.

Committee members will have until Friday, February 2nd, to submit additional questions for the record, so you may be getting some additional inquiries.

And I would now turn to Senator Casey for any closing remarks that he would like to make.

Senator CASEY. Chairman Collins, thank you. I want to thank you for this hearing and for the good work that led up to it by your staff and our staff as well.

I want to thank our witnesses. I will pay special tribute to Sharon because she did such a good job and she is from Pennsylvania. We have a special place in our heart for Fayette County. I want you to know that. But I am grateful for all of that and especially because we are dealing with such a difficult issue when we talk about the many issues we had to confront today. People turning 65 are facing a staggering number of decisions related to their health and financial security. These are complex decisions that can have lifelong consequences. It is our responsibility to provide people with information to make the best decision possible. Without information that is easy to access and understand, people are being punished for honest mistakes, and that is unacceptable. I think we can all agree on that.

We have got a lot of work to do this year on these issues. I hope that we can pass the BENES Act. I will put another plug in for that. We are grateful for this opportunity, and I am looking forward to continuing to work on these issues.

Thank you, Madam Chair.

The CHAIRMAN. Thank you.

Senator Cortez Masto, do you have anything?

Senator CORTEZ MASTO. No. Thank you.

The CHAIRMAN. Thank you. This hearing is now adjourned.

[Whereupon, at 11:14 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

January 24, 2018

STATEMENT FOR THE RECORD

JIM BORLAND
ACTING DEPUTY COMMISSIONER FOR COMMUNICATIONS
SOCIAL SECURITY ADMINISTRATION

Chairman Collins, Ranking Member Casey, and Members of the Special Committee:

I am Jim Borland, Acting Deputy Commissioner for Communications at the Social Security Administration (SSA). Thank you for inviting me to discuss how SSA provides information to help workers and their family members decide when to claim Social Security retirement benefits, and when to enroll in Medicare. These decisions are important, and we are mindful of our responsibility to provide information to help our claimants make informed decisions that best fit their individual circumstances.

Overview

We administer the Old-Age, Survivors, and Disability Insurance (OASDI) program, commonly referred to as "Social Security." Individuals earn coverage for Social Security retirement, survivors, and disability benefits by working and paying Social Security taxes on their earnings. Payroll tax revenues fund the Social Security program. We also administer the Supplemental Security Income (SSI) program, which provides monthly payments to people with limited income and resources who are aged, blind, or disabled. Adults and children under age 18 can receive payments based on disability or blindness. General tax revenues fund the SSI program.

Few government agencies touch the lives of as many people as we do. Social Security pays monthly OASDI benefits to approximately 62 million individuals. During fiscal year (FY) 2017, we paid about $934 billion to Social Security beneficiaries. This included about:

- $793 billion to an average of about 51 million retired workers, the spouses and children of retired workers, and the survivors of deceased workers a month; and
- $141 billion to an average of more than 10 million disabled beneficiaries and their spouses and children a month.[1]

Medicare is a national health insurance program administered by the Centers for Medicare and Medicaid Services (CMS). It provides health insurance for people age 65 and older, younger disabled workers, and individuals with end stage renal disease. SSA is responsible for enrolling people in Medicare. In FY 2017, we enrolled over five million people in Medicare.

Helping Individuals Understand Social Security Retirement and Medicare

Before individuals apply for and receive Social Security benefits, SSA has an important role to provide objective and clear information that individuals may use to plan for retirement and make informed decisions appropriate for their circumstances. We have a variety of ways to inform individuals about their claiming options before they decide to file for Social Security benefits or enroll in Medicare. These resources are critical

[1] There were also on average more than 8 million SSI recipients per month in Fiscal Year 2017.

because they allow individuals to consider the best age for them to start benefits based on their health, finances, and other personal circumstances. We provide this information using a variety of methods, including the *Social Security Statement*, our website and publications, outreach, and more.

Social Security Statement

The *Social Security Statement* (*Statement*) provides information on lifetime earnings as well as estimates of future benefits workers and their families may receive based on those earnings. Individuals may access their *Statement* at any time through a personal online *my* Social Security account. They also receive an annual reminder to check the most recent version of their *Statements*. Additionally, we currently mail *Statements* to individuals aged 60 and older who are not receiving Social Security benefits and do not have a *my* Social Security account.[2] In FY 2017, 15.6 million *my* Social Security users accessed their *Statements* nearly 46 million times, and we mailed around 13.5 million *Statements*.

The *Statement* provides personalized information about an individual's potential retirement benefits, as well as a detailed record of the individual's earnings history. Individuals may use the *Statement* to verify their earnings history and to inform us if their earnings need to be corrected. For retirement benefits, the *Statement* lists the benefit amounts that an individual is estimated to receive at age 62, at full retirement age (FRA), and at age 70. The *Statement* describes additional factors an individual should consider before deciding when to apply for benefits. It includes information on how work affects benefits; how a worker's claiming decision affects survivors benefits; how to avoid a Medicare late-enrollment penalty; and information on average life expectancy. Since we launched *my* Social Security accounts in 2012, more than 34 million users have registered and more workers are signing up every day. In addition, *my* Social Security accounts consistently rank among the top 10 in customer satisfaction for all Federal government websites.

Over the next few years, we plan to enhance the online *Statement* to attract more workers to sign-up, review their personal information, and conduct business with us online.

Publications and Online Tools

We offer a wealth of other information to the public through our publications, website, and other online tools. More than 99 million people visited our website a total of more than 232 million times in calendar year 2017. Numerous publications, webpages, and Frequently Asked Questions explain the effect that earnings, the age at which benefits are claimed, and the receipt of a non-covered pension may have on Social Security benefits.[3] Our resources range from providing basic information about benefits, to delving into the details of benefit calculations, factors to consider when filing for benefits, and more.

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[2] Individuals also may request a copy of their *Statement* at any time.
[3] http://faq.ssa.gov/

We offer a variety of online calculators. One of these, the Retirement Estimator, allows an individual to input a few pieces of personal information and receive an estimate of benefits that would be payable if he or she were to claim benefits at age 62, at FRA, at age 70, or at any age in between based upon his or her actual earnings information.[4] Based on surveys conducted by Foresee, the Retirement Estimator is one of the highest rated government sites in customer satisfaction. The Retirement Estimator lets individuals enter different future earnings information and expected stop work dates, to help decide the best time to retire. We also offer a Life Expectancy Calculator to aid people with their retirement planning. This calculator allows an individual to see average life expectancy based on individuals with his or her gender and date of birth.[5]

We also offer substantial information when an individual completes the online application for retirement benefits. Throughout the online retirement application, we provide links that explain why we ask for particular information, and the importance of that information based on an individual's circumstances. For example, within the online application, when an individual indicates the date they want to start receiving benefits, we inform them that if benefits begin before FRA, their monthly benefits will be permanently reduced. We also provide links to detailed information explaining the effects of receiving benefits before and after FRA. Additionally, we provide a link to the Retirement Estimator, mentioned earlier, that allows claimants to see what their benefit amount would be at various ages. This level of information is important because the majority of retirement claims are filed online (in 2017, about 53 percent of retirement applications were filed online).

Medicare Information

CMS administers the Medicare program, but individuals enroll in Medicare by contacting SSA. Thus, SSA and CMS work in partnership and both agencies maintain and communicate information about how to enroll, what the enrollment options are, and who to contact for more information about enrollment. For example, our publication *How to Apply Online for Medicare Only* explains how an individual who is not ready to apply for Social Security benefits but does want to enroll in Medicare can do so quickly and efficiently.[6]

Our publication entitled *Retirement Information for Medicare Beneficiaries* provides information that can help an individual who has already enrolled in Medicare decide when to apply for Social Security retirement benefits.[7]

Our website includes helpful information about Medicare, including information about enrolling in Medicare at 65 and delaying retirement benefits until after FRA. Our

[4] https://www.ssa.gov/retire/estimator.html
[5] https://www.ssa.gov/OACT/population/longevity.html
[6] https://www.ssa.gov/pubs/EN-05-10531.pdf
[7] https://www.ssa.gov/pubs/EN-05-10529.pdf

website also links to the CMS flagship publication, *Medicare and You*, giving the public instant access to a wealth of information.[8]

Direct Service to Customers

Our employees are dedicated to providing customers with the information they need to make a well-informed decision about claiming Social Security benefits and enrolling in Medicare. They assist the public in a variety of ways, such as through face-to-face interaction in a field office, by telephone (including our national toll-free number, 1-800-772-1213), in response to online applications, and by mail.

Employees inform individuals of the benefits for which they and their family members may be eligible; provide monthly benefits amounts at early, full, and delayed retirement ages; and discuss other information the claimant may need to know about Social Security rules, requirements, and benefits. Employees also inform individuals about the Medicare program including information about premiums, deductibles, enrollment periods, the month coverage begins, penalties for declining Medicare Part B when first eligible, as well as the prescription drug plan (Medicare Part D), and where to find help with covering prescription drug costs.

SSA employees provide detailed information about the Social Security and Medicare programs, and how the rules apply to each individual's situation. However, they do not attempt to persuade individuals regarding whether or when to file for benefits. This is because our employees are not in a position to know about or discuss the personal circumstances—such as financial resources, tax situation, health, and family longevity—that may be important in deciding which age is best for that person to claim benefits.

Outreach

Public outreach is an essential part of our strategy to educate more Americans on the retirement benefit options. We provide the public with critical information about our programs, benefits, and services. To this end, our field and regional offices are committed to connecting with the public at the local, grass-roots level.

During fiscal year 2017, Social Security employees participated in more than 6,000 events to help the American people better understand Social Security and Medicare benefits. With an estimated audience of more than 3.7 million people, these events ranged from small rural get-togethers in public libraries, senior centers, churches, and veterans' organizations to large gatherings like county and state fairs, senior expos, and employer group meetings. Whether the attendance is in the tens or the thousands, SSA employees are there to help Americans better understand their benefits.

Among those events, pre-retirement seminars are particularly effective forums to discuss options for claiming Social Security and Medicare. Since 2004, we have helped the

[8] https://www.medicare.gov/medicare-and-you/different-formats/m-and-y-different-formats.html

National Rural Electric Cooperative Association identify speakers for more than 400 such seminars throughout America's heartland.

Examples from our regions further illustrate our efforts to ensure rural and remote populations have equal access to Social Security and Medicare information:

> Our Seattle Region is experimenting with existing technologies to conduct seminars in the remote and underserved communities in the State of Alaska. In our Philadelphia Region, we have worked closely with the Pennsylvania Department of Labor and Industry to ensure that remote counties like Erie, Crawford, and Franklin are served. Our preretirement seminars in these counties help residents understand their many Social Security options. Our Boston Region has worked with Maine's Area Agencies on Aging as well as the five federally recognized American Indian Tribes located in extremely remote areas of the state.

In addition to our work in the regions, we also work closely with national organizations, advocacy groups, and other Federal agencies to maximize the reach of our public education and communication efforts.

We continue to strengthen our partnership with CMS to improve our outreach for Americans nearing the Medicare eligibility age. Recently, we have:

- Updated the *Statement* insert for older individuals to strengthen the message about when to apply for Medicare and to make the information more prominent;
- Included additional language or made existing language about the late enrollment penalty and Medicare clearer in several publications;
- Added additional frequently asked questions to address late enrollment fees, and signing up for Medicare when health insurance through current employment or when VA benefits are involved; and
- Coordinated communications with Medicare beneficiaries about the issuance of new Medicare cards in 2018, including an alert to beware of scams targeting the elderly and disabled.

Choosing When to Claim Retirement Benefits

Choosing when to start receiving Social Security retirement benefits is an important decision that affects the amount that individuals receive for the rest of their lives. Workers can claim full (unreduced) retirement benefits at FRA – currently age 66 and 4

months for people who turn 62 in 2018.[9] Social Security also allows individuals to claim benefits as early as age 62 or to allow their benefit amount to grow up to age 70.[10]

Receiving Social Security benefits before FRA permanently reduces an individual's monthly retirement benefit – and the earlier benefits begin, the greater the reduction.[11] In 2018, retirement benefits claimed at age 62 result in a reduction of up to 26.7 percent, compared to the benefit payable at FRA(66 and 4 months).[12]

On the other hand, individuals who delay claiming beyond FRA earn "delayed retirement credits" (DRCs) for every month they do not receive benefits after attaining FRA and prior to attaining age 70. For those born in 1943 and later, each month of delay increases the retirement benefit by two-thirds of one percent, or eight percent per year. For a person whose FRA is 66, delaying until 70 would result in a monthly benefit 32 percent higher than the amount that would be payable if claimed at FRA.

For example, consider an individual eligible for a $1,000 monthly benefit who was born between 1943 and 1954. He or she would have an FRA of 66. As shown in the following chart, if he or she took benefits at age 62, the monthly amount would be permanently reduced by 25 percent to $750. On the other hand, if he or she delayed benefits until age 70, the monthly amount would be permanently increased by 32 percent (eight percent per year from age 66 to 70) to $1,320. Overall, delaying the start of benefits from age 62 to 70 would increase the monthly benefit by 76 percent (from $750 to $1,320), or almost $7,000 a year.

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[9] For persons born in years 1943 through 1954, full retirement age is 66. For people who turn 62 in 2018 (born in 1956), full retirement age is 66 and 4 months, 2 months more than it was for those who turned 62 last year. The retirement age will continue to increase by 2 months every year until it reaches age 67 for those who were born in 1960 or later.

[10] Workers who are no longer covered under employer-sponsored health insurance and individuals with employers that have fewer than 20 employees must sign up for Medicare when eligible if they wish to avoid a penalty in the form of an increased premium for Medicare Part B coverage. Individuals who are still working or are covered by their or their spouse's employer's group health insurance plan, can postpone signing up for Medicare Part B without penalty until they are no longer covered by the group health insurance plan based on current employment, at which time they will have an eight-month Special Enrollment Period in which to sign up. In addition, there is a late enrollment penalty for not signing up for Medicare Part D during the Initial Enrollment Period. However, the penalty may be waived if an individual shows proof of creditable drug coverage.

[11] The monthly benefit is reduced by 5/9 of one percent for each month up to 36 months before FRA and then 5/12 of 1 percent for each additional month before FRA.

[12] For people born in 1960 or later, choosing to retire at 62 would reduce the benefit by up to 30 percent compared to the amount payable at FRA.

If receipt begins at age:[13]	The monthly benefit would be:[14]
62	$750
63	$800
64	$867
65	$933
66	$1,000
67	$1,080
68	$1,160
69	$1,240
70	$1,320

Retirement claiming decisions can also affect the amount of the benefit that the worker's spouse will receive if he or she outlives the worker. In effect, the same adjustment that applies to the worker's retirement benefit will apply to survivor benefits paid to the worker's widow or widower for the rest of his or her life.

Deciding when to claim retirement benefits can be complex, and a person should consider many factors when making his or her decision. In addition to the monthly benefit amount, individuals should consider their personal and family circumstances, including current and future financial resources and obligations, and anticipated health and longevity.

Married couples have two lives to plan for throughout retirement. Married retirees must consider important information about Social Security protection for widowed spouses. A higher-earning partner who delays benefits will receive higher monthly benefits for his or her life. This delay may also result in higher survivor's benefits for a spouse if the spouse lives longer.

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[13] See SSA Pub. No. 05-10147, "When to Start Receiving Retirement Benefits" (January 2017), available at https://www.ssa.gov/pubs/EN-05-10147.pdf.

[14] These monthly benefit amounts do not account for any benefit increase that may be due to earnings after age 61, nor do they include cost-of-living adjustment (COLA) increases.

Enrolling in Medicare

We strive to make it as easy as possible for people to get information about how to enroll in Medicare and to complete the enrollment process. It is important that people know their enrollment options in order to avoid delays in the effective date of coverage or increases in their premiums. One of our goals is to help people who are approaching age 65 know that, even though full retirement age is increasing, Medicare eligibility still begins (in most cases) at age 65. Accordingly, for people who are age 55 or older, we include with the *Statement* a document titled "Thinking of retiring?", which features a prominent message advising the person to sign up for Medicare at age 65 even if he or she does not plan to receive monthly Social Security benefits at that time.

Current Social Security retirement beneficiaries receive an enrollment package from CMS about 3 months before they turn 65. It tells them that they will be enrolled in Part A. It also tells them they will be automatically enrolled in Part B unless they inform us they do not want the coverage (except in Puerto Rico where, by law, residents must opt-in if they want Part B coverage). Disability beneficiaries who have been receiving benefits for 24 months are also automatically enrolled in Medicare and receive the same enrollment package.

Individuals who are not receiving Social Security benefits must take action to enroll in Medicare. They can do so in person, by phone, or online during one of the following enrollment periods:

- Initial Enrollment Period - the month the individual turns 65, the three months before, and the three months after;
- General Enrollment Period - January 1 to March 31 of every year; or
- Special Enrollment Period - Individuals who continue to work past age 65 or who have a spouse that works and who have employment-based health insurance may have a special enrollment period (SEP). The SEP allows the individual to file during the eight-month period that begins after the employment-based health insurance ends, without having to pay a penalty in the form of increased premiums.

Many individuals can enroll in Medicare online, even if they do not want to claim their Social Security benefits. Individuals can use our online Medicare application if they:

- are at least 64 years and 9 months old;
- want to sign up for Medicare but do not currently have any Medicare coverage;
- do not want to start receiving Social Security benefits; and

- are not currently receiving Social Security retirement, disability or survivors benefits.

Conclusion

When Congress passed the Social Security Act in 1935, it did so to provide seniors with benefits based on their earnings to sustain them throughout their retirement. This continues to be one of the program's core purposes. Currently, program rules allow individuals to claim their retirement benefits and receive different monthly benefit amounts at any time between the ages of 62 and 70, offering individuals flexibility to make decisions based on their individual circumstances. Accordingly, we understand the importance of providing useful information to the public about their choices for retirement. Through interaction with agency employees, the *Statement*, *my* Social Security accounts, other online tools, our publications, and our outreach efforts, we provide valuable ways for individuals to learn about how claiming decisions may affect their benefits.

Similarly, when Congress passed Medicare in 1965, it charged the Social Security Administration with the responsibility to enroll people in the program. We take that responsibility very seriously, and we strive to ensure that we, in partnership with the Centers for Medicare and Medicaid Services, provide accurate, useful information that helps ensure people know when and how to contact us to enroll in Medicare, especially when they are not yet receiving Social Security benefits.

Thank you again for inviting me here today. I would be glad to answer any questions.

Testimony of
Anna Maria Chávez

Submitted to the
Special Committee on Aging
U.S. Senate

on
Turning 65: Navigating Critical Decisions to Age Well

January 24, 2018

National Council on Aging
251 18th Street, Suite 500
Arlington, VA 22202

Chairwoman Collins, Ranking Member Casey, and members of the Committee, I appreciate the opportunity to speak with you today on behalf of the National Council on Aging (NCOA) about the critical decisions that older adults face as they turn 65.

Life after age 65 has changed dramatically in the last 30 years. Where retirement once meant spending several years of leisure buoyed by the financial security of a pension, today's older Americans have both the gift and challenge of planning for a bonus 20 to 30 years of life.

According to the Social Security Administration, a man reaching age 65 today can expect to live, on average, until age 84 and a woman until age 86. What's more, one out of every four 65-year-olds today will live past age 90, and one in 10 will live past age 95.[1]

Few Americans are prepared for the challenges and opportunities of this increased longevity. Traditional defined benefit retirement plans have mostly disappeared, and Americans' individual savings for retirement have not caught up. According to a 2017 BlackRock survey, the average pre-retirement baby boomer — defined as 55-64 years old — has only $127,000 in savings.[2] Yet the Elder Economic Security Standard™ Index calculates that people over age 65 with a mortgage need a minimum of $31,000 per year just to afford the basic necessities like housing, food, health care, and transportation.[3] In Maine, York County has the highest Elder Index at $31,080. In Pennsylvania, the highest is Chester County at $37,404.

In addition to higher daily costs, living longer means increased chronic disease and rising health care costs. The National Center for Health Statistics reports that more than 85% of Americans aged 65 and over are coping with at least one chronic health condition, and 56% are coping with two or more.[4] Chronic conditions – which include asthma, diabetes, heart disease, and arthritis, among others – account for 85% of the nation's $2.7 trillion annual health care expenditures, according to the U.S. Centers for Disease Control.[5]

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[1] Social Security Administration, https://www.ssa.gov/planners/lifeexpectancy.html
[2] BlackRock, https://www.blackrock.com/investing/insights/investor-pulse/retirement
[3] University of Massachusetts Boston, https://scholarworks.umb.edu/demographyofaging/13/
[4] U.S. Centers for Disease Control, National Center for Health Statistics, https://www.cdc.gov/nchs/health_policy/adult_chronic_conditions.htm
[5] U.S. Centers for Disease Control, https://www.cdc.gov/chronicdisease/overview/index.htm

Today's women, in particular, face unique hurdles past age 65. They begin retirement with a challenge that has followed many throughout their lives – the pay gap. Lower pay means less money saved. Women who chose to leave the workforce to be a parent or caregiver have fewer Social Security benefits built up. Overall, women receive nearly $4,000 a year less in Social Security benefits than men.[6] Women of color face an even deeper disparity. Over 70% of elderly Hispanic women and more than 64% of elderly African American women are economically vulnerable, according to the Economic Policy Institute.[7]

While this situation may sound dire, the good news is that there are proven, cost-effective ways to help Americans successfully navigate life after 65. Many of them are small steps that can have a huge impact on quality of life.

Since 1950, NCOA has been working to empower older adults with the information and resources they need to take these steps. With the help of thousands of partners across the country, NCOA has developed innovative programs that help older adults remain healthy, economically secure, and independent in their communities.

At NCOA, we envision a just and caring society in which each of us, as we age, lives with dignity, purpose, and security. To achieve that vision, we are focused on improving two essential pillars of life past age 65 – health and economic security.

HEALTH

At every age, good health ensures independence, security, and productivity. Unfortunately, millions of older Americans struggle every day with health challenges such as chronic disease, falls, and behavioral health issues – all of which can severely impact quality of life.

[6] Social Security Administration, https://www.ssa.gov/news/press/factsheets/ss-customer/women-ret.pdf
[7] Economic Policy Institute, https://www.epi.org/publication/economic-security-elderly-americans-risk/

Chronic Disease

Older adults are disproportionally affected by chronic conditions, such as diabetes, arthritis, and heart disease. The National Center for Health Statistics reports that more than 85% of Americans aged 65 and over are coping with at least one chronic health condition, and 56% are coping with two or more.[8]

Chronic conditions are costly to individuals' lives and to the health care system. They can limit a person's ability to perform daily activities, cause them to lose their independence, and result in the need for institutional care, in-home caregivers, or other long-term services and supports. They are also the leading causes of death among older adults in the U.S.[9] Chronic diseases account for 93% of Medicare spending, yet less than 1% of U.S. health care dollars is spent on prevention to improve overall health.[10]

Healthy behaviors can improve health and reduce spending. There is strong evidence that patients with chronic illnesses have better outcomes and lower costs when behavior changes are implemented, and these changes can be made only when patients have the confidence in their ability (self-efficacy) to effect change. Community-based aging services organizations and the public health community have an important role to play in improving healthy behaviors by promoting self-management and addressing the social determinants of health.

Chronic diseases can be managed to improve quality of life and reduce costs. Chronic Disease Self-Management Education (CDSME), created and tested by researchers at Stanford University, includes cost-effective, evidence-based programs that have been proven to help people better manage their chronic conditions. The Chronic Disease Self-Management Program (CDSMP), for example, is a six-week, interactive, small-group workshop – also available online – that helps participants deal with fatigue, pain, frustration, or isolation; maintain strength, flexibility, and endurance; manage and adhere to medications; communicate with family, friends, and health professionals; and eat healthy.

The results show improved health outcomes and lower costs. CDSMP participants in randomized studies have reported improved health status in six indicators: fatigue, shortness of breath, depression, pain, stress, and sleep problems; improved health-related quality of life, unhealthy physical days, and unhealthy mental days; and improved communication with doctors, medication compliance, and health

[8] U.S. Centers for Disease Control, https://www.cdc.gov/nchs/data/hus/hus16.pdf#020
[9] U.S. Centers for Disease Control, https://www.cdc.gov/nchs/data/hus/hus16.pdf#020
[10] U.S. Department of Health and Human Services, http://www.hhs.gov/asl/testify/2011/10/t20111012b.html

literacy. Moreover, cost savings among participants included $714 per person in emergency room visits and hospital utilization. Based on the data, the nation could save $6.6 billion by bringing CDSMP to just 10% of Americans with one or more chronic disease.

There is also an online version of the program for people who cannot attend an in-person workshop. Recent research by NCOA, Stanford University, Anthem, and HealthCore, funded by Bristol-Meyers Squibb Foundation, showed that the online version improves diabetes outcomes, improves depressive symptom and medication adherence, and helps people increase exercise by 43 minutes per week.

NCOA serves as the National Resource Center for CDSME. With funding from the U.S. Administration on Aging, NCOA supports the expansion and sustainability of evidence-based health promotion and disease prevention programs to bring them to more older adults both in the community and online through collaboration with national, state, and community partners.

As recently as eight years ago, the federal investment in CDSME was $16 million annually. Current funding has dropped to $8 million, made available through an annual allocation from the Prevention and Public Health Fund (PPHF). NCOA is extremely concerned about the implications of proposed cuts, the looming sequester, and threats to the PPHF on CDSME funding. The Senate Appropriations Committee has proposed level funding CDSME for FY18, but both the Administration and the House Appropriations Committee have proposed a $3 million cut. It is critical that funding for CDSME at least be protected, and in the event that a deal is reached to raise the Budget Control Act (BCA) caps, the investment should be restored to $16 million to improve access to those in need.

Congress should move beyond appropriated programs to provide more sustainable funding for these proven interventions. NCOA supports the development of a Medicare demonstration program to test Integrated Self-Care Management, in which primary care and community service providers collaborate and integrate support to help older adults and their caregivers reach personal goals for healthy aging. The initiative would have two overarching goals: (1) improving health and quality of life outcomes for older people who have multiple chronic conditions and (2) reducing preventable hospitalizations, readmissions, and emergency room visits in order to lower per capita health care expenses for the target population.

In addition, Preventive Health Services authorized by Title III-D of the Older Americans Act (OAA) provide formula grants to support evidence-based health promotion and disease prevention. Annual

funding to provide formula grants to the 50 states, the District of Columbia, and five territories has remained at $19.8 million in recent years. An investment of at least the $20.8 million authorization for FY18 approved in the 2016 bipartisan OAA reauthorization would help the aging network disseminate these proven programs that empower older adults to adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits.

On an individual level, healthy behaviors are the name of the game when it comes to preventing and managing chronic disease as you age. Older adults with chronic disease can stay healthier if they:

- **Exercise regularly.** Physical activity boosts physical and mental health. A mixture of aerobic, strength and balancing building, and stretching movements are best for older adults.
- **Quit smoking.**
- **Drink in moderation.** For most older adults, moderation is defined as no more than one drink per day.
- **Sleep well.** Getting at least seven hours of deep sleep each night is crucial for older adults.
- **Eat a healthy diet.** Older adults should focus on foods that are high in nutrients and limit consumption of alcohol, caffeine, artificial sweeteners, and highly processed foods.
- **Manage stress levels.** It's important for seniors to reach out to family and friends during rough spells and consider regular meditation.
- **Talk to their doctor.** Older adults who have experienced any of the warning signs of depression or other behavioral health issues should talk to their doctor about treatment options.

Falls Prevention

Falls are another pervasive and significant health concern for older adults. Like chronic conditions, falls can severely impact a person's quality of life and health care costs.

One in four older adults falls each year. Every 11 seconds, an older adult is treated in the emergency room for a fall, and every 19 minutes, an older adult dies from a fall. Fear of falling can lead older adults

to limit their activities, which can result in more falls, further physical decline, depression, and social isolation.[11]

Falls are the leading cause of fatal and nonfatal injuries among older adults, causing hip fractures, head trauma, and death.[12] Today, the nation spends $31 billion a year in Medicare costs[13] treating older adults for the effects of falls and, if falls rates are not reduced, direct treatment costs are projected to reach $67.7 billion by 2020.

The good news is that falls are not a normal part of aging, and they are preventable. Just as with chronic conditions, there are proven, cost-effective programs and education that can help older adults prevent a fall. These programs – which include A Matter of Balance and Stepping On – have been shown to reduce the incidence of falls by as much as 55% and produce a return on investment of as much as 509%.

NCOA leads both the National Falls Prevention Resource Center, funded by the U.S. Administration on Aging, and the Falls Free® Initiative, a national coalition of groups working together to bring proven education and prevention to their communities. The goal is to increase public awareness about the risks of falls and how to prevent them; support and stimulate the implementation, dissemination, and sustainability of evidence-based falls prevention programs; and serve as the national clearinghouse of tools, best practices, and information. Every September on the first day of Fall, NCOA sponsors Falls Prevention Awareness Day to spotlight this critical health issue and solutions. Thank you to Senator Collins for sponsoring the Senate Proclamation declaring September 22, 2017 as Falls Prevention Awareness Day.

Since enactment of the bipartisan Safety of Seniors Act of 2008, an annual appropriation of approximately $2 million has been provided to the U.S. Centers for Disease Control (CDC) National Center for Injury Prevention and Control for falls prevention research and dissemination of best practices to the public health sector. Starting in FY14, the PPHF made possible new funding to the U.S. Administration for Community Living (ACL), with an annual allocation of $5 million to support grants for evidence-based community falls prevention programs.

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[11] U.S. Centers for Disease Control, https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html
[12] Bergen, G et al. Falls and Fall Injuries Among Adults Aged ≥65 Years — United States, 2014. Morbidity and Mortality Weekly Report. September 23, 2016 / 65(37);993–998.
[13] U.S. Centers for Disease Control, https://www.cdc.gov/homeandrecreationalsafety/falls/fallcost.html

The nation can no longer afford to spend over $31 billion annually to treat the results of falls when evidence-based programs have been designed to prevent them. As with CDSME, NCOA is extremely concerned about the threats to falls prevention funding with proposed appropriations cuts, threats to the PPHF, and the looming sequester. The Administration proposed eliminating falls prevention funding at CDC but level-funding the ACL investment for FY18, while the Senate and House Appropriations Committees protected funding for both. Sufficient federal investments are needed to make these important, cost-effective programs available to more older Americans at risk, and increases should be considered if the BCA caps are raised.

On the individual level, NCOA promotes 6 Steps to Prevent a Fall[14]. They include:

1. **Find a good balance and exercise program.** Look to build balance, strength, and flexibility.

2. **Talk to a health care provider.** Ask for falls risk assessment. The CDC has developed an assessment guide for health care professionals to use for this purpose. Older adults need to feel comfortable speaking with their health care providers about their falls history and if they have a fear of falling.

3. **Have medications regularly reviewed by a doctor or pharmacist.** Medication side effects and drug interactions increase the risk of falling.

4. **Get vision and hearing checked annually.** Your eyes and ears are key to keeping you on your feet.

5. **Keep the home safe.** Remove tripping hazards, increase lighting, make stairs safe, and install grab bars in key areas.

6. **Talk to family members.** Enlist their support in taking simple steps to stay safe. Falls are not just a seniors' issue.

[14] National Council on Aging, https://www.ncoa.org/healthy-aging/falls-prevention/preventing-falls-tips-for-older-adults-and-caregivers/take-control-of-your-health-6-steps-to-prevent-a-fall/

Behavioral Health & Social Connections

Good health is not only physical, but also mental. One in four older adults experiences depression, anxiety, risk for suicide, or substance abuse.[15] Older adults also have been significantly affected by the opioid epidemic with increased use of opioids due in part to experiencing painful chronic conditions, such as arthritis, back pain, and fibromyalgia.

Behavioral health problems can complicate the treatment of other medical conditions, reduce quality of life, increase use of health care services, and lead to premature death. In 2014, nearly 11,000 people aged 60 and over died by suicide. Men aged 85 and over have a suicide rate that is about four times higher than the rate for all ages. Excessive alcohol use accounts for more than 23,000 deaths among older Americans each year. These problems are not a normal part of aging and can be treated. However, 66% of older adults are not receiving the care they need.[16]

Social isolation and loneliness can exacerbate both physical and mental health concerns among older Americans. One in six older adults lives in social and/or geographical isolation.[17] In addition to living alone, isolated seniors face physical, cultural, and geographical barriers that prevent them from receiving important services and supports from family members, friends, and private and governmental agencies.

Social isolation refers to an objective state of having minimal contact with other people, while *loneliness* refers to a subjective state of negative feelings associated with perceived social isolation. The effects can be just as significant as physical health problems. Older adults without adequate social interaction are twice as likely to die prematurely.[18] Their mortality risk is comparable to that of smoking 15 cigarettes a day or drinking 6 alcoholic beverages a day[19] and is twice as dangerous as obesity.[20]

Several factors contribute to older adults becoming isolated and lonely. Widowhood affects older women who are more likely to outlive their spouses. Older people's social networks often get smaller when children move away and aging relatives and friends die. For some, retirement decreases self-

[15] U.S. Centers for Disease Control, https://www.cdc.gov/aging/pdf/mental_health.pdf
[16] U.S. Centers for Disease Control, https://www.cdc.gov/aging/pdf/mental_health.pdf
[17] National Council on Aging, https://www.ncoa.org/wp-content/uploads/crossing-new-frontiers.pdf
[18] PLOS Medicine, http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000316
[19] SAGE Journals, http://journals.sagepub.com/doi/full/10.1177/1745691614568352
[20] American Psychological Association, http://www.apa.org/news/press/releases/2017/08/lonely-die.aspx

worth and reduces engagement due to lack of work-related connections. Approximately one in three people aged 60 or older indicate that they feel lonely some of the time or often.[21]

Research also has shown a clear biological link between loneliness and depression.[22] Depression can impair an older adult's ability to function and enjoy life, and it contributes to poor health outcomes and high health care costs. Compared to their peers, older adults with depression often need greater assistance with self-care and daily living activities and often recover more slowly from physical disorders. Without appropriate treatment, symptoms of depression can lead to such negative consequences as substance misuse disorders, further isolation, suicide, and death.[23]

In the community, senior centers serve as a beacon for older adults seeking support and social connections. Almost 10,000 senior centers serve more than 1 million older adults every day. Senior centers serve as a gateway to the nation's aging network — connecting older adults to vital community services that can help them stay healthy and independent, as well as fun and friendships.

Senior centers offer a wide variety of programs and services, including meal and nutrition programs, information and assistance, health and wellness programs, transportation services, public benefits counseling, employment and volunteer opportunities, and social and educational programs. Research shows that older adults who participate in senior center programs can learn to manage and delay the onset of chronic disease and experience measurable improvements in their physical, social, spiritual, emotional, mental, and economic well-being.

Socialization is an important benefit of senior center participation. Survey data from program participants aged 60 and over at multipurpose senior centers found that more than half (56%) report the people they associate with at the senior center sites are usually the only people they spend time with and interact with during the day. The great majority (90%) view personal contacts made with people at the senior center as important to them.[24]

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[21] Wilson C & Moulton B (2010). Loneliness among older adults: A national survey of adults 45+. Prepared by Knowledge Networks and Insight Policy Research, Washington DC: AARP.
[22] Matthews GA, Niel EH et al (2016). Dorsal raphe dopamine neurons represent the experience of social isolation. Cell: 164, 617–631.
[23] Substance Abuse and Mental Health Services Administration (2013). Older Americans Issue Brief Series, Issue Brief #6: Depression and Anxiety in Older Adults.
[24] Turner KW (2004). Senior citizens centers: What they offer, who participates, and what they gain. Journal of Gerontological Social Work, 43:37.

NCOA runs the National Institute of Senior Centers (NISC), the nation's only organization dedicated to improving senior centers. NISC supports a national network of over 3,000 senior center professionals, and promotes cutting-edge research, promising practices, professional development, and advocacy. NISC also offers the nation's only National Senior Center Accreditation Program[25], which provides official recognition that a senior center meets nine national standards of senior center operations.

The Older Americans Act defines a multipurpose senior center as "a community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals." To effectively engage and address the needs of the aging population, it is crucial that their expertise be fully tapped to leverage resources and partnerships to achieve the goals of the OAA in communities across the nation.

In the 2016 OAA reauthorization, NCOA's proposals resulted in the addition of language to support the modernization of senior centers, with the identification of best practices and provision of technical assistance to facilitate the dissemination of these strategies. As NCOA begins to envision a bold reauthorization for 2020, we intend to build upon this language.

ECONOMIC SECURITY

Along with health, economic security is integral to enabling people over age 65 to live their best lives. Today, over 25 million Americans aged 60 and over are economically insecure — living at or below 250% of the federal poverty level (FPL), or $29,425 per year for a single person. More accurate measures of economic well-being — including the Elder Economic Security Standard™ Index managed by NCOA and the Gerontology Institute at the University of Massachusetts Boston — show that half of older adults living alone struggle to meet their monthly expenses.[26]

Even for those who can afford daily expenses, rising debt is taking a toll. Today, 61% of senior households have some form of debt, and almost 34% of senior households owe money on a mortgage, home equity line of credit, or both. NCOA research shows that 48% (67% of low-income adults) worry

[25] National Council on Aging, https://www.ncoa.org/national-institute-of-senior-centers/standards-accreditation/
[26] National Council on Aging, https://www.ncoa.org/economic-security/money-management/elder-index/

they won't have sufficient finances as they age, and 23% (44% of low-income adults) struggle to pay their bills each month.[27]

Older women of color are disproportionately economically insecure. More than 70% of elderly Hispanic women and 63.5% of elderly African American women are economically vulnerable.[28] The number of older adults who are struggling is likely to grow given that the 65 and older population is the fastest growing age group in the country.

Despite these sobering statistics, there are concrete ways to support older adults who are struggling economically. NCOA is focused on improving access to benefits, supporting optimal Medicare choices, and employment.

Benefits Access

Connecting low-income older adults to money-saving programs as soon as they are eligible can have a profoundly positive impact on both economic well-being and health — by improving access to affordable health care, medicine, and nutritious foods. But many older adults are unaware of these programs or how to apply for them.

Senior participation rates in the core set of safety net programs is low. These core benefits include Medicare Savings Programs (MSPs), the Medicare Part D Extra Help/Low-Income Subsidy (LIS), Supplemental Nutrition Assistance Program (SNAP), Medicaid, and Low Income Home Energy Assistance Program (LIHEAP). Only 42% of eligible seniors are enrolled in SNAP,[29] and current estimates suggest that of eligible non-institutionalized Medicare beneficiaries aged 65 and older, only 54.6% and 48.3% are enrolled in LIS and MSP, respectively.[30]

NCOA estimates that low-income seniors are eligible for and not receiving more than $20.5 billion in aggregate annual benefits. Why? A nationally representative survey of 1,000 low-income older adults conducted on behalf of NCOA points to lack of awareness, assuming the application process is a lot of

[27] National Council on Aging, https://www.ncoa.org/economic-security/money-management/debt/senior-debt-facts/
[28] Economic Policy Institute, https://www.epi.org/publication/economic-security-elderly-americans-risk/
[29] U.S. Department of Agriculture Food and Nutrition Services, https://www.fns.usda.gov/snap/trends-usda-supplemental-nutrition-assistance-program-participation-rates-fiscal-year-2010-fiscal
[30] Unpublished research for the National Council on Aging

paperwork, not knowing where to begin to apply, and falsely believing that other people need more help than they do.[31]

NCOA is the nation's leader in connecting seniors with the benefit programs for which they are eligible. With support from the Medicare Improvements for Patients and Providers Act (MIPPA) funding, NCOA's Center for Benefits Access helps community-based organizations find and enroll seniors and younger adults with disabilities with limited means into benefits programs, so they can remain healthy, secure, and independent. Currently, NCOA funds 69 Benefit Enrollment Centers in 36 states that help low-income older adults enroll in core benefit programs.

Funding for this important Medicare outreach and enrollment work must be extended. The goal is not to expand Medicare eligibility, but merely to assist those who already qualify under current law. Outreach and enrollment efforts have led to important, proven results. MIPPA resources enabled state agency partners and community-based organizations to:

- Help increase the number of low-income Medicare beneficiaries enrolled in the Medicare Savings Programs from 6.4 million in 2008 to 10.5 million in 2016.
- Provide individual assistance to 2.5 million beneficiaries in need.

Since 2001, NCOA also has offered BenefitsCheckUp®, the nation's most comprehensive free, online tool to screen seniors with limited income for benefits. It includes more than 2,500 public and private benefits programs from all 50 states and the District of Columbia. As of today, over 6.4 million people have discovered eligibility for $23.3 billion in benefits on the site.

Moreover, NCOA's Senior Hunger Initiative works to combat senior hunger by enrolling eligible older adults into SNAP. The initiative combines technical assistance to local community organizations with online help and advocacy to make it easier for eligible older adults to access SNAP to pay for healthy food.

Medicare

Understanding the A, B, C, and Ds of Medicare is an overwhelming, isolating experience if older adults go without help. Yet making sub-optimal choices when enrolling in Medicare can mean years of

[31] National Council on Aging, https://www.ncoa.org/centerforbenefits/outreach-toolkit/what-the-research-says/

overpaying for coverage and even long-term penalties for late enrollment. For people coming from Medicaid or who get subsidies on Health Insurance Marketplace, turning 65 can sometimes be a "cliff" where they fall off benefits and have to start paying costly Medicare premiums.

The basic rules underpinning the Part B enrollment system were developed more than 50 years ago, when Medicare was first established. Knowing whether and when to enroll in Part B requires that a person understand when to sign up during time-limited windows, how their other insurance will work with Medicare, and what penalties may result if enrollment is delayed. The consequences of missteps can be significant and include higher out-of-pocket costs, significant gaps in coverage, and lifetime penalties. In 2014, 750,000 people with Medicare were paying a Part B Late Enrollment Penalty (LEP) with the average LEP amounting to nearly a 30% increase in a beneficiary's monthly premium.[32] In addition to this considerable penalty, many retirees and people with disabilities face large out-of-pocket health care costs, gaps in coverage, and barriers to care continuity because of honest enrollment mistakes.

The bicameral, bipartisan BENES Act (S. 1909, H.R. 2575), introduced by Ranking Committee Member Senator Casey in the Senate, aims to prevent these costly mistakes by modernizing, simplifying, and improving the Medicare Part B enrollment process. It fills long-standing gaps in notice and education for those approaching Medicare eligibility and aligns and simplifies enrollment periods, bringing Part B rules in line with Medicare Advantage and Part D rules.

Medicare State Health Insurance Assistance Programs (SHIPs) are also vital federally funded resources that help seniors navigate this complexity. SHIPs provide local, in-depth, insurance counseling and assistance to Medicare beneficiaries, their families, and caregivers. This encompasses a broad range of areas, including coverage options, fraud and abuse issues, billing problems, appeal rights, and enrollment in low-income protection programs. This scale of support cannot be replicated by agents and brokers.

SHIPs receive funding under ACL for 54 grantees (all states, Puerto Rico, Guam, DC, and the U.S. Virgin Islands), overseeing a network of more than 3,300 local SHIPs and over 15,000 counselors, 57% of whom are highly trained volunteers who donate almost 2 million hours of assistance. Several states that estimate savings to beneficiaries resulting from SHIP assistance reported achieving significant savings in

[32] Congressional Research Service, https://fas.org/sgp/crs/misc/R40082.pdf

2015, including $110 million in Massachusetts, $56 million in Michigan, and $53 million in North Carolina.

Over the past two years, more than 7 million people with Medicare received help from SHIPs, and individualized assistance provided by SHIPs almost tripled over the past 10 years. It is critical that, at a minimum, SHIP funding be maintained to meet rapidly growing needs. SHIPs offer increasingly critical services that cannot be supplied by 1-800 MEDICARE, online or written materials, or other outreach activities. In fact, approximately one-third of all partner referrals to SHIP originate from Medicare Advantage and Part D prescription drug plans, local and state agencies, the U.S. Centers for Medicare and Medicaid Services (CMS), the Social Security Administration, and members of Congress and their staff.

If the federal investment in SHIPs had simply kept pace with inflation and the increasing number of Medicare beneficiaries since FY 2011, FY18 funding would be at least $67 million. However, FY17 appropriations for SHIP were cut by $5 million to $47.1 million, and the Administration and the House Appropriations Committee have proposed eliminating all funding in FY18. We applaud the Senate Appropriations Committee for yet again rejecting proposed FY18 cuts in aging services and calling for level-funding SHIP. If a BCA deal provides additional FY18 resources, we urge that SHIP at least be restored to its FY16 level of $52.1 million.

Too many Medicare beneficiaries still do not understand or have access to effective tools for comparing and choosing among increasingly complex plan options and do not shop around when they should. Our vision is that millions of informed, engaged Medicare beneficiaries will make optimal decisions about public and private insurance, providers, and treatments. In response to these concerns, NCOA has launched an Improving Medicare Markets Initiative, with an expert Advisory Group of diverse stakeholders that has been meeting and collaborating since 2014. The group has provided extensive comments to CMS on improving tools to make informed choices, and will soon be issuing a report, along with others, on improving the Medicare Plan Finder.

NCOA offers an additional tool to help individuals navigate Medicare. My Medicare Matters® is a free, educational website that helps visitors choose the best Medicare plan for their needs and make the most of their benefits. Since launch in 2015, it has cost-effectively brought Medicare education materials to millions of Americans.

EMPLOYMENT

Millions of older Americans continue to work past age 65 – out of financial need or a desire to stay active. The Senior Community Service Employment Program (SCSEP) is the nation's oldest program to help low-income, unemployed individuals aged 55 and over find work. It provides nearly 70,000 older adults with part-time jobs at community service organizations. Participants build skills and self-confidence, while earning a modest income. For most, their SCSEP experience leads to permanent employment.

SCSEP is unique in that it's the only U.S. Department of Labor program that does not overlap with any other similar programs, and it is specifically targeted to senior workforce development. The value of the community service provided is estimated around $820 million yearly – which is more than double the program's yearly appropriation. NCOA is one of 19 national SCSEP sponsors, running programs in California, Georgia, Kentucky, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Virginia, West Virginia, and Puerto Rico.

Federal investment in SCSEP is critical, but threatened. Final FY17 funding was cut by $34.4 million, to $400 million. The Senate Appropriations Committee has proposed level funding for FY18, but the Administration has proposed eliminating all funding and the House Appropriations Committee has proposed cutting the program by $100 million, or 25%. This investment in low-income older workers must be protected, and if raising the BCA caps provides additional resources, funding should not only be restored to the FY16 level, but at a minimum, increased to the $454.5 million level authorized for FY18 in the bipartisan 2016 OAA reauthorization.

CONCLUSION

Recognizing that Americans need support to navigate both health and economic security after age 65, NCOA has developed its own innovative approach called the Aging Mastery Program® (AMP). The 10-class in-person workshop and new at-home Aging Mastery® Starter Kit are a fun, engaging way to empower older adults to make their own personal pathway for aging well.

The program incorporates evidence-informed materials, expert speakers, group discussion, actionable goals, and small rewards to give participants the skills and tools to achieve measurable improvements. Topics covered include nutrition and fitness, sleep, relationships, economic health, civic engagement,

advance care planning, and more. The program encourages mastery — developing sustainable behaviors across many dimensions that lead to improved health, stronger economic security, enhanced well-being, and increased societal participation.

To date, more than 10,000 older adults have graduated from AMP, and results have shown that participants significantly increased their social connectedness, physical activity levels, use of advanced planning, and participation in evidence-based programs. The new in-home Starter Kit will bring the benefits of AMP to older adults who are socially isolated, live in rural communities, or cannot easily attend community-based classes. NCOA is optimistic that the Aging Mastery Program® will grow rapidly across the United States as community organizations, Medicare Advantage plans, and employers recognize its value and benefits.

After serving older adults for more than 67 years, NCOA knows that aging is not something you just let happen to you. Like your career decisions, your education decisions, your relationship decisions – aging well means making informed, deliberate choices.

As a society, we're not doing enough to help people prepare for and navigate their third stage of life. We don't teach them how their bodies are going to change as they age or how to manage their savings so it will last an extra 20 to 30 years. We teach young people how to become adults – but we don't teach older people how to age well. At NCOA, we offer tools and solutions to help people make smart choices to age on their terms.

We can't stop the inevitable. You, me, your parents. We're all aging. But that doesn't mean we have to be afraid of it – or pretend it's not happening. Instead, we can face it head on. And we can be prepared.

Statement of Dr. Mehrdad Ayati, M.D.

Dr. Mehrdad Ayati, M.D., is an Adjunct Assistant Professor of Medicine at Stanford University School of Medicine where he teaches and trains medical students, residents, fellows, and nurses in Geriatrics. Dr. Ayati is board certified in family and geriatric medicine. He joined the Stanford University School of Medicine in 2011 as a member of its faculty, where he taught and practiced Internal Medicine and Geriatrics prior to starting a private geriatric practice in 2016. Doctor Ayati is a member of the Ethnogeriatrics Committee of the American Geriatrics Society and serves as a Faculty Advisor for the Center on Longevity at Stanford University. He is a member of the Health Care Advisory Committee of Northern California and Nevada Chapter of the Alzheimer's Association and is the Geriatric Consultant on Aging Research Projects at SRI (Stanford Research Institute) International. He founded the Bay Area Senior Care Society. He has served as the Medical Director and Medical Advisor of multiple skilled nursing facilities in the San Francisco Bay Area in California. Dr. Ayati is the Founder of the Geriatric Concierge Center in Menlo Park, California, where he currently practices, and is co-author of the book *Paths to Healthy Aging.*

Before the
U.S. Senate Special Committee on Aging

Turning 65: Navigating Critical Decisions to Age Well

January 24, 2018

Executive Summary

Dear Madam Chair, Ranking Member, and distinguished members of the U.S. Senate Special Committee on Aging. Thank you for inviting and giving me the opportunity to discuss critical challenges regarding the aging population in the U.S. My name is Dr. Mehrdad Ayati. I am a board-certified Geriatrician and an educator. I am also board certified in Family Medicine. I am presenting myself as a physician who has treated and managed, and continues to treat and manage, thousands of senior Americans.

I would like to start with some statistics. Today, the number of Americans ages 65 and older is approximately 49 million. This number is estimated to grow to 98 million by 2060. Currently, there are about 7,000 geriatricians in practice in the United States, yet according to the Alliance for Aging Research, we should instead have 20,000 geriatricians—nearly three times our current number—just to accommodate the needs we have right now. By 2030, this group estimates that our country will need about 37,000 of these specialists.

Since 2011, approximately 10,000 Americans have been enrolling in Medicare every day. This aging population is faced with multiple challenges on the path to healthy aging. I would like to outline eight of these challenges briefly and suggest some directions for overcoming them.

There is a Lack of Experts in the Field of Geriatric Medicine and Gerontology

Unfortunately, our health care and education systems have not been designed to train enough senior care providers such as doctors, nurses, physician assistants, pharmacists, social workers, dementia experts, and physical and occupational therapist who can specifically manage seniors. As we age, our physiology changes. For example, absorption of drugs through our digestive system can be altered. Our liver function decreases, and it becomes harder for our body to metabolize and eliminate drugs. Changes in our circulatory and nervous systems affect our reactions to drugs. Therefore, we might need lower or higher doses of medications compared to other age groups. Additionally, there are medications that while working perfectly well for younger adults, should not be prescribed for the geriatric population. Therefore, it is crucial for the elderly to be managed by healthcare providers who have been educated and trained in this field. In the U.S., 80% of those 65 and older have at least one chronic condition (more than 3 out of 4) and 50% have two chronic conditions. Forty percent of the seniors take at least five medications, not taking into account over-the-counter supplements and herbal remedies. They see many different specialists and are prescribed a number of different medications through each. This situation can result in polypharmacy or over-medication, and even Drug Cascade Syndrome, where an undesirable side effect is misinterpreted as a medical condition and results in a new prescription. That is the reason why 4.5 million Americans visit the emergency rooms and physician offices each year. Adverse drug events account for a large number of hospital stays and deaths among the elderly. Therefore, there is a critical need for training more senior care providers.

There is a Dearth of Scientific and Research-backed Medical Information Regarding Healthy Aging

Despite the fact that we live in an era of advanced technology, with massive amounts of information on the subject of aging at our fingertips, the validity of much of such information is highly questionable. Our seniors are bombarded with contradictory claims, literature that is overly technical and hard to understand, recommendations that are impossible to follow, and often marketing-oriented myths about how to take care of themselves. They lack simple, straight forward, easy to follow information about aging on topics such as nutrition, mental and physical health, frailty, medications, finding the right physician, and end of life decisions. For example, misleading marketing campaigns at every corner are enticing our seniors to take drastic measures such as taking unregulated vitamins and supplements or undergo harmful diets to live longer and healthier. This is regardless of the fact that scientific data collected over many years indicate that such over-the-counter supplements and drastic diets are not contributing to better health and could even be detrimental to our health. Consequently, there is a critical need for reliable information, valid guidelines, and effective strategies so that senior can avoid or more effectively manage chronic diseases and have a better quality of life.

Very few clinical research and trials are designed for or even include older people, which consume majority of the pharmaceuticals currently available in the market. As such, the safety of most medications in the elder population is not well researched.

There is also a lack of academic and scientific research on the subject of aging. There is also an urgent need for the development of innovative tools to help the el-

derly stay in the comfort of their homes as long as possible and avoid spending time in nursing homes.

The Elderly are Becoming more Racially and Ethnically Diverse

In 2010, more than one in eight U.S. adults 65 and older were foreign born, a share that is expected to continue to grow. The U.S. elderly immigrant population rose from 2.7 million in 1990 to 4.6 million in 2010, a 70% increase in 20 years. It is estimated that the number of U.S. immigrants 65 and older will quadruple to more than 16 million by 2050. This increase is due to the aging of the long-term foreign-born population and the recent migration of older adults as part of family reunification and refugee admissions. In 2014, about 15% of people age 65 and older lived in a home where a language other than English was spoken. Currently, we lack the resources to address the challenges of this growing ethnic and racial groups. These challenges include language barriers, cultural differences, religious and belief differences, physiological factors such as genetic backgrounds, and financial inequalities.

We Live in an Anti-Aging Society

We are a youth-oriented society that is not properly focused on aging and the older generation. As people grow older, they need more attention, care, support, companionship, and love. We need to raise awareness about the needs of the elderly as well as the hardships they face and to promote the respect, gratitude and appreciation they deserve. All too often, older adults are forced out of the workforce and replaced by cheaper and unskilled labor. They may then retire to the solitude of their homes, where they can become isolated and lonely, and as a consequence, develop depression and cognitive impairment. Later, they may be institutionalized and set aside by the society they built and the children they raised. They can even be mistreated, cheated and taken advantage of.

We Need More Infrastructure and Resources

Our seniors face a lack of appropriate resources in the areas of transportation, affordable housing, senior centers, organized and affordable social activities, and qualified healthcare centers. These problems are magnified for those suffering from dementia. Currently five million Americans suffer from this condition, and in the next 15 years this number is expected to triple. However, we lack the dementia units as well as the professionally trained staff to provide care for this population.

Seniors are Experiencing Financial Difficulties

A large number of seniors are living in poverty. The recent global economic crisis of 2008, the collapse of the housing market and the astronomically high cost of healthcare in the U.S. are among the many factors contributing to the growth of debt among the elderly. Some of them are forced to forgo retirement and seek very low paying jobs, which they may still have a very hard time finding due to age discrimination. Often, they are faced with a hard choice between paying their mortgage, buying the many medications they can't survive without, or purchasing food. Too often, they become not only financially but also physical dependent on their children, which are known as the "sandwich generation" when they care for parents while at the same time raising their own children.

We Expect Quick Fixes

We live in a modern society where more is considered better. This kind of mentality tells us that for every single problem, there should exist a quick fix—even if there is no logic behind it. "Modern medicine" dictates that health issues should be resolved with either medications or interventions. But in reality, the statistics do not support this. The Congressional Budget Office in 2015 estimated that 5% of the nation's gross domestic product, $700 billion per year, goes to tests and procedures that do not improve health outcomes. Therefore, modern medicine, with its emphasis on attempted solutions rather than prevention, does not necessarily make happier and healthier citizens.

Medicare Expenditures Are Not Aligned With Needs

As the Medicare system is set up today, it does not pay for the medically necessary services, which can have tremendous impact toward a better physical and mental quality of life for adults. For instance, if an older adult needs more physical therapy to help with mobility or needs a necessary piece of equipment to have a better quality of life, it will be denied by Medicare. However, if the same person wants to undergo an expensive diagnostic test, the test will be quickly authorized. Unfortunately, as we discussed, many of these diagnostic tests do not change the quality of life for the elderly. Sometimes they do not even improve the management

of the disease. I see on a daily basis that Medicare would fully pay for diagnosing and treating my patient's cancer, even if it would extend their life for just a few weeks. However, Medicare would not pay a penny if the same patient needed help at home, nor would it pay if he/she required counseling to overcome anxiety and depression. I had a patient a few years back with advanced dementia in a nursing home. He also had advanced colon cancer. He could not eat, was in severe distress and could not recognize anyone. His life expectancy was less than 2 months. On one of his visits to the ER, his family members were instructed to consult with a cardiologist. The cardiologist advised them to get a pacemaker for him. They put a patient with advanced dementia and cancer under general anesthesia to give him a pacemaker. And Medicare paid for it. He died less than a month later.

Solutions

Expansion of Geriatric Education

A large number of the teaching physicians in the U.S. medical schools don't have the appropriate expertise or background in the field of Geriatrics. As a result, medical students, residents, fellows, and practicing physicians who currently treat the elderly lack the basic knowledge in the field of geriatrics. Therefore, too often the elderly are misdiagnosed and mismanaged. In contrast, in Great Britain, every medical school has a department of geriatrics, as do one-half of Japanese medical schools. Of the 145 U.S. medical schools, only 11 have geriatric departments (7.6%). Plus, the geriatric curriculum at over three-quarters of the U.S. medical schools is an elective, not a required field of study. As a consequence, many older Americans will not get the most knowledgeable care they need when they most desperately need it. In fact, it's already too late for a solution that involves training enough certified geriatricians. The experts admit this and offer an alternative solution. This solution hinges on creating enough geriatric educators to ensure that every new physician, of which there are over 16,000 per year, will have been sufficiently trained in geriatrics in medical school to know the differences between medical care for non-geriatric patients and medicine for the oldest of us. Another recommendation is that all primary care physicians and specialists should have mandatory training in the field of geriatrics as part of their CME (Continuing Medical Education). This rule should also be mandatory for nursing, advanced nursing and physician assistant practice education.

Earlier this year, the American Geriatric Society endorsed the Geriatrics Workforce and Caregiver Enhancement Act (H.R. 3713), a bipartisan proposal for programs addressing the shortage of health professionals equipped to care for the elderly. Introduced by Reps. Jan Schakowsky (D–IL), Doris Matsui (D–CA), and David McKinley (R–WV), the bill draws on considerable insights from the Eldercare Workforce Alliance (EWA), a collaborative comprised of more than 30 member organizations co-convened by the AGS and now reflecting the diverse expertise of millions of professionals who support health in aging for older Americans. The proposed legislation would codify into law and authorize funding for the Geriatrics Workforce Enhancement Program (GWEP). The GWEP is the only federal program designed to increase the number of health professionals with the skills and training to care for older adults.

Launched in 2015 by the Health Resources and Services Administration (HRSA) with forty-four 3-year grants provided to awardees in 29 states, the GWEP is helping geriatrics experts develop innovative local solutions. When approved, H.R. 3713 will authorize GWEP funding of more than $45 million annually through 2023, allowing current and future GWEP awardees to educate and engage with family caregivers, promote interdisciplinary team-based care, and improve the quality of care delivered to older adults. I hope this bill will be finalized soon, as this can be a big victory for our vulnerable older adults, allowing them to receive better care for their future. But this is only a beginning and we need more funding in the future.

Medicare Reimbursement Model

With the passage of the Affordable Care Act, the reimbursement basis is slowly shifting from a Fee for Service (FFS) structure to one which puts emphasis on improving performance and outcomes. However, the level of reimbursement is still not adequate. Geriatric counseling and geriatric assessments require time. Keep in mind that there is a shortage of geriatricians and there is a large population of geriatric patients with multiple chronic conditions on many medications. As such, the amount of time spent per patient needs to be long enough to be effective. However, at the current low reimbursement levels, geriatric professionals need to see many patients in a short timeframe to survive financially. Geriatrics is one of the lowest-paying specialties, and experts say this low pay and factors such as the high cost of living and office overheads as well as the long work hours are driving new physi-

cians away from the field. Increasing reimbursement fees for geriatric consultations would undoubtedly create more attraction for medical centers and doctors' offices to expand their geriatric care and hire more geriatric care providers. It would also allow the care providers to spend an effective amount of time with each patient to provide all the necessary assessments, management and education.

Expand Geriatric Consultation

One efficient way of properly taking advantage of the currently low number of geriatricians in the field is to use geriatricians as consultants rather than primary care providers for the elderly. To accomplish this, all healthcare providers could send their elderly patients for a geriatric consult at least once or twice a year. This would allow geriatric professionals to evaluate patients and their list of medications and make the proper recommendations to their primary care physicians and other specialists. It should also be made mandatory for primary care physicians to consult with a board certified geriatrician or a gero-psychiatrist for their patients suffering from dementia. Of course, a proper reimbursement method is necessary for this model to survive.

Medicare Annual Wellness Visits

Medicare has a comprehensive and well detailed annual wellness visit structure. Unfortunately, many physicians do not follow the well-established CMS annual wellness instructions. The majority of discussion time between patients and the physicians is spent on management of high blood pressure, high cholesterol, refill of medications, and/or vaccinations. Although these are relevant topics which need to be well addressed, this annual wellness visit should in addition include a thorough geriatric assessment and evaluation. This includes screening for depression, discussing nutrition, and screening for memory loss. It should also include discussing goals of care and life preferences. Primary care physicians should consult geriatricians during these CMS annual wellness visits to properly assess their older patients.

Coordination of Care

Bringing together a team of health care providers, with a geriatrician at the center, and working closely with the senior patients, family caregivers, primary care physicians, specialists, case managers, and other care professionals is of essence to ensure healthy aging. This team can coordinate individual needs, synchronize the variety of short-term and long-term medical services, improve health care access and outcomes, support and improve communication resulting in improved individual well-being and health outcomes.

Physical Health of our Older Adults

Frailty is defined as a progressive deterioration of multiple body systems resulting in physical and functional decline. It is characterized as a drop in the body's energy production and utilization as well as a deterioration of its repair systems. It can occur at any age but is much more prevalent in the elderly. As we grow older, we eventually lose about 40% of our muscle tissue. Unfortunately, as we discussed, our seniors lack the basic infrastructure to stay healthy and fit. For example, there is a lack of senior-friendly exercise centers in this country. Such centers should have suitable equipment designed for seniors and have certified trainers who can help them stay physically strong, and to prevent, slow, or reverse the development of frailty. Seniors also need transportation systems to reach such physical and social centers.

We also need more effective, continuous adult education in medical centers, physician offices, media, and public programs about the importance of exercise for older adults. It is essential that providers be honest with their patients and explain to them that medications and procedures alone are insufficient: they must be accompanied by regular physical activity in order to maintain their mental and physical well-being.

Mental Health of our Older Adults

Mental health is the most important aspect of healthy aging. As we discussed, people in this group are highly susceptible to becoming lonely and isolated and to suffer from depression and/or anxiety. Unfortunately, this will lead them toward increased cognitive impairment and disability over time. Data is showing that loneliness in the elderly is associated with the use of psychotropic drugs. Further, seniors who feel lonely and isolated are more likely to report having poor physical and mental health, as indicated in a 2009 study using data from the National Social Life, Health, and Aging Project. It is therefore essential to expand senior day center programs providing intellectual stimulation, extend adult educational programs, and

increase community support for the seniors. There is also a strong need for social engagement and interaction centers for the elderly. We should also develop mechanisms to help our older adults to engage in voluntary programs in their community.

Another important factor is the lack of professional geriatric counselors or therapists who can treat depression and anxiety in this population. Medicare does not currently provide funding to support geriatric counseling or psychotherapy. Consequently, depressed seniors are only to receive pharmacological treatment options. Furthermore, with the increase of ethnic and racial groups in the U.S., there is a crucial need for therapists with different cultural and language backgrounds.

Nutrition

Proper diet and nutrition are essential factors for health. Unfortunately, many of our seniors are looking for the best supplement that could act as a magic solution for better health. Sadly, this unfounded belief in the power of supplements has become a practice model in our society and is gradually replacing the healthy diet for this population.

As we age, we lose bone mass, muscle, and water content while increasing fat content. Other physiological factors such as losing taste buds and sense of smell, dental issues, lack of companionship, medical and psychological illness, and stress also result in weight loss. Many medications also cause loss of appetite and weight loss. Medical and social education for this group should put emphasis on proper hydration, maintaining a balanced diet, practicing mindful eating, avoiding fad diets, and not relying on over-the-counter supplements and herbal remedies. Social support programs providing meals for older adults are crucial. Eating meals in senior centers can help not only nutrition but also help to avoid loneliness in this group.

Polypharmacy and Drug Cascade Syndrome

As discussed before, prescribing for older patients offers unique challenges. A periodic evaluation of the drug regimen that a patient is taking is an essential component of the medical care of an older person. Such a review may indicate the need for changes to prescribed drug therapy. These changes may include discontinuation of a treatment prescribed for an indication that no longer exists, substitution of a required treatment with a potentially safer agent, reduction in the dosage of a drug that the patient still needs to take, or an increase in dose or even addition of a new medication. An interdisciplinary geriatric team will be the best group to help our older adults avoid the negative impacts of polypharmacy. It is essential that all medical centers follow Beers criteria. These are guidelines for healthcare professionals to help improve the safety of prescribing medications for older adults.

Physicians who have not been trained enough in the geriatric field should avoid prescribing psychotropic medications for dementia-related behavioral disturbances. These medications have very serious side effects such as confusion, disorientation, hallucinations, seizures and delirium, and memory loss. In the elderly, they can result in falls and death.

Through medical and social media, it is essential to educate the seniors and their care givers to have a current list of their illnesses and their medications, including the dosage, and to share that list with all their physicians and pharmacists. Patients and their caregivers are often unaware of the reasons why some of their medications have been prescribed. Patients should question their physicians thoroughly about each of the medications prescribed for them. They should ask what side effects to look out for.

They should also ask their physicians to ensure that any new medications do not interact with or inactivate their existing medications. The public should also be aware that over-the-counter medications, vitamins, antioxidants, supplements and herbal remedies are not necessarily safe to use and can interact with their existing medications.

Conclusion

A joint effort involving better public education, widespread training of caregivers in the field of geriatrics, and changing Medicare and government regulations is required to ensure that the growing wave of seniors live healthier and happier lives.

I would like to thank the Senate Special Committee on Aging for giving me the opportunity to discuss healthy aging and the challenges currently faced by the aging population in the U.S. as well as offering solutions.

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Prepared Statement of Sharon Hill, Apprise Volunteer, State Health Insurance Assistance Program, Vanderbilt, Pennsylvania

Chairman Collins, Ranking Member Casey, and Members of the Committee, thank you for inviting me to testify today. It is an honor to be here.

My name is Sharon Hill. I am 63 years old and a resident of Vanderbilt, Pennsylvania. I have two sons and six grandchildren, with a seventh due any day. My granddaughter, August, has joined me here today. I am a volunteer with the Pennsylvania APPRISE program. Nationally, APPRISE is also known as the State Health Insurance Assistance Program or SHIP.

In addition to volunteering with the APPRISE program, I work cleaning my church. I also care for my 89-year-old father and help care for my 92-year-old neighbor, who is blind. I have a disability and rely on the support of state and federal programs to remain active and engaged in my community.

I have been an APPRISE volunteer for 4 years. I initially saw an ad in our local senior newspaper, called the Senior Times News, asking for volunteers to help people with Medicare issues. At that time, I was on Medicare due to a disability and had recently been left with $67,000 in medical bills after a cancer diagnosis. I also recalled the difficult decisions my parents had to make about their Medicare coverage. Both events were behind my interest in volunteering for the APPRISE Program.

To be an APPRISE volunteer I had to attend many training sessions. At these sessions, I learned about the different parts of Medicare, including Medicare Part A, Part B, Part C, Part D as well as Medigap. I also learned about programs that can help low-income seniors and people with disabilities, like Medicare Extra Help, and even Pennsylvania-specific programs that help individuals who have high medical expenses. I was trained on how to use the computer system and enter information into Medicare Plan Finder. Each year we receive a refresher training to provide volunteers with updated information.

The more I learned, the more I realized I did not know. People have a lot to consider when signing up for Medicare, and the decisions can be daunting. I wish I would have known about these resources sooner, because had I known that programs like this existed, I do not think I would have faced the hardship that I described.

It is because of my own experiences that I am passionate about the APPRISE program. APPRISE is the only place that older adults can go, in person, to get unbiased information to help with their Medicare decisions. As a volunteer, I give speeches at local senior centers and provide in-person counseling sessions. Each counseling session is 60 to 90 minutes long, and during Medicare open enrollment season, we are very busy.

Sometimes people come in with specific questions about their coverage and other times we are starting with the basics. It is common for people to make Medicare coverage decisions based on the well-intended advice of friends, family, or others. What I have learned during my time as an APPRISE volunteer is that people do not have all the information they need to make the best decisions for their health care or financial needs.

Making a bad decision when signing up for Medicare can have unintended, lifelong consequences. When I see people with gaps in coverage or seniors paying lifelong penalties, it is often because of misinformation. Knowledge is important in helping beneficiaries maximize their benefits and avoid the pitfalls of life-long penalties.

Thankfully, as an APPRISE counselor, I am trained to help those that are having trouble with their Medicare due to misinformation. We can liaison with organizations to appeal a decision or screen people for programs that help cover the cost of their medication. APPRISE counselors not only provide information, they help beneficiaries navigate a complex system and serve as advocates. We also find that once people come to APPRISE for help, they come back each year to be sure their coverage is right for them.

People's lives are changing and they need to be educated or they will fall through the cracks. It is because of this that I tell everyone I meet about the program. APPRISE counselors do not make Medicare decisions for beneficiaries, we instead provide them with information to make the best choices for themselves.

Again, thank you for the invitation to testify before the Committee. I look forward to answering your questions.

Additional Statements for the Record

Medicare Rights Center Support Letter for the BENES Act

December 19, 2017

The Honorable Mitch McConnell
Majority Leader, U.S. Senate
Washington, DC 20510

The Honorable Chuck Schumer
Minority Leader, U.S. Senate
Washington, DC 20510

The Honorable Paul Ryan
Speaker, U.S. House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader, U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader McConnell, Minority Leader Schumer, Speaker Ryan, and Minority Leader Pelosi:

The undersigned organizations share a commitment to advancing the health and economic security of older adults, people with disabilities, and their families. Together, we represent the 57+ million Americans who rely on Medicare. We need your commitment to pass the bipartisan Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (S. 1909; HR 2575) by the year's end. This bi-partisan, bi-cameral legislation is urgently needed to improve Medicare Part B enrollment, and to modernize the now-outdated 1965 law to align with changes in the Social Security and Medicare Advantage laws. The legislation has widespread support from everyone from MA Plans to beneficiary advocacy groups, and needs your support now.

The basic rules underpinning the Part B enrollment system were developed more than 50 years ago, when Medicare was first established. The BENES Act offers long-overdue solutions to modernize and simplify Part B enrollment. Through bipartisan, low-cost reforms, the BENES Act shields people with Medicare from steep premium penalties and fills needless gaps in coverage.

Knowing whether and when to enroll in Part B requires that a person understand when to sign up during time-limited windows, how their other insurance will work with Medicare, and what penalties may result if enrollment is delayed. The consequences of missteps can be significant and include higher out-of-pocket costs, significant gaps in coverage, and lifetime penalties.

In 2014, 750,000 people with Medicare were paying a Part B Late Enrollment Penalty (LEP) with the average LEP amounting to nearly a 30% increase in a beneficiary's monthly premium.[1] In addition to this considerable penalty, many retirees and people with disabilities face large out-of-pocket health care costs, gaps in coverage, and barriers to care continuity because of honest enrollment mistakes.

The BENES Act significantly alleviates these challenges. It fills long-standing gaps in notice and education for those approaching Medicare eligibility and aligns and simplifies enrollment periods, bringing Part B rules in line with Medicare Advantage and Part D rules. Together, these changes will help prevent costly enrollment slipups among the 10,000 people becoming Medicare eligible each day. For these reasons, we strongly support the BENES Act, and we believe it should be a priority for Congress.

Far too many people with Medicare are irreversibly harmed due to a cumbersome and confusing Part B enrollment system. The BENES Act presents an important opportunity for members of Congress to advance

[1] P. Davis, "Medicare: Part B Premiums," (Congressional Research Service: August 2016), available at: https://fas.org/sgp/crs/misc/R40082.pdf

commonsense, bipartisan, low-cost reforms that are in the best interest of the many millions of Americans who will soon come to rely on Medicare. Thank you.

Sincerely,

ACCSES
Aetna
AgeOptions
Aging Life Care Association
Alliance for Aging Research
Alliance for Retired Americans
AMDA – The Society for Post-Acute and Long-Term Care Medicine
American Association on Health and Disability
American College of Clinical Pharmacy (ACCP)
American Federation of Government Employees (AFGE)
American Foundation for the Blind
American Geriatrics Society
American Society on Aging
Association of University Centers on Disabilities (AUCD)
Austim Society of America
B'nai B'rith International
Better Medicare Alliance
Blue Shield of California
BlueCross BlueShield Association
Brain Injury Association of America
California Health Advocates
Center for Independence of the Disabled
Center for Medicare Advocacy, Inc.
Community Catalyst
Compassion & Choices
Dialysis Patient Citizens
Disability Rights Education and Defense Fund (DREDF)
Disabled In Action of Metro NY
Empire Justice Center
Epilepsy Foundation
Families USA
Family & Children Association, Senior Services HIICAP
Gerontological Society of America
International Association for Indigenous Aging
International Union, United Automobile, Aerospace & Agricultural Implement Workers of America
The Jewish Federations of North America
Justice in Aging
Lakeshore Foundation
LeadingAge
Lutheran Services in America

MAXIMUS
Medicare Rights Center
Metro New York Health Care for All
National Academy of Elder Law Attorneys (NAELA)
National Active and Retired Federal Employees Association (NARFE)
National Adult Day Services Association (NADSA)
National Adult Protective Services Association (NAPSA)
National Association for Home Care & Hospice (NAHC)
National Association of Area Agencies on Aging (n4a)
National Association of Health Underwriters (NAHU)
National Association of Nutrition and Aging Services Programs (NANASP)
National Association of Social Workers (NASW)
National Association of State Head Injury Administrators
National Association of State Long-Term Care Ombudsman Programs (NASOP)
National Coalition on Health Care (NCHC)
National Committee to Preserve Social Security and Medicare
National Consumer Voice for Quality Long-Term Care
National Consumers League
National Council on Aging (NCOA)
National Partnership for Women & Families
New York Legal Assistance Group
New Yorkers for Accessible Health Coverage
Partnership to Improve Patient Care (PIPC)
Patient Advocate Foundation
Service Employees International Union (SEIU)
Smart Policy Works (formerly Health & Disability Advocates)
Social Security Works
Southern Tier Independence Center (STIC)
The Arc of the United States
The National Multiple Sclerosis Society
Third Way
UAW Retiree Medical Benefits Trust
United Jewish Organizations of Williamsburg
Women's Institute for a Secure Retirement (WISER)

CC: The Honorable Orrin Hatch, Chairman, Senate Committee on Finance
The Honorable Ron Wyden, Ranking Member, Senate Committee on Finance
The Honorable Greg Walden, Chairman, House Committee on Energy & Commerce
The Honorable Frank Pallone, Ranking Member, House Committee on Energy & Commerce
The Honorable Kevin Brady, Chairman, House Committee on Ways & Means
The Honorable Richard Neal, Ranking Member, House Committee on Ways & Means

Centers for Medicare & Medicaid Services Support Letter for the BENES Act

August 22, 2016

The Honorable Orrin Hatch
Chairman, Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
U.S. Senate
Washington, DC 20510

The Honorable Kevin Brady
Chairman, Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Sander Levin
Ranking Member, Committee on Ways & Means
U.S. House of Representatives
Washington, DC 20515

The Honorable Fred Upton
Chairman, Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member, Committee on Energy & Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Hatch, Ranking Member Wyden, Chairman Brady, Ranking Member Levin, Chairman Upton, and Ranking Member Pallone:

As former Administrators of the Centers for Medicare & Medicaid Services/Health Care Financing Administration, Republicans and Democrats, we frequently disagree among ourselves about any number of issues. But we all agree on the importance of treating Medicare beneficiaries fairly, efficiently, and as helpfully as possible. That's why we have come together in support of the bipartisan Beneficiary Enrollment Notification and Eligibility Simplification (BENES) Act (S. 3236 and H.R. 5772).

Many of the problems addressed by the BENES Act did not exist when most of us were in the government, but the decoupling of eligibility ages for Medicare and full Social Security benefits, revisions to Medicare Secondary Payor law, and the growing number of Americans working past the age of 65 have, together, substantially complicated the decision making process for eligible individuals and couples in deciding when and how to enroll in Medicare.

Signing up for Part B is not a straightforward task, particularly for the increasing share of Americans who are working longer and delaying retirement. For these individuals, knowing when and whether to enroll in Part B requires understanding complex and varied rules. Enrollment missteps are a common occurrence and often lead to a lifetime of higher Part B premiums. In 2014, 750,000 people with Medicare were paying a Part B Late Enrollment Penalty (LEP) and the average LEP amounted to nearly a 30 percent increase in a beneficiary's monthly premium.[1] Gaps in coverage, higher health care costs, and limited access to needed care are also consequences experienced by those who make honest enrollment mistakes.

To prevent costly enrollment errors among people new to Medicare, the BENES Act provides enhanced notice and education for those approaching Medicare eligibility, aligns and simplifies Part B enrollment periods, and updates existing mechanisms for those seeking reprieve from Part B premium penalties and coverage delays. We encourage you to support the BENES Act.

Thank you.

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[1] P. Davis, "Medicare: Part B Premiums," (Congressional Research Service: August 2016), available at: https://www.fas.org/sgp/crs/misc/R40082.pdf

Sincerely,

Leonard D. Schaeffer
Administrator
Health Care Financing Administration
1978 – 1980

William L. Roper, MD, MPH
Administrator
Health Care Financing Administration
1986 – 1989

Gail R. Wilensky, Ph. D.
Administrator
Health Care Financing Administration
1990 – 1992

Bruce C. Vladeck, Ph. D.
Administrator
Health Care Financing Administration
1993 – 1997

Nancy-Ann DeParle
Administrator
Health Care Financing Administration
1997 – 2000

Tom Scully
Administrator
Centers for Medicare & Medicaid Services
2001 – 2004

Mark McClellan, MD, Ph. D.
Administrator
Centers for Medicare & Medicaid Services
2004 – 2006

Donald M. Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
2010 – 2011

CC: The Honorable Mitch McConnell, Majority Leader, U.S. Senate
The Honorable Harry Reid, Minority Leader, U.S. Senate
The Honorable Paul Ryan, Speaker, U.S. House of Representatives
The Honorable Nancy Pelosi, Minority Leader, U.S. House of Representatives

BETTER MEDICARE
ALLIANCE

STATEMENT FOR THE RECORD

Submitted to the Special Committee on Aging

United States Senate

Hearing On

Turning 65: Navigating Critical Decisions to Age Well

January 24, 2018

Better Medicare Alliance
1090 Vermont Avenue, N.W.
Suite 1250
Washington, DC 20005
http://bettermedicarealliance.org

Better Medicare Alliance (BMA) is a broad alliance of more than 100 organizations, including doctors and other professional health care providers, health systems, aging service agencies, business groups, retiree organizations, health plans as well as beneficiaries. Collectively, we support and advocate for Medicare Advantage and the innovative, quality care it delivers. BMA works to ensure the Medicare Advantage program is stable, accessible, high quality, cost effective, and financially viable through the ongoing support of policymakers. We achieve these goals through information, research, education, commentary on policy, and advocacy.

We applaud the Committee for its hearing to discuss the important decisions older Americans must make as they approach age 65. Turning age 65 is a considerable milestone and momentous occasion for Americans, a point at which they generally have the opportunity to enroll in Medicare in a timely manner.

In the US, over 48 million Americans are age 65 or older, a number that is increasing rapidly. This population is projected to nearly double by 2050 making them the fastest growing group in the US, dominated by the Baby Boomers (born from 1946 to 1964), who are reaching retirement and Medicare eligibility. Thus, efforts to support older adults age successfully with optimal health outcomes, access to quality care, financial stability, and tools to make decisions independently have become a priority.

Approximately 10,000 Americans turn 65 and become eligible for Medicare each day and understanding the decision points and coverage options of Medicare can be an overwhelming, isolating experience if older adults and people with disabilities do not have timely, accurate, accessible and understandable information about their important health coverage choices.

This trigger of age 65 and the years leading up to it presents a number of key considerations for which older Americans must plan; including the ability to manage health care expenses through suitable and adequate health coverage; the ability to determine health needs and understand treatment options; and the ability to make sound health care decisions given available financial resources.

Medicare Advantage — also known as Medicare Part C — is an option within Medicare that provides the same benefits and services as Traditional Fee-for-Service Medicare, under a managed care model. Offered and administered by private health insurance providers, Medicare Advantage is the preferred choice of health coverage for 20 million seniors — one in three Medicare beneficiaries — in large part because of the affordability, value, high-quality care and additional benefits these plans provide.

Medicare Advantage's framework focuses on preventive care – which means fewer hospitalizations – and incentivizes innovation and value-based care models. Plan offerings often include additional cost-effective services and coverage that seniors highly value like prescription drugs, vision, hearing, dental, disease management, fall prevention programs, nurse help hotlines, nutrition support, and wellness care. Surveys indicate that 92 percent of beneficiaries are satisfied with the quality of care they receive, their health insurance plans, and their benefits.

Medicare Advantage protects seniors' financial health, too. Unlike Traditional Fee-for-Service Medicare, Medicare Advantage caps out of pocket costs — helping protect seniors and disabled beneficiaries from potential catastrophic health care expenses that could threaten their financial security.

Choices for Medicare Coverage

BMA has engaged in considerable work over the past year with more than 300,000 beneficiaries to gauge beneficiary understanding of their health insurance coverage options upon turning 65, and to improve public educational materials so that they can make the most suitable choices for their near- and longer-term health care needs.

Currently, there are over 100,000 Medicare Advantage beneficiaries who have signed up to be BMA Advocates. Our beneficiaries are racially, socio-economically, and geographically diverse with beneficiaries represented in both rural and urban areas across the country. In addition to the beneficiaries in our email database, BMA also has 300,000 followers on Facebook and we see about 1,000 posts from advocates every week.

We also have a task force of BMA Ambassadors who are our most engaged Medicare Advantage advocates. There are 483 beneficiaries who have joined this task force who we interact with daily.

We engage our beneficiaries in a number of ways including: educating them on Medicare Advantage, conducting surveys, collecting stories, and posting other advocacy activities on our website including sending letters to the editor and contacting representatives in Congress. BMA advocates have made over 10,000 calls to Congressional offices and wrote personal letters to CMS and their Members of Congress on Medicare Advantage, joined telephone town halls, signed petitions and joined BMA on Capitol Hill.

The Medicare program has complicated rules about how other health insurance interacts with, or "coordinates" with Medicare coverage. This includes health insurance that someone has because of current, active

employment. In certain circumstances, individuals can stay on their employer-based health coverage and forego enrolling in Medicare Part B without penalty, until they retire. Unfortunately, people are often unaware of these complicated rules or get mis-information about how they work. As a result, they may have to pay premium penalties and may face many months, or longer, without access to Part B coverage.

That is why BMA is pleased that Ranking Member Casey has led the introduction of and Chairman Collins has cosponsored the bipartisan BENES Act (S. 1909 / H.R. 2575), legislation aimed at simplifying and modernizing the Medicare Part B enrollment process. We urge Congress to take up and swiftly and pass the BENES Act in order to help older Americans avoid inadvertently incurring fees and penalties for late enrollment.

Part A and Part B Is Not the Only Choice

Most Americans believe that simply enrolling in Medicare Part A and Part B (Fee-for-Service) Medicare completes their decision-making process. And while this is an important step for timely enrollment and planning health insurance coverage options, it is by no means the completion of the process.

A recurring theme in BMA's beneficiary engagement and work with policymakers is the importance of explaining to beneficiaries **in addition to** Medicare Part A and Part B enrollment they have a **choice** in how they receive their Medicare coverage. Omission of Medicare Advantage or failure to accurately explain the option of Medicare Advantage is an issue that policymakers and public educational materials should resolve.

In fact, research conducted in 2017 by Morning Consult on BMA's behalf, a national survey of 2,000 adults over age 65 found that many seniors do not know there are other important choices to make, nor do they understand the different options they have. Specifically, the survey found that:

- 43% of adults 65+ are not familiar with Medicare Advantage.
- 59% of adults 65+ are not confident that they know the difference between Medigap and Medicare Advantage.
- Only 2% of adults 65+ use the Medicare Plan Finder tool to research Medicare enrollment options.
- Only 50% of adults 65+ said that the option of Medicare Advantage was made clear to them.
- 41% experience confusion in finding the best type of Medicare Advantage plan for their needs.

BMA believes that in order for beneficiaries to make the best choice for themselves as they enroll in Medicare, they deserve easily accessible, clearly understandable information on the choices available to them.

There is a notable lack of information in the material that the Social Security Administration (SSA) sends to would-be beneficiaries in advance of their turning age 65. In SSA's letter sent to near-65 year old soon to be beneficiaries the basic steps for enrollment in Medicare Part A and Part B is clear. However, there is no mention of the choice between Fee-for-Service Medicare and the option of Medicare Part C (Medicare Advantage). BMA believes this should be remedied.

BMA was pleased that the Centers for Medicare & Medicaid Services (CMS) undertook a number of positive changes to the "Medicare & You 2018"

Handbook to better communicate the availability, as well as the differences and benefits, of the option of Medicare Advantage.

We welcomed the opportunity to propose changes to the Handbook and the Welcome to Medicare package when CMS called for public input in 2017. Our feedback included suggestions to add more charts, tables, and illustrations to clarify information on coverage options, provide more information on the out-of-pocket spending limit in Medicare Advantage, update language and placement to better explain Medicare Advantage, and additional information on specialized care and benefits available under Medicare Advantage. We appreciate that a number of these improvements were adopted in the 2018 Handbook, and we look forward to working further with CMS and other stakeholders to build on these changes to clarify the choices for beneficiaries. BMA also provided recommendations to CMS Planfinder and is working in corporation with other stakeholders engaged in this process.

Experience has shown that older adults learn and process information on health coverage differently than younger adults. In addition to one's personal health literacy, presentation of enrollment options, reading level of written materials, formatting, and source of information all influence older adults' understanding of their Medicare coverage options. Improving readability and comprehensibility of the information sent to beneficiaries — especially those who may have low health literacy — are all essential.

BMA Convening on Medicare Beneficiary Understanding of Choices

In December 2017, BMA brought together a group of approximately 50 thought leaders, including beneficiary advocates, researchers, health plans, practitioners, community partners and policymakers, to discuss how to

improve consumers' understanding of Medicare coverage options, particularly Medicare Advantage. The meeting discussion focused on three topic areas: (1) assessing the Medicare population's educational needs; (2) discussing currently available educational resources on Medicare coverage options and educational gaps; and (3) developing recommendations for improving education and decision-making tools for Medicare beneficiaries. Overall, stakeholders agreed that educational materials must be improved to engage and assist Medicare beneficiaries in making optimal coverage decisions.

BMA would welcome sharing with the Committee a copy of the final report from our Convening, but we wish to highlight for the Committee three key take-aways:

- Overall, there was broad stakeholder consensus at the convening that improving outreach, education, and decision-making tools for Medicare beneficiaries must be a priority for the Administration, policymakers, and advocates.
- Stakeholders agree that CMS should be conducting additional outreach to beneficiaries on choosing Medicare coverage, particularly the choice of Medicare Advantage.
- Recommended changes described in the report include readily doable action, as well as those that require public investment.

BMA also commends the Committees attention to the valuable role that Medicare State Health Insurance Assistance Program (SHIP) counselors play in helping older Americans navigate their health insurance coverage options.

SHIPs provide local, in-depth, insurance counseling and assistance to Medicare beneficiaries, their families and caregivers. This encompasses a broad range of areas, including coverage options, fraud and abuse issues, billing problems, appeal rights, and enrollment in low-income protection

programs. BMA urges Congress to continue adequate funding for the Medicare SHIP counselor program, so that these important community resources can continue to advise, educate, and empower individuals to navigate the complex Medicare program including adequate training on the choice of Medicare Advantage.

BMA again thanks the Committee for holding this timely and necessary forum. Ensuring that Americans turning 65 have easy access to timely, accurate, understandable public educational materials about their Medicare coverage options is an ongoing process. While Medicare Advantage may not be the right coverage choice for everyone, it is clear that it is a growing and important choice of meaningful coverage and health services 20 million Medicare beneficiaries. BMA and our ally organizations are proud to be strong advocates for Medicare Advantage and continues to lead the way in integrated and coordinated care delivery, improved health outcomes, lower costs, and provider payment models that reward value over volume.

We look forward to working with the Committee and serving as a resource as you consider policy options addressing these important issues.