SOCIETY OF ACTUARIES
SOCIAL INSURANCE & PUBLIC FINANCE SECTION

Chairperson's Corner

By Greg Fann

How do I start? 2020 has a been a good year for the Social Insurance and Public Finance (SIPF) Section Council. Like everything else this year, it has not turned out exactly as we planned, but it was a year of accomplishments and a year of transition. During our face-to-face meeting in January, we reviewed Section Member statistics and learned that 46 percent of us list "health" as our primary area of practice and 25 percent list "retirement." Throughout the year, we expanded section activities and added more health-related content and plan to continue strengthening that effort in 2021.

To no one's surprise, the staff at the Society of Actuaries (SOA) have been a valuable partner throughout the year. Our section specialist, Dee Berger, has been with us the entire time and helped us navigate through the newfound circumstances. Retirement staff fellow Mary Stone retired (no pun intended) during the summer and her warmth and friendliness have been missed. SOA leaders Mike Boot and Joe Wurzburger have participated in monthly calls and have kept us abreast of the changing dynamics this year and what to expect as we move into next year.

A sampling of 2020 highlights include:

- Multiple webcasts were recorded including sessions on "Social Security Coverage for State and Local Government Employees" and "Pension Risk Appetite."
- The council hosted a town hall session. Flick Fornia moderated the event and council members Paul Angelo and Tom Vicente were two of the seven expert participants.
- We published four issues of *In The Public Interest*. Our editors Bruce Schobel and Tom Vicente recruited authors to cover a wide range of topics, including Social Security, pension plan assumptions, Long-Term Care, COVID-19 and ACA market dynamics.
- SOA Board member Flick Fornia and I have hosted frequent podcasts, with recent discussion of the impact of COVID-19 on Social Security and in ACA markets.
- We are providing two sessions this year at the SOA annual meeting. Steve Goss, chief actuary at the Social Security Administration, and Bruce Schobel will be presenting on the Social Security update on Monday. Brian Blasé, a former health care advisor to President Trump, and I will discuss the health care initiatives of the presidential candidates on Wednesday.

To keep up with everything going on with the section, a good place to start is on the section's webpage. It is managed by Stephanie Entzminger and updated quarterly. The resources page on the website includes various research articles and a link to each of our podcasts. We will continue recording podcasts with roughly the same frequency. Flick Fornia will continue to manage the pension-related podcasts and Chris Merkel will take the lead on the health podcast. Let them know if you have any content suggestions or would like to volunteer for a discussion. On that note, everything we do is dependent on volunteers. If you are interested in learning about volunteer opportunities, you can sign up using the SOA Volunteer Database. Michael Stephens is our volunteer liaison and would love to connect with you.

As the year comes to a close, we are indebted to three council members who will complete their three-year terms this month. I want to extend appreciation to Janet Cranna, Douglas Fiddler, and Jim Rizzo. We appreciate their valuable service and trust they will remain connected.

I am excited to welcome newly elected council members Piotr Krekora, Bruce Schobel and Marilyn McGaffin. Piotr and Bruce are both former council chairs with an abundance of section-related knowledge and have been active council friends. Marilyn and I served together on the Health Section Council and I am delighted that she is bringing more health expertise to the SI&PF Council.

If you have ideas or suggestions for the council, please reach out to me or other council members. I am looking forward to a fantastic year. ■

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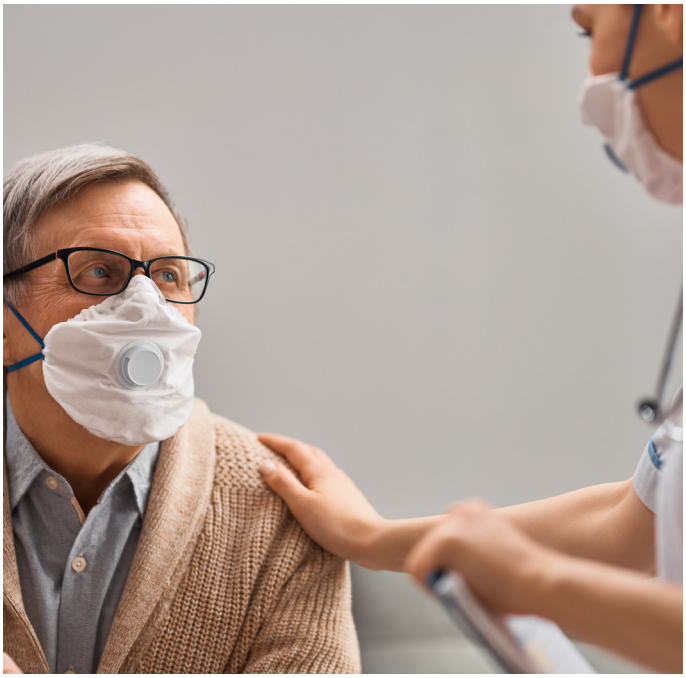
The Future of Post-Acute and Long-Term Care

By Stephanie Entzminger



Nursing homes are facing an unprecedented crisis. Over 80 percent of nursing homes in the U.S. have reported at least one COVID-19 infection among staff or residents.[1] Over 20 percent of nursing homes reported staff shortages in August. And as of Sept. 1, COVID-19-related deaths in long-term care (LTC) facilities[2] comprise the majority of documented deaths from the disease in 22 states, even though fewer than 1 percent of the U.S. population resides in LTC facilities.[3]

As an example of the disproportionate COVID-19 mortality burden attributable to LTC facilities, consider Idaho. As of Aug. 28, COVID-19 cases associated with long-term care facilities comprised about 7 percent of documented cases in Idaho (confirmed and probable). Deaths associated with these facilities, however, comprised 54 percent of reported COVID-19 deaths.[4]

But the COVID-19 caseloads and mortality rates are not the only crises facing nursing homes. There are myriad downstream complications of the COVID-19 pandemic: decreased revenue, increased expenses, and staffing shortages are all prevalent in facilities across the country.[5] These financial and safety-related issues are dramatically impacting the lives of two of America's most vulnerable populations: Medicare and Medicaid beneficiaries.

Nursing homes[6] serve two broad constituencies: short-term patients who need skilled nursing care following a hospital stay (called "post-acute care"), and long-term patients who need help with activities of daily living in addition to skilled nursing care. The first group of patients is generally funded by Medicare,[7] while the second group of patients is generally funded by Medicaid. Over 60 percent of nursing home residents are covered through Medicaid,[8] though the cost of their care is often subsidized by revenue from patients with private insurance, Medicare, or self-paid.

The spread of SARS-CoV-2 is clearly already impacting the lives of Medicare and Medicaid beneficiaries in nursing homes, as evidenced by the number of facility-related deaths as well as the strict visitation limits and infection prevention and control protocols currently in place in most nursing homes.

But what will be the lasting impact of the COVID-19 pandemic on nursing homes? How will those changes affect the delivery of post-acute and long-term care services? And how will this all affect Medicare and Medicaid beneficiaries who require these services?

Below, I'll investigate these questions in two parts. First, I will focus on the ways in which pandemic-spurred changes to nursing homes might affect Medicare beneficiaries. Second, I will address the ways in which COVID-19's impact on nursing homes might affect Medicaid beneficiaries.

NURSING HOME ISSUES AFFECTING MEDICARE BENEFICIARIES

The nursing home issues predominantly affecting Medicare beneficiaries are payment reform and telemedicine advances. Payment reform will encourage providers to discharge Medicare patients straight home after a hospital stay rather than

to a nursing home. This trend may be further encouraged by enhanced use of telemedicine for post-acute care.

Payment Reform

The COVID-19 pandemic is accelerating hospitals' shift away from traditional fee-for-service (FFS) contracts, with major downstream impacts on nursing home revenue sources.

Hospitals' shift away from FFS and toward alternative payment models (APMs) was already in effect for many years prior to the pandemic. Per the Health Care Payment Learning and Action Network, 62 percent of health care payments in the U.S. were paid under a traditional FFS model in 2015, while in 2018 that proportion was only 39 percent.[9] The movement away from FFS payment has advanced under all payers—commercial, Medicaid, and Medicare. It has been further spurred by the introduction of Accountable Care Organizations through the Affordable Care Act as well as by provisions in the Medicare Access and CHIP Reauthorization Act (MACRA), among many, many other public and private initiatives.

Momentum was already clearly in favor of APMs before COVID-19 hit. But then the COVID-19 pandemic exposed huge fault lines in the FFS model. FFS payments are a function of volume of services provided, so when procedures were canceled in droves in the spring, hospitals' revenue dried up. On top of that, the COVID-19-driven recession has caused millions to lose their employer-based health insurance coverage.[10] This loss is driving a shift in payer mix from commercial reimbursement to payment from Medicaid, the individual market, and self-pay/uninsured patients. Commercial payers tend to have higher contractual rates with hospitals than any other payer type. As such, a drop in the share of commercial business implies that, even if the volume of services returns to pre-pandemic levels, hospital revenue will fall. For these reasons, industry stakeholders are now calling to accelerate the movement toward APMs.[11]

There is evidence that some hospital-centric APMs may incentivize lower utilization of nursing homes[12] by Medicare beneficiaries. For example, the largest driver of savings in a study of Medicare Shared Savings Program Managed Care Organizations was a reduction in spending in post-acute care facilities.[13] Similar findings emerged from studies of the Centers for Medicare & Medicaid Services' (CMS) original Bundled Payments for Care Improvement initiative, CMS' Comprehensive Care for Joint Replacement (CJR) program, and comparisons of spending for FFS Medicare beneficiaries versus Medicare Advantage (MA) members.[10] All this evidence led one paper to deem nursing homes "the piggy bank for savings" in APMs.[14]

The basic idea underlying each of these studies is that under the APM, the hospital receives a bundled payment (or a case rate) intended to finance all care required for a patient over a defined period. As the cost to provide care to the patient decreases, the hospital's profit margin increases since they receive the same payment regardless of their costs. One of the most effective ways to lower the cost of care is to avoid or reduce the length of a patient's stay in a post-acute care facility.[10] And as lower-acuity patients are routed away from nursing homes, the average acuity level of nursing home patients increases, which puts further strain on the nursing home's finances and staffing needs.

Given the increased motivation to shift away from FFS payment structures due to the COVID-19 pandemic, and the large financial incentive for hospitals under APMs to reduce utilization of institutional post-acute care, Medicare beneficiaries may soon find themselves more often discharged straight home following a hospital stay, rather than discharged to recuperate in a nursing home.

Interestingly, this may be the case regardless of whether the beneficiary has coverage through FFS Medicare or Medicare Advantage (MA). CMS piloted the Comprehensive Care for Joint Replacement (CJR) program, an APM for hip and knee replacements. Providers were randomly assigned to participate in the CJR program or not. The providers who were randomly assigned to participate in the CJR program were paid through the APM for hip and knee replacements, while providers who were randomly assigned as the control were paid under the traditional FFS structure for those procedures. Note that this discrepancy in payment only applied to FFS Medicare patients; there was no impact of the CJR program on payment for hip and knee replacements for MA patients.

A study of the CJR program found that FFS Medicare beneficiaries receiving hip and knee replacements at CJR-participating providers were discharged to post-acute care facilities at lower rates than those receiving treatment at non-participating providers.[16] This is not surprising; as explained above, the APM incentivizes providers to bypass nursing homes. However, Medicare Advantage members receiving hip and knee replacements at CJR-participating providers were **also** less likely to be discharged to a nursing home, even though the provider's payment for the MA patient would not change either way. This "spillover" impact could imply that payment-driven changes to discharges of Medicare beneficiaries could ripple through the senior population relatively quickly.

Telemedicine

CMS has encouraged a shift from in-person care to virtual care for Medicare beneficiaries during the COVID-19 pandemic[17] using a plethora of incentives, including the following:[18]

- Allowing provider payment irrespective of originating site for the telemedicine visit (previously, the beneficiary would have to be in a designated rural area before Medicare would consider paying for a telemedicine service).

- Accepting various types of telemedicine services for payment, including communications between a patient and provider via an online portal, some audio-only visits, and services provided through video- and audio-enabled platforms.
- Paying for telemedicine visits at the same rate as in-person visits.
- Waiving the requirement for the beneficiary to receive the telemedicine service in a medical facility, so that they could instead conduct the visit in their home.
- Allowing providers to treat new patients via telemedicine, rather than established patients only.
- Permitting providers to have the discretion to waive cost-sharing for some telemedicine services.
- Notifying providers that the Office for Civil Rights was exercising enforcement discretion such that they would not be fined for HIPAA violations if they conducted telemedicine visits through non-HIPAA compliant platforms like FaceTime or Skype.

Given these pushes, the telemedicine take-up rate has been astonishing. The weekly number of Medicare beneficiaries receiving services via telemedicine was 13,000 prior to 2020. In the last week of April, the number of beneficiaries receiving services via telemedicine was 1.7 million.[19] Services received through telemedicine included preventative care, mental health care, and evaluation and management (E/M) visits, along with some nursing home visits.14 And proposed changes to Current Procedural Terminology (CPT) coding requirements for E/M visits beginning in 2021 will further encourage the use of telemedicine.[20]

CMS is now proposing to make some of the telemedicine payment changes permanent. If some of the permanent changes will allow providers to be paid to monitor and treat patients in their home following a hospital discharge, providers may be encouraged to discharge patients to their home rather than to a post-acute care facility. This could have a dramatic impact on nursing homes. A decline in Medicare patients would cause a shift in payer mix. This shift could be detrimental for facilities that rely on Medicare revenue to subsidize the care delivered to Medicaid patients. As such, a decrease in the Medicare census could impact facility finances that could have a downstream impact on the quality of care provided to the facility's remaining patients.

CMS also broadened the definition of a hospital campus during the PHE to include home care under certain conditions as being rendered at the hospital and enabled at a higher payment rate than home health care allowances.[22] This initiative further reduces the use of post-acute facilities, thus exacerbating the effects described above.

For Medicare patients who are bypassing a post-acute facility stay and recuperating at home, there could be a concern about the quality of the care they are receiving. This could be assessed using hospital readmission rates; if discharging a patient to their home is just as safe as discharging them to a nursing home for a given procedure, readmission rates shouldn't increase for the home-based patients on a risk-adjusted basis. Avoiding a post-acute facility stay can also mean reduced risk of exposure to COVID-19 and other infectious diseases.

NURSING HOME ISSUES AFFECTING MEDICAID BENEFICIARIES

Situs of care preference and consolidation are the nursing home issues predominantly affecting Medicaid beneficiaries. The mass movement to work from home is allowing family members to care for relatives who otherwise might need to be admitted to a post-acute or long-term care facility. Given the high COVID-19 mortality rates in nursing homes, and the desire of most people to age at home anyway, there are fewer new institutional long-term care admissions relative to pre-pandemic levels. The decline in LTC admissions, combined with the decrease in the Medicare-funded census as discussed above as well as increased PPE- and testing-related expenses, might spur a wave of closures and consolidation in the nursing home industry. This would have a disproportionate impact on Medicaid patients who rely on nursing homes as long-term residents.

Situs of Care Preference

We know that there is a demand for aging in place; the waiting lists for Home- and Community-Based Services (HCBS) for Medicaid beneficiaries needing LTC services have an average wait time of over three years.[23] And the desire for home-based LTC has increased due to the COVID-19 pandemic.[24]

Long-term care facility admissions fell dramatically beginning in March, consistent with utilization changes across the health care landscape. One hypothesis for the drop in new LTC facility admissions is that families are trying to support aging in place for their loved ones as much as possible because they are fearful to place them in a facility. As discussed above, the increased ability of many employees to work from home (and, conversely, high unemployment) has enabled families to support their aging relatives at home more easily than before the COVID-19 pandemic, even though it can still be very difficult to manage the care along with work and other responsibilities.

There have been efforts to deliver more support to families trying to provide LTC at home. For example, the HEROES Act passed by the House of Representatives in May would increase the federal share of Medicaid HCBS spending by 10 percentage points.[25] If the HEROES Act becomes law, an increase in the availability of HCBS could siphon LTC patients away from nursing homes.

But even though there is clearly demand for HBCS, the nature of long-term care will likely prohibit a 100 percent shift from institutional to home-based care. Long-term care facility admissions are generally triggered by an inability to perform some Activities of Daily Living (ADLs), such as continence, feeding, and bathing. And while assistance with ADLs may not require skilled care, it requires a lot of work from family members and friends who often have work and childcare and other responsibilities to tend to as well. As such, the ability of loved ones to care for aging relatives sometimes cannot keep up with the level of care required, and so institutional care needs to be put back on the table.

Technological advances and the firm desire of some families to avoid a nursing home admission may result in more use of HBCS by high-acuity patients, but the resources required to accommodate a high-acuity patient in a home setting may not be available to Medicaid beneficiaries and their families. Unless more resources are specifically directed to Medicaid HCBS initiatives, there may not be a lasting shift from institutional to HBCS among Medicaid LTC patients, despite the huge demand for home-based care.

CONSOLIDATION

As discussed above, LTC facility admissions in 2020 have been suppressed relative to pre-pandemic levels.[26] Nursing homes experienced significant declines in patient census, which have been attributable to a decline in admissions as well as COVID-19-related fatalities.[27]

The decline in LTC facility admissions beginning in the spring of 2020 coincided with a pandemic-induced drop in utilization across the entire health care industry. Some have theorized that this drop in utilization in traditional health settings might portend a permanent utilization shift. The theory goes: Bob experiences back pain but was unable to see his provider about it. One day he realizes the pain has gone away on its own. This is a striking realization and causes Bob to seek medical care less often in the future. And the fewer surgeries Bob gets, the less likely it is that he will require institutional post-acute care. If there are enough Bobs and their resolve to "wait it out" doesn't fade over time, the more lucrative post-acute care reimbursement that nursing homes depend on could decline.[28] Post-acute admissions and corresponding revenue could also decline due to the APM and telehealth trends discussed above. Declining revenue could portend nursing home industry closures, mergers, or acquisitions.

Even before the COVID-19 pandemic, M&A transactions involving nursing homes were common.[29,30] The interest in nursing homes is in part due to the expected need for them in the future. We have an aging population. The U.S. Census Bureau projects that 21 percent of the population will be of retirement age by 2030, with older adults outnumbering children for the first time in U.S. history by 2034.[31] Per data collected by HHS, 70 percent of retirement-age adults will need LTC at some point, and almost half of all retirement-age adults will receive some paid care, including home health, assisted living, or nursing home services.[32] Medicaid is the largest payer of these services; Medicare generally does not pay for long-term care, and the high cost of nursing home care can cause self-pay patients to spend down their retirement assets quickly (thus potentially making them eligible for Medicaid).

So, how will consolidation and M&A activity affect long-term nursing home residents? The answer might depend on who the buyer is. With respect to COVID-19, there is evidence from nursing homes in New Jersey that private equity ownership was associated with higher COVID-19 infection and fatality rates. [33]

Similarly, a report on skilled nursing facilities in California found that for-profit ownership was associated with higher case and fatality counts than non-profit or government ownership.[34]

Outside of COVID-19, studies show that private equity ownership of nursing homes is associated with declines in patient health.[35] Older studies, however, show that low-quality facilities owned by for-profit entities were low-quality before they were acquired.[23,36] This could indicate that low-quality facilities were not low-quality because of the acquisition; rather, one of the reasons they were targeted for acquisition was because they were low-quality. From an ownership perspective low quality may equate to higher profits and a more attractive investment. Investors may not be morally influenced or personally judgmental about such an investment as long as the facility can check off that it complied with applicable government regulations. As nursing homes evolve to serve patients in a post-COVID-19 world, more research should be done on the impact of M&A activity and ownership status to the facilities' patients and long-term residents.

CONCLUSION

Payment reform, increased use of telemedicine, preference for home-based care, and consolidation are all issues affecting Medicare and Medicaid nursing home patients. These trends were all in place prior to the COVID-19 pandemic but have since been accelerated.

We know that the need for post-acute and long-term care will continue to grow as the population ages. However, for both Medicare and Medicaid beneficiaries, the role of nursing homes in serving those needs may be beginning to shrink. ■

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ENDNOTES

1 Supporting data was pulled from the COVID-19 Nursing Home Dataset maintained by CMS. Retrieved from *https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset/s2uc-8wxp.* The dataset was accessed on September 2, 2020, and at that time included data through the week of August 16, 2020.

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7 For those under 65, post-acute care is typically funded by private insurance.

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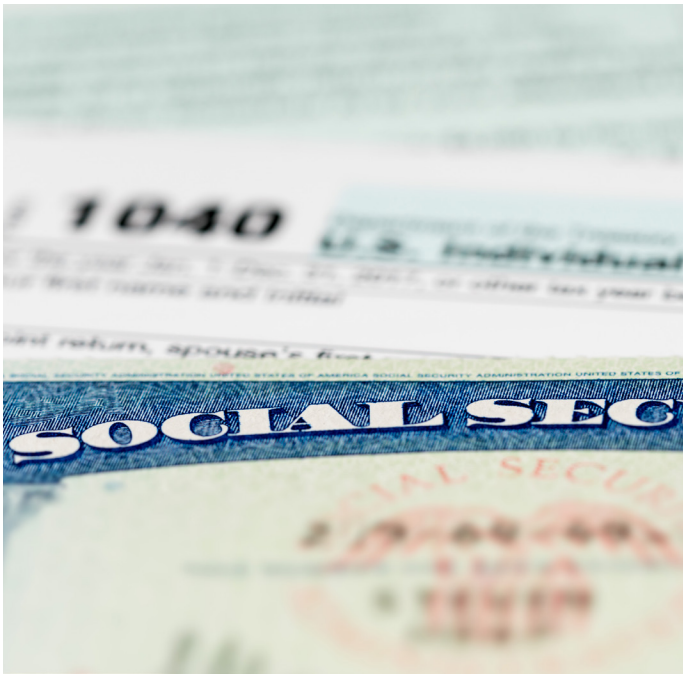
Social Security Changes for 2021

By Bruce D. Schobel



Every October, the U.S. Social Security Administration (SSA) announces certain changes in program amounts that occur **automatically**—that is, without any new legislation being necessary. The most widely publicized of these changes is the annual cost-of-living adjustment (COLA) affecting monthly Social Security benefits. Other automatic changes are important to people of working age as well as to beneficiaries. On Oct. 13, 2020, the government announced the Social Security COLA effective for December 2020 and the other increases effective for 2021.

BENEFIT INCREASE

Since 1984, Social Security's COLAs have been based on the third-quarter-to-third-quarter increase, if any, in the average Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). The CPI-W, which is computed by the U.S. Labor Department's Bureau of Labor Statistics, rose 1.3 percent (rounded to the nearest 0.1 percent) year-to-year from the third quarter of 2019 through the third quarter of 2020. Accordingly, all monthly Social Security benefits, in current-payment status or not, will rise by the same percentage, effective with benefits for December 2020. The 1.3-percent December 2020 COLA is slightly smaller than the 1.6-percent COLA effective for December 2019.

Usually, all December benefits are paid in the following January; as a rule, monthly Social Security benefits are paid in arrears, after the month is over. For January 2021, however, **some** December benefits will actually be paid in December, which is unusual. Most beneficiaries, whose payments dates are on the second, third or fourth Wednesday of the month, will receive their benefits in January, as they would expect. But mostly older beneficiaries who became entitled before the Wednesday payment-date policy was implemented in 1997, and some beneficiaries who became entitled later, are usually paid on the third of the month. In 2021, Jan. 3 is a Sunday, when banks are closed. In such cases, Social Security benefits are paid on the previous business day, which happens to be Thursday, Dec. 31, 2020. (Jan. 1 is a national holiday, and Jan. 2 is a Saturday.) Another interesting wrinkle, very deep in the nooks and crannies of Social Security's rules, is that benefit payments made on Dec. 31, 2020, will be reported on Form SSA-1099 as 2021 income, not 2020 income, preventing the distortion of reporting 13 benefit payments in one year and 11 in the next.

WAGE-INDEXED PARAMETERS

A long list of updated Social Security program parameters, some of which are rather obscure, is ordinarily announced simultaneously with the COLA each year. Unlike the COLA, changes in these parameters are based on changes in the national average wage, which the Social Security Administration computes from all W-2 forms filed by employers each year. Interestingly, workers who are self-employed, but not **also** employed by someone else, are excluded entirely from the average-wage computation. Workers who are both self-employed and employed during the year have only their earnings from employment included in the calculation of the national average wage, leading to some minor distortion in the resulting value and percentage change. The national average wage rose from $52,145.80 in 2018 to $54,099.99 in 2019. That 2019 value, which is used by SSA to

calculate the program's wage-indexed parameters for 2021, is the most recent national average wage figure available now. At the time of the October 2020 announcement, 2020 obviously wasn't over, so the 2020 national average wage could not be known then. It will be calculable in 2021, after employers file all 2020 W-2 forms with SSA. That takes several months, including correction of errors. The 2020 national average wage is expected to decline significantly from the 2019 value, due to the coronavirus pandemic.

MAXIMUM TAXABLE AMOUNT AND TAX RATES

One very important change that affects higher-income workers (employees and the self-employed) is the increase in the maximum amount of earnings in the year that is (1) subject to Social Security payroll taxes (FICA and SECA) and (2) creditable for benefit-computation purposes. This program parameter can rise (it cannot fall) in any year following the effective date of a COLA. In a few recent years when no COLA was effective, due to the CPI-W declining, the maximum taxable amount did not rise in the following year. Because a COLA is effective for December 2020, the maximum taxable amount will rise from $137,700 for 2020 to $142,800 for 2021, based on the change in the national average wage. The maximum taxable amount is rounded to a multiple of $300.

Social Security tax rates are not automatically adjusted but are set by law. The FICA tax rate, payable by employees and employers, each, has been 6.2 percent since 1990. The self-employed pay both halves of this tax and get to deduct, for income-tax purposes, the half representing the employer share. Employees cannot deduct Social Security taxes from their taxable incomes, but employers can. The tax treatment of SECA taxes is consistent with that practice.

RETIREMENT EARNINGS TEST

Another wage-indexed Social Security program parameter is the exempt amount under the retirement earnings test for beneficiaries who have not yet reached their normal retirement age, or NRA. (Social Security's NRA was 65 for workers born before 1938 and is rising gradually under present law to 67 for workers born after 1959.) The annual exempt amount for beneficiaries who will not reach their NRA during the current calendar year rises from $18,240 for 2020 to $18,960 for 2021. (A special monthly test applies in the first year of benefit entitlement only.) For beneficiaries who reached their NRA in 2020, the exempt amount was $48,600 for earnings in the months prior to reaching NRA. That exempt amount rises to $50,520 for 2021. Since January 2000, workers who have reached their Social Security NRA can earn unlimited amounts without causing any reduction in their Social Security benefits, starting with the month in which they reach that age. As always, additional covered earnings are reflected in annual benefit recomputations and can cause monthly benefits to rise (they cannot decline for this reason), effective each January after the previous year is over.

COVERAGE CREDITS

Interestingly, certain wage-indexed program amounts are permitted by law to increase (or even decrease) with or without a COLA occurring. The amount of earnings needed to receive one coverage credit was $1,410 in 2020 and rises to $1,470 in 2021. Workers who earn at least $5,880 in Social Security-covered employment (or self-employment) during 2021 will receive the maximum four coverage credits for the year. Workers need 40 coverage credits to be eligible for retired-worker benefits at age 62 or older. (These coverage credits used to be known as "quarters of coverage"; since 1978, they have been granted based on annual earnings, making the old name somewhat inappropriate.)

BENEFIT FORMULAS

The so-called "bend-points" of the formulas used to compute primary insurance amounts (PIAs) and maximum family benefits (MFBs) are also wage-indexed and can increase or decrease with or without a COLA having occurred. The two PIA bend-points for workers first becoming eligible for benefits in 2021 (that is, born in 1959 with respect to retired-worker benefits) are $996 and $6,002. The three MFB bend-points for 2021 eligibilities are $1,272, $1,837 and $2,395.

The complete list of wage-indexed program parameters for 2021 and corresponding values for previous years are available at *www.ssa.gov/oact.* ■

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