



Legislative Agenda

115th Congress

2017-2018

The National Committee to Preserve Social Security and Medicare is committed to work on behalf of its millions of members and supporters nationwide to preserve and strengthen America's most successful income and health security programs. As the first session of the 115th Congress begins its work, we've detailed a myriad of legislative priorities which would continue to build and strengthen Social Security and Medicare's historic legacy for current and future beneficiaries.

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Medicare

Medicare and Social Security form the bedrock on which the economic and health security of today's seniors and tomorrow's retirees rests. Medicare helps prevent poverty and promotes greater access to health care for people 65 years of age and older and people with disabilities. Even though half of all Medicare beneficiaries in 2014 had incomes below \$24,150, Medicare households spent over two times more than the average American household on out-of-pocket health care costs.



Older Americans should not have to choose between paying for health care, food or utilities. Medicare benefits must be improved, not cut. Medicare's long-term solvency must be strengthened, and access to health care providers and benefits must be enhanced and preserved. Unfortunately, the majority leadership of the 115th Congress

have prioritized a plan that would undermine the health security of current and future retirees and people with disabilities by ending traditional Medicare, cutting improvements made to Medicare by the Affordable Care Act, and raising the Medicare eligibility age.

Protect Medicare **Oppose Ending Traditional Medicare**

Under the proposals to privatize Medicare, beneficiaries would not enroll in the current program; rather, they would receive a capped payment or voucher to be used to purchase private health insurance or traditional Medicare. Private plans would have to provide benefits that are at least actuarially equivalent to the benefit package provided by fee-for-service Medicare, but they could manipulate their plans to attract the youngest and healthiest seniors. This would leave traditional Medicare with older and sicker beneficiaries whose higher health costs could lead to higher premiums that they and others may be unable or unwilling to pay, resulting in a death spiral for traditional Medicare. In addition, there is no public policy justification for privatizing Medicare because the traditional program is more efficient than private insurance, mainly because it does not spend large sums on overhead and marketing and is not driven by profit motives.

Oppose Repealing Medicare Improvements in the ACA

Repealing the ACA would eliminate improvements already in place for current Medicare beneficiaries - closing the Medicare Part D prescription drug coverage gap, known as the “donut hole;” preventive benefits and annual wellness exams with no deductibles or copayments; and improvements in the quality of care they receive.



In previous attempts to repeal the health reform law, the Medicare savings in the ACA – cutting waste, fraud and abuse, eliminating taxpayer handouts to insurance companies who offer private Medicare plans and slowing the rate of increase in payments to some providers – were maintained but the savings were used for deficit reduction and tax breaks for the wealthy, not to strengthen Medicare and expand benefits.

Oppose Raising the Medicare Eligibility Age from 65 to 67

Raising the eligibility age, coupled with repealing the ACA, would increase costs for millions of older Americans. Without the guarantees in the ACA, such as requiring insurance companies to cover people with pre-existing medical conditions and limiting age rating, it would be very difficult and expensive for people 65 and 66 to purchase private insurance. Raising the eligibility age would also increase costs for Medicare as younger, healthier people are eliminated from the risk pool and costs are spread across an older, less-healthy population.

Strengthen Traditional Medicare

Build on the Affordable Care Act (ACA) and Medicare

Provisions in the ACA have already resulted in additional years of solvency in the Medicare program. Accountable Care Organizations and medical homes, which improve care for beneficiaries with multiple chronic conditions including Alzheimer’s disease, are strategies that contain costs and promote access to high-quality care.

Combat Waste, Fraud and Abuse

The ACA expands initiatives to prevent, detect and recover improper payments, with an emphasis on preventing the payment of improper claims in order to avoid the costlier process of trying to recover payments from Medicare’s hundreds of thousands of providers. Adequate funding will ensure effective implementation of these initiatives.



Oppose Further Means-Testing of Part B and Part D Premiums

Medicare beneficiaries with incomes above \$85,000 for individuals and \$170,000 for couples are paying higher Part B and D premiums due to provisions in the Medicare Modernization Act of 2003 (MMA) and the Affordable Care Act (ACA). In addition, beginning in 2018, beneficiaries with incomes above \$133,500 will pay a higher premium subsidy than the current amount due to a provision in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015.

The share of beneficiaries paying the Part B income-related premium has increased from 3.5 percent in 2011 to 5.7 percent in 2015, and is projected to rise further to 8.3 percent of enrollees by 2019. Some in Congress have proposed increasing means testing until 25 percent of beneficiaries are subject to higher premiums. Middle-income seniors with incomes equivalent in 2014 to \$45,600 for an individual and \$91,300 for a couple would be hit hard financially by this proposal. Means-testing could also increase costs for middle- and lower-income seniors if higher-income seniors, who are often younger and healthier, are driven away by increased cost-sharing. This will undermine the 50 years of success with this social insurance model.

Extend Medicare Part B Hold Harmless Protections to All Beneficiaries

The Medicare “hold harmless” provision protects Social Security benefits from being reduced if there is no cost-of-living adjustment (COLA) or the COLA is not large enough to cover the increase in the Part B premium. However, about 30 percent of beneficiaries are not protected by the hold harmless provision. They include Medicare Part B beneficiaries new to Medicare, current enrollees who do not have the Part B premium withheld from their Social Security benefit, and higher-income beneficiaries (incomes exceeding \$85,000 for an individual and \$170,000 for a couple). State Medicaid programs – that pay the Part B premiums for low-income beneficiaries dually eligible for Medicare and Medicaid – are also not protected. In 2010, 2011, 2016 and 2017, no or low COLAs coupled with increases in the Part B premium resulted in about 30 percent of Medicare beneficiaries paying higher premiums. While Congress mitigated the 2016 premium increase in the Bipartisan Budget Act of 2015, lawmakers failed to enact legislation to reduce the 2010 and 2011 Part B rate hikes for beneficiaries not protected. In November 2016, Health and Human Services (HHS) Secretary Sylvia Burwell exercised her statutory authority to use reserves

in the Supplemental Medical Insurance trust fund to mitigate the 2017 Part B premium increase. Although legislative and administrative action can lower Part B premium increases, Congress and the HHS Secretary are not required to reduce the burden of high Medicare premium increases for the 30 percent of beneficiaries not protected by the hold harmless. As a matter of equity, the Medicare Part B hold harmless should be extended to all beneficiaries.

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Reduce the Late Enrollment Penalty

Beneficiaries who do not sign up for Part B when first eligible, or who have a break in coverage, may have to pay a late enrollment penalty, which is a 10 percent increase in the standard Part B premium for each 12-month non-covered period. The penalty is not applicable to beneficiaries who have health insurance through their own or a spouse’s current employer.

Unlike individuals who claim Social Security benefits by age 65, individuals who defer Social Security benefits until after age 65 are not automatically notified about their initial Medicare eligibility. As a result, they may fail to enroll in Medicare when they first become eligible. If they do fail to enroll, they may be, because of the late enrollment penalty, subject to permanently higher Part B premiums with no upper limit.

The National Committee believes the penalty is too severe. To mitigate the penalty, individuals delaying Part B enrollment should be treated like those who delay Part A enrollment for at least 12 months beyond their initial enrollment period.

In other words, late enrollees should be subject to a 10 percent premium surcharge regardless of the length of the delay, but the surcharge should only apply for a period equal to twice the number of years (i.e., 12-month periods) during which the late enrollee delays their enrollment.

Coordinate Enrollment Periods with Private Plans

Align the Medicare fee-for-service enrollment period with the Open Enrollment Period for Medicare Advantage (Part C) and Part D prescription drug plans.



Eliminate Coverage Gaps Due to Delayed Coverage Start Dates

There is a seven-month Initial Enrollment Period (IEP) for Medicare – three months before your 65th birthday, with coverage effective on the first day of your birthday month; your birthday month, with coverage effective the first day of the month after your birthday; and three months after your birthday month with coverage delayed by 3-6 months from your birthday month. In the latter case, we believe the 3-6 month coverage delay should be eliminated. Instead, coverage should begin on the first day of the month after the beneficiary enrolls. Similarly, when a beneficiary enrolls during the General Enrollment Period which is from January to March each year, coverage should also begin on the first day of the month after they sign up, instead of the current delay of coverage until July 1.

Expand Assistance to Those Who Erroneously Delay or Decline Part B

Under the current system of “equitable relief,” relief from premium penalties and coverage delays is only available to those who can prove an entity of the federal government supplied misinformation on Part B enrollment. Equitable relief should be available if misinformation is provided from other sources – employers, health plans and State agencies. In addition, the process should be more transparent and consumer-friendly through a standard application, a timeframe for review, a written notice explaining the determination, and an opportunity for an independent review.

Enhance Benefits Provide Vision, Dental and Hearing Coverage



Medicare does not pay for routine dental care and dentures, routine vision care or eyeglasses, or hearing exams and hearing aids, all services of great importance to many older people and which contribute to their high out-of-pocket health care costs. Medicare benefits should be expanded to cover vision, dental and hearing health services and equipment because they are important for healthy aging.

Enact a Catastrophic Out-of-Pocket Limit for Spending in Traditional Medicare

There are various deductibles and copayments for services which are covered by Medicare. The Part A deductible and other cost-sharing are quite high. Medicare does not have a limit – a so-called “stop-loss” or catastrophic cap – on annual out-of-pocket spending. A catastrophic out-of-pocket limit on spending and a combined Part A and Part B deductible would bring Medicare more in line with large-employer plans and the Federal Employees Health Benefits Program (FEHBP). A version of this approach - Medicare Essential – would provide a new government-administered plan with a comprehensive benefit package as an alternative to traditional Medicare and Medicare Advantage. It would combine Medicare’s hospital, physician and prescription drug coverage into an integrated benefit with an annual limit on out-of-pocket expenses for covered benefits.

Count Observation Days toward Meeting the Three-Day Rule

Medicare beneficiaries are being denied access to Medicare’s skilled nursing facility (SNF) benefit because acute care hospitals are increasingly classifying their patients as outpatients receiving observation services, rather than admitting them as inpatients. Under the Medicare statute, patients must have an inpatient hospital stay of three or more consecutive days, not counting the day of discharge, in order to meet Medicare criteria for coverage of post-acute care in a skilled nursing facility (SNF). As a result, although the care received by patients in observation status is indistinguishable from the care received by inpatients, outpatients in observation who need follow-up care in a SNF do not qualify for Medicare coverage. If the “three-day” rule remains, then observation stays should be counted toward the three-day mandatory inpatient stay for Medicare coverage of SNF services. Consideration should also be given to limiting beneficiaries’ payments to the lesser of inpatient or outpatient costs.

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Eliminate the Three-Day Rule

Preferably, the three-day prior hospitalization requirement for SNF coverage should be eliminated. Beneficiaries may need SNF-level skilled nursing care, or physical, occupational or speech therapy without a prior inpatient hospitalization.

Eliminate the 24-Month Waiting Period for Medicare Coverage for Disabled Individuals

Individuals receiving Social Security Disability Benefits are likely to need medical care and should become eligible for Medicare when they start receiving Social Security.



Improve Medicare Supplemental Insurance (Medigap) for Individuals with Disabilities

Most Medicare beneficiaries have Medigap, an individual, standardized insurance policy designed to fill some of the coverage gaps in Medicare. Nearly 25 percent of Medicare beneficiaries rely on Medigap policies to provide financial security and protection from high, unexpected out-of-pocket costs. When an individual 65 or older first enrolls in Medicare there is a six-month period during which an insurance company cannot refuse to sell that individual any Medigap policy it offers, nor can the insurance company charge that individual more than it charges someone with no health problems. Younger, disabled Medicare beneficiaries do not have this “guaranteed issue”

protection, unless they live in a state that requires it. The guaranteed issue of Medigap policies should be required for individuals with disabilities who are eligible for Medicare (See section below on Better Informed Beneficiaries).

Reform Part C - Medicare Advantage

Allow the Government to Negotiate Lower Medicare Part D Drug Prices

Medicare Part D drug prices are determined through a negotiation between the private drug plan that administers the benefit and the drug manufacturer. By law, the federal government cannot negotiate for Medicare drug prices.

The Secretary of Health and Human Services (HHS) should be the responsible authority in charge of negotiating the best price available for drugs purchased on behalf of beneficiaries, especially for those who are low-income. This would include the creation of one or more Medicare-administered drug plans with uniform premiums, allowing seniors the opportunity to purchase drugs directly through the Medicare program, and requiring the federal government to use its purchasing power to negotiate lower prices. The Secretary of HHS should negotiate discounts, rebates and other price concessions to lower the cost paid by Medicare to pharmaceutical manufacturers.

Accelerate Closure of the Medicare Part D Coverage Gap

The Medicare Part D coverage gap, also known as the “donut hole,” requires beneficiaries to pay substantially more for their drugs when they reach a certain level of spending, forcing many seniors with high prescription drug costs to forgo needed medication. In 2017, Medicare Part D beneficiaries will enter the coverage gap when their out-of-pocket spending, not including premiums, totals \$3,700 during the year. The coverage gap ends when a beneficiary has spent a total of \$4,950, not counting premium costs.

The donut hole is scheduled to be phased out completely by 2020. President Obama's Fiscal Year 2017 budget increases manufacturer discounts for brand name drugs in Medicare Part D to 75 percent and closes the donut hole in 2018, two years earlier than under current law. The National Committee supports this recommendation.

Complete Payment Reductions to Private Medicare Advantage Plans

As a result of the "Medicare Modernization Act of 2003," the federal government must pay Medicare Advantage (MA) plans, which serve about 30 percent of the Medicare population, more per beneficiary than traditional Medicare for providing the same services. Despite opposition from MA plans, the "Affordable Care Act" (ACA) reverses that obligation by gradually ending the overpayments and restoring legitimate competition, saving \$156 billion over 10 years. It makes no sense for the federal government to pay MA plans more than traditional Medicare for providing the same services, especially at a time when policymakers are trying to rein in rising health care costs. It is also unfair for taxpayers to subsidize extra payments to private health insurers that benefit only one group of Medicare beneficiaries. Aligning MA and traditional Medicare payments extends the program's long-term solvency.

Too many seniors are being denied access to Medicare's skilled nursing benefit because of the growing use of "observation status" classifications

Complete Payment Reductions to Private Medicare Advantage Plans

MA plans can drop health providers from their networks at any time with little notice to beneficiaries. This can be problematic for seniors, especially those with serious illnesses and/or long-term relationships with their providers.

"Medicare Advantage Participant Bill of Rights" legislation would prohibit MA plans from dropping providers without cause during the middle of the plan year, require MA plans to finalize their provider networks for the following plan year at least 60 days in advance of the annual enrollment period, and mandate increased notice to beneficiaries and providers when MA plans change their networks.

Reform Medicare Part D

Restore Drug Rebates for Medicare-Medicaid Eligible Individuals

Prior to creation of the Medicare Part D drug benefit, Medicaid paid the drug costs for individuals who were dually eligible for Medicare and Medicaid benefits and drug manufacturers provided the government with discounts (rebates) on drugs for this population. These practices ended after Part D went into effect.



Legislation requiring drug manufacturers to pay rebates for the drugs used by individuals who are dually eligible for Medicare and Medicaid and for people receiving the Medicare Part D Low-Income Subsidy (LIS) is needed. This will save Medicare \$121 billion over 10 years.

Stop Pay-for-Delay Agreements of Generic Drugs

Some brand name drug manufacturers pay generic drug manufacturers to keep less expensive generic drugs off the market for a certain period of time. This extends the duration of profitability for the brand-name drug makers, limits beneficiaries' access to generic drugs, and reduces savings to the government. Prohibiting "Pay for Delay" agreements would save Medicare \$11.5 billion over 10 years.

Promote Faster Development of Generic/Biologic Drugs

Providing for faster development of drugs derived from living organisms would help lower pharmaceutical costs. Under current law, brand-name biologic manufacturers receive a 12- year exclusivity period for these drugs. Lowering the period of exclusivity to seven years and prohibiting additional periods of exclusivity for brand-name biologics due to minor changes in product formulations could result in improved consumer access to safe and effective generic drugs. This is estimated to save Medicare \$4.5 billion over 10 years.

Improve Transparency around drug price increases

Frequently, drug manufacturers cite research and development (R & D) costs as the reason for high prices. In reality, lack of transparency around pricing can make it difficult for Medicare to know what a reasonable price for a product is. Legislation is needed to require manufacturers to provide information about R & D costs, advertising, profits and other data that informs pricing decisions.

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Cap out-of-pocket costs for Part D

Currently, once beneficiaries enter the catastrophic phase of coverage under Part D, they are responsible for paying 5% of a drug's costs. However, with some drugs priced at several hundred thousand dollars, this can be unaffordable. Legislation is needed to cap out-of-pocket spending for Part D.

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Allow Drug Importation from Canada

Pharmaceutical companies may charge U.S. consumers higher prices for medications while selling the same drugs in other countries for much less. Safe drug importation from Canada is a way to control prescription drug costs and provide needed price relief for seniors through competition.



Ensure that Low-Income Seniors are Enrolled in Medicare Part D Plans Appropriate for their Health Needs

Financial assistance, known as the Low-Income Subsidy (LIS) or Extra Help, is provided to about 11 million seniors with limited income and assets to help them pay for out-of-pocket drug expenses.

If eligible LIS beneficiaries do not select a Part D plan on their own, they are automatically enrolled in a plan with premiums at or below the regional average. These automatic assignments may result in beneficiaries being placed into plans that do not cover all of their needed medications. Improvements need to be made to the auto enrollment process to better communicate the implications of the process to beneficiaries. Additional funding is needed to improve LIS plan assignment and to counsel beneficiaries enrolling in Part D in order to take into account the medications the beneficiary is currently taking, thereby avoiding costly and life threatening mistakes (See section below on Better Informed Medicare Beneficiaries).

Eliminate the Part D Low-Income Subsidy Asset Test

The amount of LIS assistance depends on beneficiaries' income and assets. In 2017, income is limited to \$17,820 and assets to \$13,640 annually for an individual. The LIS asset test should be eliminated because it punishes low-income seniors who have accumulated modest savings for retirement.

Create Transparency Around Pharmacy Benefits Managers (PBMs) that Administer Pharmacy Benefits for Medicare Prescription Drugs

Part D plans and Medicare Advantage plans engage PBMs to administer their pharmacy benefits. PBM's duties include creating and managing formularies, processing prescription drug claims on behalf of plans, and negotiating with pharmacies and drug manufacturers. While PBMs are supposed to act in the interest of the plans they serve, conflicts of interest and lack of transparency can create perverse incentives that result in higher costs to the Medicare program and beneficiaries. There needs to be more transparency around the way PBMs operate to make sure that PBMs have incentives to base their formulary placement decisions on best available clinical evidence, choose drugs that are cost effective for the Medicare

program and pass along savings to the Medicare program and beneficiaries.

Improve Beneficiary Comprehension

In order for Medicare to really fulfill its promise to seniors to provide quality health care coverage, seniors must be better able to navigate it in order to maximize benefits. Recommendations include:

Provide notice to individuals aging into Medicare and those nearing eligibility because they receive Social Security disability benefits

Beneficiaries should know when and how to enroll in Medicare and what may result from delayed enrollment. Without education many individuals who have insurance such as COBRA benefits, retiree health insurance or an ACA Marketplace plan do not realize that they need to enroll in Medicare or face severe consequences such as a coverage gap and a late enrollment penalty.

Provide additional funding for State Health Insurance Assistance Programs (SHIPs)

SHIPs assist Medicare beneficiaries with their enrollment decisions, offering local, personalized counseling and assistance at no cost to people with Medicare and their families. They answer questions about benefits, coverage and cost sharing. They can also help beneficiaries with enrolling or leaving a Medicare Advantage Plan (like an HMO or PPO), any other Medicare health plan, or Medicare Prescription Drug Plan (Part D).

Improve the annual notice of change

Coverage notices sent annually to Part C and Part D enrollees can be improved by consumer testing and tailoring the notices to the individual beneficiary's circumstances. Beneficiaries should be told whether their plans will change in a way that will raise their costs or limit access to a product or service.

For example, beneficiaries should know if a drug they use will be removed from a Part D formulary or moved to a tier with higher cost sharing.

Make the Centers for Medicare and Medicaid Services (CMS) Medigap website more user friendly

The website can be improved by including data on the website on plan pricing, insurer financial stability and the history of policy price increases. There is dramatic price variability in the Medigap market with little indication that price improves value.

Medicaid and Long-Term Services and Supports



Over 13 million Americans, the majority of whom are senior citizens, rely on long-term services and supports (LTSS) to assist them with activities of daily living such as eating, dressing, bathing and toileting. Medicaid is the main source of coverage of LTSS, and many older adults and people with disabilities depend on the program for their health care needs. Medicare coverage for these services is limited. Without a national comprehensive approach to paying for LTSS, many individuals forgo needed assistance or turn to unpaid help from family, friends and neighbors, imposing significant costs on society. As the baby boom

generation ages, Congress will need to legislate solutions to meet the rising demand for LTSS to decrease the strain on American families and the Medicaid program. Regrettably, the Republican leadership of the 115th Congress proposes to block grant Medicaid. This would destroy the existing LTSS safety net.

Maintain Federal Matching Support for State Medicaid Programs and the Affordable Care Act's Medicaid Expansion Proposal

Efforts to block grant Medicaid, cap Medicaid payments on a per-beneficiary basis (per capita caps) and/or repeal the ACA's Medicaid expansion should be opposed. These policies financially hurt states and lead to states cutting services, quality and eligibility for the most vulnerable of our senior population.

Provide Incentives to Encourage States That Have Not Expanded Medicaid to Do So

Thirty-two states and the District of Columbia have opted to expand Medicaid. Policies that encourage remaining states to expand Medicaid coverage to the ACA population should be pursued.

Develop a National Long-Term Care Insurance Program

Individuals and families who pay for the care of patients with physical disabilities and/or cognitive impairments, including Alzheimer's disease and other dementias, need assistance in paying for that custodial care. They should not have to impoverish themselves or their spouses. Policies that impact higher income individuals' access to Medicaid's long term services and supports benefits should be done in the context of developing a rational long-term care program that works for individuals across income levels.

Eliminate the “institutional bias” in Medicaid

For Medicaid beneficiaries who require long-term services and supports, institutional care is usually their only option. Home and community based care is infrequently allowed as an alternative. The institutional bias in Medicaid should be eliminated so that more people needing long-term services and supports can receive them where they want to be – in their own homes – rather than in nursing homes.

Social Security



Social Security is our nation’s most important and effective income security program for American workers, retirees and their families. The 2016 Trustees Report states that Social Security is well funded, remains strong and as currently structured will be able to pay full benefits until 2034. In addition to the \$920.2 billion in income received by the program in 2015, there is \$2.8 trillion in the Social Security Trust Fund. Congress has ample time to make reasonable changes to strengthen Social Security’s long term financing, and should also address the issue of benefits adequacy since a growing share of Americans depend on Social Security for all or most of their retirement income. The National Committee supports the following proposals:

Benefit Improvements

Strengthen the COLA

Future cost-of-living adjustments (COLAs) should be based on a fully-developed Consumer Price Index for the Elderly (CPI-E). We believe this index would more accurately measure the effect of inflation on the price of goods and services that are purchased by seniors than does the current CPI-W, which reflects price increases based on the purchasing patterns of urban wage earners and clerical workers.

Emergency Payment to Seniors in Lieu of COLA

To meet the immediate hardship that will result from no COLA in 2016 and a miniscule 0.3% COLA in 2017, Social Security beneficiaries and veterans should be offered a one-time emergency benefit payment equal to a 3.9 percent pay raise. The cost of the emergency benefit payment could be offset by closing the CEO “performance pay” corporate tax loophole.

Improve the Basic Benefit of all Current and Future Beneficiaries

After years of operating under a COLA that does not reflect seniors’ spending patterns and given the fact that seniors devote a higher percentage of their monthly income to meeting health care costs, all seniors need to have their rising costs offset by an across-the-board benefit increase. Women, especially, who have worked a lifetime with low pay (often the result of sex-based wage discrimination) are more financially vulnerable in retirement because they are less likely to have private pensions or discretionary income that would allow for saving.

Improve Survivor Benefits

Seniors living alone are often forced into poverty because of benefit reductions stemming from the death of a spouse. Widows and widowers from low-earning or wealth-depleted households are particularly at risk of poverty. Providing a widow or widower with 75 percent of the couple's combined benefit would treat one-earner and two-earner couples more fairly and would reduce the likelihood of leaving the survivor in poverty.

Provide Caregiver Credits

Interrupting participation in the labor force to look after other family members, usually children and elderly parents or relatives, can result in a significant reduction in the amount of the caregiver's Social Security benefit. This disproportionately impacts women. When calculating an individual's Social Security benefit, caregivers should be granted imputed earnings equal to 50 percent of that year's average wage for up to as many as five years spent providing care to family members.



Enhance the Special Minimum Primary Insurance Amount (PIA)

The Special Minimum Benefit is intended to provide a slightly more generous benefit amount to individuals who work for many years in low-wage employment. The method by which this benefit amount is calculated should be updated so that more individuals, many of them women, can qualify.

This benefit should be calculated by giving individuals credit for up to ten years spent outside the workforce providing care to family members.

Increase Benefits for Seniors Who Have Received Social Security for a Long Period of Time

Seniors who live beyond the age of 85 are more likely to be financially vulnerable, even with Social Security. Additional security should be offered by increasing benefits for all beneficiaries 20 years after retirement by a uniform amount equal to five percent of the average retired worker benefit in the prior year. This proposal would be particularly helpful to women because they live longer than men and are more likely to outlive their retirement savings.

Equalize Rules for Disabled Widows and Widowers

Widows and widowers can qualify for disabled spouse's benefits beginning at age 50. They are the only disabled persons whose benefits are subject to an actuarial reduction. These individuals should receive 100 percent of their benefit without any reduction, just like disabled workers, and they should be able to qualify for disabled spouse's benefits at any age. Moreover, the seven-year application period should also be eliminated.

Provide Benefit Equality for Working Widows and Widowers

Under current law, a widow's or widower's benefit is capped at the amount the deceased husband or wife would receive if he or she were still alive. If a husband or wife retires before normal retirement age, the widow or widower generally inherits the deceased spouse's early retirement reduction. The widow's or widower's benefit should no longer be tethered to the reduction the deceased spouse elected to receive when he or she applied for retirement benefits. Instead, the benefit should be reduced only by the surviving spouse's own decisions about when to retire.

Restore Student Benefits

Social Security pays benefits to children until age 18, or 19 if they are still attending high school, if a working parent has died, become disabled or retired. In the past, those benefits continued until age 22 if the child was a full-time student in college or a vocational school. Congress ended post-secondary students' benefits in 1981. Restoring this benefit would help those who must defer saving for their retirement because they are assisting their children with college or vocational school expenses.



Improve Benefits for Disabled Adult Children

Adult children who become disabled before reaching age 22 should be allowed to reestablish entitlement to benefits after divorce and their benefit should be computed without regard to the family maximum. Currently, benefits for these individuals can be started again only if the marriage is annulled.

Increase Program Revenue

Eliminate the Cap on Social Security Payroll Tax

Currently, only the first \$127,200 of a worker's wages are subject to the Social Security payroll tax. Eliminating this wage cap and modestly adjusting the benefit formula when determining benefits for high-wage earners would play a central role in strengthening Social Security's finances.

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Increase the Social Security Tax Rate by 1/20th of One Percent Over 20 Years

A gradual increase in the Social Security payroll tax rate by a very small percentage to be phased in over a long period of time would significantly strengthen Social Security's long-term financial outlook and provide revenue for some of the benefit improvements discussed above.

Strengthen and Restore the Supplemental Security Income (SSI) Program

The Supplemental Security Income (SSI) program provides vital and much needed economic security for 8.4 million low-income seniors and people with disabilities, including children with marked and severe functional limitations. Unfortunately, Congress has failed to keep the SSI program up-to-date for our nation's most vulnerable Americans who depend on SSI to meet their basic needs. The National Committee supports the following long-overdue improvements in this program:

Increase the Income Exclusion

Rules that disregard a portion of an individual's income when determining an individual's eligibility for SSI benefits have not changed in 45 years. Since 1972, the cost of living has risen more than 550 percent, but the "general income" exclusion (e.g. money received through means other than work) has remained constant at \$20 per month, while the monthly "earned income" (e.g. money received through work) exclusion is still \$65. The general income exclusion should be raised to about \$110 per month and the earned income exclusion should be increased to at least \$360 per month.

Increase the Asset Limit

For decades, the SSI program asset limit has been set at \$2,000 for an individual and \$3,000 for a married couple. This unrealistic limit, which has been increased since 1972 by only 33 percent, prevents many truly needy people from qualifying for SSI. The asset limit should be increased by \$10,000 for an individual and \$15,000 for an eligible couple, which represent more realistic amounts for the purpose of planning for emergencies and other unexpected expenses.

Eliminate the Reduction in Benefits For In-Kind Support

SSI beneficiaries currently lose some of their benefits if they receive non-cash in-kind assistance, such as food and housing support. This provision is unfair to affected individuals and has proven to be enormously difficult for the Social Security Administration to administer. Eliminating this provision would make the program more consistent with America's family values and simplify administration of the program.

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Increase the Administrative Budget **Restore SSA Infrastructure to Appropriate Levels**

Approximately 65 million Americans are enrolled in programs administered by the Social Security Administration (SSA). This includes the Old-Age, Survivors program, the Disability Insurance program, and Supplemental Security Income (SSI). Budget cuts have forced SSA to operate at a reduced capacity, resulting in a disability claims crisis affecting about 1.2 million individuals who are waiting an average of more than 545 days for a hearing decision. SSA's staffing is low relative to demand for service, which is increasing significantly with the arrival of 77 million baby boomers who are applying for benefits at the rate of 10,000 claims per day. Increasing the agency's budget must be a priority for 2017. Illustrating the importance of better agency funding is the fact that, sadly, about 8,000 individuals died in Fiscal Year 2016 while waiting for a decision on their claim for disability benefits.

No Privatization **Oppose the Privatization of Social Security**

In 2005, the American people and the majority in Congress rejected a proposal that would have privatized Social Security by diverting money out of Social Security and into private investment accounts. Since then, the proposal has disappeared from the public discussion surrounding Social Security. But some prominent leaders of the 115th Congress seem intent to dust off this discredited concept. Private account proposals will worsen Social Security's long-term financing, reduce Social Security benefits for future retirees, trade Social Security guarantees for the volatility of the stock market and add trillions of dollars to the federal debt.

No “Fast-Track” or “Entitlement Commission” Approaches

Oppose the Establishment of a Commission or Task Force to Address Social Security’s Finances

Under these scenarios a very small group of legislators and administration officials would write legislation which would then be fast-tracked through Congress on a limited time schedule with no opportunity to make amendments. Enacting restrictive timelines to limit debate, and prohibiting amendments to push through changes, ultimately disenfranchises the public and harms the political process.

Parity for Public Service Workers

Repeal the Government Pension Offset (GPO) and Windfall Elimination Provision (WEP)

The GPO unfairly reduces the Social Security spousal and survivor benefits for government employees who earned pensions under a system not covered by Social Security. Lower income women are disproportionately hurt by the GPO.

The WEP reduces the earned Social Security benefits of individuals who also receive a public pension from a job not covered by Social Security. It diminishes the promised protection of low-income earners by its universal application to any annuitant with less than 30 years of substantial Social Security earnings.

Older Americans Act

“Older Americans Act” (OAA) programs provide local services and assistance at the community level to help seniors live with independence and dignity in their own homes within their own communities. These services save lives, preserve families and reduce demand for more costly

hospital and institutional care paid for by Medicare and Medicaid. However, funding for the OAA has not kept pace with inflation or population growth and eligible seniors face waiting periods for some services in most states.

Increase Funding

Substantial, across-the-board increases are needed in federal funding for OAA programs for a rapidly increasing frail, older population who are most in need of services, and for 77 million baby boomers who are reaching retirement age. In addition to keeping pace with inflation in the future, we need to make up for past years of cuts in OAA services resulting from federal funding not keeping pace with inflation.

Alzheimer’s Research

Funding for Alzheimer’s Disease Research

The number of people suffering from Alzheimer’s disease or a related dementia is expected to skyrocket over the next few decades because many people are living longer and the incidence of Alzheimer’s disease increases with age. Meeting the challenges that Alzheimer’s disease presents and lessening the economic impact it has on families and government programs requires investing more federal funds in Alzheimer’s disease research in order to find a cure and/or a way to slow down the progression of the disease. Increasing research funding would save millions of lives and curb rising Medicare and Medicaid costs associated with Alzheimer’s disease and other dementias.



In December 2015, President Obama signed into law the Consolidated Appropriations Act of 2016 (P.L. 114-113) that increased Alzheimer's disease research at the National Institute on Aging by \$350 million or 59.7 percent over FY 2015. While the National Committee welcomed this increase, Congress and the President need to appropriate billions more on Alzheimer's research to mitigate the growing cost of the disease which is expected to reach \$1.1 trillion by 2050.

Civil Rights

Ensure Women Have a Livable Retirement by Ending Gender Wage Discrimination

The economic inequalities faced by women continue to threaten their retirement security because they have generally worked for lower wages due to persistent gender wage discrimination, leading to a smaller Social Security benefit. While Congress passed the "Equal Pay Act" in 1963 to address gender wage discrimination, women continue to make only 77 cents on the dollar compared to men.

Congress should strengthen and reform the "Equal Pay Act" by putting an end to pay secrecy, strengthening workers' ability to challenge discrimination and bringing equal pay law into line with other civil rights laws.

Conclusion

Americans of all ages and political persuasions overwhelmingly support the social insurance system and safety net programs that have protected generations of seniors, workers with disabilities, survivors and children. However, growing income inequality and declining employer-sponsored retirement and health benefits mean that protecting and improving the social insurance safety net is even more essential than ever to keeping middle and working class Americans out of poverty. The National Committee to Preserve Social Security and Medicare urges the 115th Congress to protect, improve and strengthen Social Security, Medicare, Medicaid and the "Older Americans Act" for current and future generations.

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