



Legislative Agenda

116th Congress, First Session, 2019



The National Committee to Preserve Social Security and Medicare is committed to working 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 116th 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 nearly 60 million people 65 years of age and older and people with disabilities. Even though half of all Medicare beneficiaries in 2016 had incomes below \$26,200, 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 Republican leadership of past Congresses prioritized a plan that would undermine the health security of current and future retirees and people with disabilities by ending traditional Medicare, reversing improvements made to Medicare by the Affordable Care Act (ACA) (P.L. 111-148), and raising the Medicare eligibility age. While the new House majority will oppose these proposals, the Senate majority may continue to embrace them.

Strengthen Traditional 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 traditional 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

On December 14, 2018, federal district judge Reed O'Connor ruled in *Texas v. US* that the Affordable Care Act is unconstitutional. If the decision is upheld by higher courts, Medicare benefit improvements in the ACA would be eliminated, including 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 beneficiaries receive. In addition, Medicare cost savings achieved 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 – would be eliminated. As a result, the exhaustion of reserves held in Medicare’s Part A Trust Fund will be accelerated. Congress must reenact the Medicare provisions in the ACA if higher courts uphold the 2018 decision in *Texas v. US*.

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 and Medicare

Provisions in the ACA have already resulted in additional years of solvency for 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 reduce improper payments, with an emphasis on preventing incorrect claims before they are made. This helps to avoid the costlier process of attempting to claw back payments from hundreds and 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 are paying higher premium subsidies than the previous amount due to a provision in the Medicare Access



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and CHIP Reauthorization Act (MACRA) of 2015 (P.L. 114–10). And starting in 2019, individuals with incomes above \$500,000 and couples with incomes above \$750,000 are paying a higher share of their Medicare premiums due to a provision in the Bipartisan Budget Act of 2018 (P.L. 115-123).

The income thresholds for income-related premiums are frozen under current law through 2019, meaning a greater proportion of beneficiaries are affected each year as incomes rise and more people cross the threshold. The number of Medicare beneficiaries subjected to higher premiums increased from 3.5 percent in 2011 to 6.6 percent in 2017. Under current law, the thresholds will be indexed to price inflation beginning in 2020 except for the top-level income thresholds of \$500,000/\$750,000, which are frozen until 2028. This means that more higher-income beneficiaries will be paying the top premiums each year. Means testing can also increase costs for middle-and lower-income seniors if higher-income seniors, who are often younger and healthier, are driven away from Medicare by increased cost sharing. This would undermine the success with this important social insurance program.

Oppose Administration Efforts to Undermine the Traditional Program

The Centers for Medicare and Medicaid Services (CMS) actively undermined the traditional Medicare program during the 2018 open enrollment campaign. CMS’ open enrollment educational materials and programs were incomplete and biased toward Medicare Advantage (MA) often failing to even mention traditional Medicare.

The National Committee strongly believes that Medicare beneficiaries need better and unbiased information to make more informed decisions about their health care coverage options.

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. 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.

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Unlike individuals who claim Social Security benefits by age 65, individuals who defer Social Security benefits are not automatically enrolled in Medicare when they first become eligible at age 65. If they fail to enroll in Medicare during their initial enrollment period – the three months before they turn 65, the month they turn 65 and the following three months – they may be subject to permanently higher Part B premiums with no upper limit due to the late enrollment penalty.

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 General Enrollment Period with the Annual 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 the month you turn 65; the month you turn 65, 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 beneficiaries enroll during the General Enrollment Period, which is from January to March each year, coverage should begin on the first day of the month after they sign up, instead of the current delay of coverage until July 1.

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 that 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.

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

There are various deductibles and copayments for Medicare-covered services. 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 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.

Eliminate the Three-Day Rule

Preferably, the three-day prior hospitalization requirement for SNF coverage should be eliminated, as it has been in some Medicare Advantage plans and Accountable Care Organizations. 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 Insurance benefits are likely to need medical care and should become eligible for Medicare when they start receiving Social Security.

Improve Medicare Supplemental Insurance (Medigap)

Congress should fill Medicare coverage gaps so that supplemental private Medigap plans are no longer needed. But until that happens, lawmakers should enact legislation to remedy the following shortcomings in Medigap rules and coverage:

Medigap rules currently do not require plans to guarantee issue to individuals with disabilities or to any beneficiaries outside of specified enrollment periods.

Most Medicare beneficiaries have insurance – Medigap, Medicaid or a Medicare Advantage (MA) plan – to fill some of the coverage gaps in Medicare. Twenty-five 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 Improve Beneficiary Understanding).

Currently, Medicare beneficiaries who are enrolled in MA can switch back to traditional Medicare and be eligible for guaranteed issue of Medigap if they switch within a year of first enrolling in an MA plan. Congress should extend this right to guaranteed issue to all individuals who leave MA plans regardless of when they make the switch to traditional Medicare.



The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114–10) phased out two popular Medigap plans, C and F, that cover the Part B deductible. While individuals with these plans will be able to keep them, the plans won't be able to take new enrollees. Over time, the inability to enroll younger Medicare beneficiaries will make the plans more expensive. Congress should support legislation that would create a special enrollment period where current enrollees in C or F plans can switch to other Medigap plans without consideration to any pre-existing conditions they may have.

Reform Part C - Medicare Advantage

Complete Payment Reductions to Private Medicare Advantage Plans

As a result of the Medicare Modernization Act of 2003 (P.L. 108-173), the federal government was required to 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 ACA gradually ends the overpayments and restores legitimate competition, saving \$156 billion over 10 years. The ACA made great strides in reducing plan overpayment to Medicare plans relative to traditional Medicare for a similarly situated individuals from 114



percent – prior to passage of the ACA – down to 101 percent in 2017. However, MA plans continue to draw down larger reimbursements than they should receive by using inappropriate diagnostic coding for enrollees' medical conditions. CMS and Congress should aggressively monitor inappropriate coding so that the gains made by the ACA in making payments to plans fair will not be reversed through falsified coding practices.

Expand Medicare Advantage Beneficiary Protections

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 the Medicare Part D Prescription Drug Program

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 plans that administer the benefit and the drug manufacturer. By law, the federal government cannot negotiate 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 Medicare beneficiaries, especially for those who are low-income. The Secretary should have bargaining leverage to negotiate with a manufacturer such as the discretion to include a drug on a national formulary, the ability to use a default price for a drug such as the price the Department of Veterans Affairs pays or to issue a license to a competitor to manufacture the drug when Medicare can't secure a reasonable price.



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 is estimated to save Medicare \$121 billion over 10 years.

Stop “Pay-for-Delay” Agreements that Delay Generics Entering the Market

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 is projected to save Medicare \$11.5 billion over 10 years.

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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 biosimilars 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. But lack of transparency around pricing can make it difficult for Medicare to know what is a reasonable price for a product. Legislation is needed to require manufacturers to provide information about R & D costs, advertising, profits and other data that inform pricing decisions.

Retain the Part D Provisions in the Bipartisan Budget Act (BBA)

The Bipartisan Budget Act (P.L. 115-123) closed the donut hole for brand drugs in 2019, one year earlier than under prior law. It also provided for higher manufacturer discounts on brand-name prescription drugs for beneficiaries who are in the coverage gap. The manufacturer discounts are included in the calculation of out-of-pocket costs that determine when a beneficiary crosses the threshold from the coverage gap into catastrophic coverage, where beneficiaries' costs are much lower. As a result, the BBA allows beneficiaries to move through the donut hole more quickly and see lower out-of-pocket costs. Reducing the share that Part D plans contribute to prescription drug costs should also lower premiums for beneficiaries and government outlays for the near term.

Fix the Part D Catastrophic Cliff

The threshold for individuals to enter the catastrophic phase of the prescription drug benefit — where beneficiary costs decline from 25 percent to just five percent — will jump from \$5,100 to \$6,350 in 2020 unless a provision in the Affordable Care Act, which lowers the threshold and expires after 2019, is extended. Legislation is needed to avoid this large jump in the threshold.

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 five percent of a drug's cost. 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.

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 over 12 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 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 Improve Beneficiary Comprehension).

Eliminate the Part D Low-Income Subsidy Asset Test

The amount of LIS assistance depends on beneficiaries' income and assets. In 2019, income is limited to \$18,210 and assets to \$14,100 annually (including burial costs) 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 Benefit 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 the best available clinical evidence, choose drugs that are cost effective for the Medicare program and pass along savings to the Medicare program and beneficiaries.

Oppose Provisions in NAFTA 2.0 that would Increase Prescription Drug Costs

During the 116th Congress, lawmakers will be asked by the Trump Administration to approve the revised North American Free Trade Agreement (NAFTA 2.0). NAFTA 2.0 contains several objectional provisions that would undermine access to affordable medicines and increase the cost paid by current and future retirees, including:

- New monopoly protections requested by pharmaceutical manufacturers.
- Forcing countries to allow “evergreen” drug patents or to issue new patent terms for new uses of old drugs.
- “Transparency” provisions that would give drug companies more opportunities and leverage to contest reimbursement amounts when government health care programs negotiate prescription drug costs with manufacturers.
- Investor-State Dispute Settlement provisions that could allow corporations to bypass domestic health care policies, potentially undermining state and federal efforts to contain the costs of prescription drugs and medical devices.

Congress should oppose NAFTA 2.0 changes to pharmaceutical patents and pricing policies that would undermine access to affordable medicines.

Improve Beneficiary Understanding

For Medicare to 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 Comprehensive 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 at age 65 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 a Medicare Prescription Drug Plan (Part D).

Improve the Annual Notice of Change

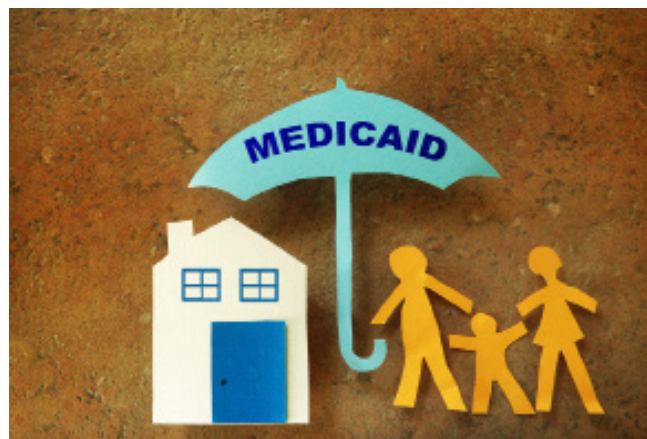
Coverage notices sent annually to Part C and Part D enrollees can be improved by consumer testing and tailoring the notices to the individual beneficiary's circumstances. Beneficiaries should be told whether their plans will change in a way that will raise their costs or limit access to a product or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

Improve the Centers for Medicare and Medicaid Services (CMS) Medigap Website to be More User Friendly

The website should include data on plan pricing, insurer financial stability and the history of policy price increases. There are dramatic price variations in the Medigap market with little indication that a higher 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 and to decrease the strain on American families and the Medicaid program.



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

Thirty-seven 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.

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.

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.

Money Follows the Person

This is a long-term care demonstration program in Medicaid that provides grants to states to help seniors stay in their homes. It has helped nearly 90,000 people stay in their homes. The program should receive a long-term or permanent authorization.

Home and Community-Based Services Spousal Impoverishment Protections

Since Congress amended the Medicaid law in 1988, a spouse of a Medicaid beneficiary receiving institutional long-term care has been allowed to retain a certain amount of the couple's combined resources. The Affordable Care Act temporarily extended "spousal impoverishment protections" to people married to individuals receiving Medicaid home and community-based services (HCBS). Medicaid HCBS spousal impoverishment protections should receive a permanent extension.

Social Security

Social Security is our nation's most important and effective income security program for American workers, retirees and their families. The 2018 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 \$996.6 billion in income received by the program in 2017, there is \$2.89 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.

Supplemental Payment to Seniors in Lieu of COLA

The 2019 COLA increase of 2.8 percent is inadequate and does not compensate for no COLA in 2016 and a miniscule 0.3 percent COLA in 2017. Social Security beneficiaries and veterans should be offered a one-time supplemental benefit payment equal to a 3.9 percent pay raise. The cost of the 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. We propose an increase to the basic benefit of all current and future beneficiaries by 5 percent of the average benefit (approximately \$70 per month).

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

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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 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 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 their marriage is annulled.

Program Improvements

Reinstate Production and Delivery of the Social Security Statement

Under current law, the Social Security Administration (SSA) is generally required to provide Social Security statements annually to all insured individuals age 25 or older who are not receiving Social Security benefits. Despite the unambiguous provisions of the law (section 1143 of the Social Security Act), SSA unilaterally discontinued production and delivery of the statements in 2011. For a time, the agency's plan was to provide statements to workers every five years. Now SSA provides statements only to individuals who are 60 or older and who are not receiving Social Security benefits, about 15 million individuals. At its peak, SSA was mailing about 130 million statements annually. Because these statements are so important in informing individuals of their rights under Social Security and in making sure that wages have been properly recorded, we believe that SSA should resume full production of the statements for all eligible individuals, with a possible exception for those who access their statements via SSA's online MySSA portal.

Office Closures

Since 2000, SSA has closed a total of 125 field offices nationwide. Along with these closures, SSA has eliminated nearly all small contact stations that it previously used to provide service to seniors in more remote and sparsely populated areas. The result has been a significant deterioration in the level of service it provides in its remaining field offices. Given the vital importance of local offices in providing the assistance that seniors and people with disabilities need to access benefits, we urge Congress to hold hearings that focus on office closures and how the fabric of SSA's network of local service delivery can be strengthened. The Appropriations Committees should carefully consider the allocation of resources made to the agency to assure that adequate levels of service can be maintained. In addition, Congress should enact legislation that would require SSA to follow specific guidelines when proposing to close or consolidate field offices.

Review of Recent Regulations and Other Actions Related to Disability Adjudication

Over the course of the past few years, and without regard to concerns expressed by disability advocates, SSA and others have issued several rule changes related to the adjudication of claims for disability benefits. Among these are rules that change the weighting of medical evidence provided by a claimant's treating physicians; rules related to submission of medical evidence by claimants and their representatives; rules requiring that all hearings before administrative law judges (ALJs) be held, at SSA's discretion, via video conferencing; the evaluation of pain when deciding whether an individual is disabled; and an executive order making significant changes to the procedures used by the federal government in selecting and hiring new ALJs. While the overall effect of these rule changes is not yet clear, their general thrust appears to militate against the interests of claimants. We believe these rule changes should be closely scrutinized by the committees of jurisdiction in Congress.

Improved Service to Seniors Regarding Benefit Filing Issues

Beginning around 2011, SSA decided to substantially curtail the advice it would provide to seniors who were struggling to decide when to apply for benefits. Known as "month-of-election," or MOE, SSA had prior to this time always provided guidance to prospective claimants on the complex ins and outs of deciding when to apply for benefits. With SSA no longer providing useful advice on these matters in local field offices, many seniors face the decision of when to apply with little or no meaningful guidance. And sadly, we now see retired agency employees benefitting from the knowledge vacuum thus created by training financial advisors on the intricacies of MOE. While future beneficiaries who can afford to pay for financial advice will learn when it is best for them to file for benefits, individuals without a professional advisor will have greater difficulty making an informed decision about when to file. That's why we urge Congress to hold hearings on this matter to encourage SSA to restore the practice of providing meaningful advice to seniors regarding their MOE.

Strengthen Safeguards for Widows, Widowers and Surviving Divorced Spouses

Since Congress eliminated several filing options in 2015, only widows, widowers, and surviving divorced spouses can limit the scope of their application so that it applies only to a single type of benefit to which that individual can qualify. If such individuals are eligible for benefits both on their own Social Security record and the record of a former spouse, they can choose the filing option that is most advantageous to them. For example, a widow might choose to receive benefits on her late husband's record at her full retirement age while deferring application on her own work record until she reaches age 70. These are complex issues that can be sorted out only with the help of staff at Social Security. And of course, there is the second step, which is to remember to apply at the appropriate time for the benefit that has been deferred. As recent audits have shown, some widows and widowers lose significant amounts of benefits when they make the wrong choice or fail to follow through on the second application. We urge the committees of jurisdiction in Congress to hold hearings that focus on these types of claims to determine whether there are options available to SSA to strengthen the protection provided to these claims.

Increase Program Revenue

Eliminate the Cap on Social Security Payroll Tax

In 2019, only the first \$132,900 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.

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 8.2 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 46 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.




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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 to \$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.

Increase the Administrative Budget

Restore SSA Infrastructure to Appropriate Levels

Over 67 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 almost one million individuals who are waiting an average of nearly 600 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, 10,000 of whom are reaching age 65 every day. Increasing the agency's budget must be a priority for fiscal year 2020. Illustrating the importance of better agency funding is the fact that, sadly, almost 10,000 individuals died in fiscal year 2018 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 116th Congress seem intent on dusting off this discredited concept. Private account proposals would 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.

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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 Social Security 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.

The GPO and WEP should be repealed or their reduction of public service retirees' Social Security benefits should be mitigated.

Women's Retirement Security

Due to persistent pay discrimination, part-time jobs and time away from the workforce for family caregiving, the average income for older women is less than for men. That's why women have lower average Social Security and retirement benefits than men.

As a result, women who are only eligible for Medicare, and not Medicaid, spend a high percentage of their income on out-of-pocket health care costs. Beneficiaries are responsible for premiums, deductibles, coinsurance and copayments on most services with no catastrophic cap, as well as for the cost of drugs when they reach the Part D prescription drug coverage gap. Medicare beneficiaries also pay premiums for supplemental Medigap insurance or retiree health coverage, and for health care services not covered by Medicare. These uncovered services include vision, dental and hearing services, as well as long-term custodial care. According to the Centers for Medicare and Medicaid Services' Medicare Current Beneficiary Survey, out-of-pocket spending in 2013 for Medicare beneficiaries was \$6,164 for women compared to \$5,129 for men.

While Medicare has provided five decades of health and economic security to seniors and people with disabilities, the program has been especially vital to women because:

- More than half of Medicare's nearly 60 million beneficiaries are women; for beneficiaries 85 and over, nearly 70 percent are women.
- Women live longer than men and are more likely to suffer from three or more chronic conditions including arthritis, hypertension and osteoporosis.
- More women than men suffer from physical limitations and cognitive impairments that limit their ability to live independently.
- Women have lower incomes than men.



Women Would Benefit from the Enactment of Several Medicare Proposals, Including:

- Adding a catastrophic cap on out-of-pocket expenses.
- Providing hearing, dental and vision benefits to Medicare beneficiaries.
- Building on provisions in the Affordable Care Act that will provide better care to Medicare beneficiaries by preventing disease and disability and expanding coordination of care for beneficiaries with multiple chronic conditions. The ACA has already helped millions of women who are Medicare beneficiaries by providing them access to preventive screenings -- with no deductibles or copayments -- including mammograms, cervical cancer tests and bone density measurements.
- Generating greater savings on the cost of prescription drugs by:
 - Allowing Medicare to negotiate drug prices with manufacturers.
 - Allowing Medicare to receive the same rebates as Medicaid for brand name and generic drugs provided to beneficiaries who are dually-eligible for Medicare and Medicaid or who receive the Part D Low-Income Subsidy.
 - Promoting lower drug costs by providing for faster development of generic versions of biologic drugs, and prohibiting “Pay-for-Delay” agreements between brand name and generic pharmaceutical companies that delay entry of generic drugs into the market.



Long-Term Services and Supports (LTSS)

Since women live longer on average than men, they are more likely to be widowed and to live alone. In addition, women represent over 70 percent of Medicare beneficiaries living in nursing homes and other facilities. Because Medicare’s coverage of long-term care services is very limited, many women have high or unaffordable out-of-pocket costs if they cannot live independently or need care for long periods of time. The cost of long-term services and supports is high, and out of the financial reach of many older women. On average, a semi-private room in a nursing home costs over \$89,000 a year, assisted living over \$48,000 a year, and home health aide services over \$50,000 per year. As a result, most women who need long-term services and supports are compelled to impoverish themselves to become eligible for Medicaid LTSS benefits.

The Senate Majority is likely to reaffirm their support for lowering the federal payment to state Medicaid programs by block granting the program or capping payments on a per-beneficiary basis (per capita caps). These proposals would force states to cut Medicaid LTSS service, quality and eligibility for the most vulnerable of our senior population, particularly women.

Lawmakers should legislate solutions to meet the rising demand for LTSS, including the development of a new national LTSS social insurance program, which would decrease the strain on American families.

Income Security

The retirement challenges facing millions of American women are compelling. On average, women live longer than men, yet their lifetime earnings are generally lower. Pay inequity while they’re working and inadequate benefits once they retire means millions of women face retirement insecurity in their old age.

As a result, women depend substantially in retirement on the benefits they receive from Social Security. Benefits last a lifetime and unlike many pensions, are adjusted for increases in inflation. In 2018, 46 percent of elderly unmarried women receiving Social Security relied on it for 90 percent or more of their total income.

Women deserve an adequate retirement income whether a work life is spent in the home, in the paid workforce, or a combination of the two. The National Committee supports improving benefit equity and safeguarding benefits for women by enacting several important changes to Social Security including: providing a caregiver credit, strengthening the cost-of-living adjustment, increasing benefits for seniors who have received Social Security for a long period of time, improving survivor benefits, providing benefit equity for working widows and widowers and restoring student benefits.

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.

Older American’s 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.

Reauthorize the Older Americans Act and Increase Funding

Congress should reauthorize the vital services and assistance provided by the OAA before the law’s current authorization expires at the end of fiscal year 2019. Substantial, across-the-board increases in authorization levels and appropriations 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, congressional appropriators need to make up for past years of cuts in OAA services resulting from federal funding not keeping pace with inflation.



Alzheimer's Disease

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.

Funding for Alzheimer's Disease Research

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. We should build on the fiscal year 2019 increase of \$425 million, which brought National Institutes of Health (NIH) funding for Alzheimer's disease/dementia research to \$2.34 billion annually. Increasing research funding would save millions of lives and curb rising Medicare and Medicaid costs associated with Alzheimer's disease and other dementias.



Treating and Curing Alzheimer's Disease

In addition to increased NIH research funding, we support proposals to provide testing for cognitive impairment in the Medicare Initial Preventive Physical Examination and Annual Wellness Visit, to establish Medicare payments that incentivize the detection and early diagnosis of Alzheimer's disease, provide training and support services for family members and caregivers and provide technical assistance to public health departments to focus on increasing early detection, diagnosis and education efforts.

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 116th Congress to protect, improve and strengthen Social Security, Medicare, Medicaid and the Older Americans Act for current and future generations.

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Social Security & Medicare**

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