



Legislative Agenda

118th Congress, First Session, 2023



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 second session of the 118th 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.

**111 K Street, N.E.
Suite 700
Washington, DC
20002
(202) 216-0420**

**Max Richtman,
President/CEO**

NCPSSM.ORG

COVID-19 Response

Enhance Health Security During COVID-19

Improve Nursing Home Safety

Older people have been the hardest hit by the coronavirus pandemic, and congregate residential long-term care showed the highest morbidity and mortality rates. Nine out of 10 deaths from COVID in the U.S. are adults 65 years old and older. Long-term care facility residents and staff account for over one-fifth of U.S. COVID-19 deaths.

As of December 2022, 60 percent of nursing home residents were not up to date on their COVID boosters. Despite the Center for Medicare and Medicaid Services (CMS) having amended Federal regulations to require that nursing home staff in Medicare/Medicaid facilities be fully vaccinated against COVID-19, with exemptions for medical and religious reasons, nursing home staff are not required to be boosted. Although regulations requiring nursing homes to do outreach and education around the importance of boosters, an alarming 76 percent of nursing home staff were behind on their vaccination boosters. According to data reported to the Centers for Disease Control and Prevention's National Healthcare Safety Network, COVID-19 infections among nursing home residents were higher in nursing homes with lower vaccination coverage among staff.

To improve infection control Congress and the Biden Administration should work to implement evidence-based national staffing standards for Medicare and Medicaid-certified nursing facilities, improve oversight of facilities with poor infection control and low resident and staff vaccination rates, and improve long term care facility workforce compensation and retention.

Further Congress should fund, and the Administration should implement, continued vaccine and treatment development and distribution.

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Prevent COVID Vaccine and Treatment Price Gouging

In exchange for increased funding for vaccine development, Congress should require reasonable pricing of any treatments or vaccines developed using public funding. Expansive patent and regulatory monopolies – including additional ones for existing therapies that can be used to treat COVID – should not be granted. The global scale of the pandemic will enable drug manufacturers to make large profits from fairly priced products on volume alone.

Transitioning from the Public Health Emergency

The Administration should extend coverage for at-home Covid-19 tests once the public health emergency (PHE) ends. Currently, Medicare coverage for at-home Covid-19 diagnostic tests is set to expire at the end of the Covid-19 PHE.

The Consolidated Appropriations Act of 2023 (P.L. 117-328) delinked the requirement that states must continuously enroll individuals who got on Medicaid under temporary pandemic rules. States may disenroll people who do not meet standard Medicaid eligibility rules beginning in April of 2023 but must meet redetermination requirements under the Act to keep the increased emergency funding that will gradually phase out in 2023. CMS should work with states to ensure that older adults are educated about transitioning to Medicare, that states transition eligible to the Medicare Saving Program, that CMS use new special enrollment periods liberally to allow individuals who have missed their initial part B enrollment period to transition to Medicare without penalty.

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 more than 61 million people 65 years of age and older and people with disabilities. Even though half of all Medicare beneficiaries in 2020 had incomes below \$29,650,

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.



Strengthen Traditional Medicare

Reject Calls to Weaken Medicare

Under possible returns of “premium support” proposals that would privatize Medicare, beneficiaries would not enroll in the current traditional Medicare 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 structure their plans to attract the youngest and healthiest seniors.

In addition, private plans control costs by utilization management tools such as requiring prior authorization for services and by negotiating fees with a limited number of physicians that comprise their networks while traditional Medicare offers access to nearly all physicians. Studies have consistently show that Medicare Advantage plans disenroll healthy beneficiaries at higher rates than the traditional program. Premium support would exacerbate the phenomenon of older and sicker beneficiaries being disproportionately represented in the traditional program. Sicker seniors have higher health costs that lead to higher premiums that many beneficiaries may be unable or unwilling to pay, and could over time result 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 Raising the Medicare Eligibility Age from 65 to 67

NCPSSM is opposed to raising the eligibility age for Medicare because the proposal would increase costs for millions of older Americans. Communities of color would be hardest hit because they tend to be in poorer health at earlier ages, accumulate less wealth that can be used to pay for health care due to lower lifetime earnings, and have shorter life expectancies on average. More broadly, increasing the age of eligibility would shift costs to Medicare beneficiaries, employers, and the states. For example:

- 65- and 66-year-olds who would lose Medicare coverage and would, on average, face higher out-of-pocket health care costs. Two-thirds of this group – 3.3 million people – would face an average of \$2,200 more each year in premiums and cost-sharing charges.
- Employers who provide health care coverage to their retirees would face higher costs as more 65- and 66-year olds received primary coverage through their employer rather than Medicare.
- State Medicaid programs, whose costs would rise as some of the people who lost Medicare coverage would shift to Medicaid.
- Raising the eligibility age would also serve to increase costs for Medicare if and as younger, healthier people are eliminated from the risk pool and costs were to be spread across an older, less healthy population.

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 (ACOs) 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 annual incomes above \$91,000 for individuals and \$182,000 for couples are paying higher Part B and D premiums due to provisions in the Medicare Modernization Act of 2003 (MMA) (P.L. 108-173) and the Affordable Care Act (ACA). In addition, beneficiaries with incomes above \$153,000 pay higher premium subsidies than the previous amount due to a provision in the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (P.L. 114-10). Individuals with incomes above \$500,000 and couples with incomes above \$750,000 pay 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 were frozen through 2019, affecting a greater proportion of beneficiaries each year as incomes rose and more people crossed the threshold. The number of Medicare beneficiaries subjected to higher premiums increased from 3.5 percent in 2011 to 8 percent in 2022. Under current law, the thresholds were 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 additional 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.

Reverse Efforts to further Privatize Traditional Medicare

The Centers for Medicare and Medicaid Services (CMS) is continuing a controversial program started under the Trump Administration that would aggressively incentivize private Accountable Care Organization (ACO) “direct contracting” entities to manage care in the traditional program. As part of the Biden Administration’s effort to rebrand direct contracting entities as “ACO Realizing Equity, Access, and Community Health” (ACO REACHs), changes were made to discourage participation by private equity backed organizations and increase participation by physicians. However, more work needs to be done to close loopholes that allow investor driven direct contractors into the program. Also, oversight is needed to ensure that ACO REACHs aren’t stinting on care or inappropriately steering beneficiaries to other providers in their networks or without making it clear beneficiaries are free to go to any doctor they want.

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 Medicare 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 (usually certain federal, state and local government retirees) and higher-income beneficiaries (incomes exceeding \$97,000 for an individual and \$194,000 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.

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 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.

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.

Permanently Count Observation Days Toward Meeting the Three-Day Rule

Medicare beneficiaries have been denied access to Medicare’s skilled nursing facility (SNF) benefit when acute care hospitals classify 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, 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 will not qualify for Medicare coverage. If the “three-day” rule remains, 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.

Fortunately, the Center for Medicare and Medicaid Services waived this requirement for the duration of the COVID-19 public health emergency. That’s why, before the pandemic waiver expires, Congress must pass legislation to count hospital observation days toward meeting the three-day rule.

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:

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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 additional coverage – Medigap, Medicaid or a Medicare Advantage (MA) plan, and some have retiree coverage from a prior employer – that fills some of the benefit gaps in Medicare. Twenty-one percent of Medicare beneficiaries rely on Medigap policies to provide financial security and protection from high, unexpected out-of-pocket costs. This coverage could be strengthened.

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.

Disabled Medicare beneficiaries age 64 and younger do not have this “guaranteed issue” protection until they turn 65. Upon turning 65, federal law requires that these beneficiaries be eligible for the same six-month open enrollment period for Medigap that is available to new beneficiaries age 65 and older.

In addition to the six-month initial period of guaranteed issue, Medicare beneficiaries who are enrolled in Medicare Advantage can switch back to traditional Medicare and be eligible for guaranteed issue of Medigap under the following “qualifying events”: when their MA plan withdraws from their area, when moving to a new area not covered by their MA plan, and when voluntarily disenrolling from a MA plan within a trial period. Under these circumstances, the Medigap guaranteed issue protection is limited within a year of the qualifying event. Four states (Connecticut, Massachusetts, Maine and New York) require either continuous or annual guaranteed issue protections for Medigap for all beneficiaries in traditional Medicare ages 65 and older, regardless of medical history.



Congress should extend Medigap guaranteed issue protection to individuals with disabilities who are eligible for Medicare and individuals who leave MA plans regardless of when they make the switch to traditional Medicare (see section below on Improve Beneficiary Understanding). The National Committee recognizes requiring this protection could result in some beneficiaries waiting until they have a serious health problem before purchasing Medigap coverage, which could increase premiums. To prevent such “adverse selection”, guaranteed issue protection could be limited to a year-long “special enrollment period” triggered by a much broader definition of a “qualifying event” – like when a beneficiary switches from Medicare Advantage 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. Overtime, the inability to enroll younger Medicare beneficiaries will make the plans premiums 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 more per beneficiary than traditional Medicare for providing the same services. According to projections, following a 9 percent increase from 2021 to 2022, enrollment in the Medicare Advantage (MA) program is expected to surpass 50 percent of the eligible Medicare population in 2023,

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and at current enrollment growth rates is on track to reach 69 percent of the Medicare population by the end of 2030. 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 104 percent in 2022. However, MA plans continue to draw down larger reimbursements than they should receive by using inappropriate diagnostic coding for enrollees’ medical conditions. To address this problem, Congress should require the Centers for Medicare and Medicaid Services to use a specific and even-handed method of computing coding intensity. A formula for measuring coding intensity would bring payments to MA plans more in line with payments for other providers.

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.

Increase consumer protections around use of prior authorizations including creating standards for timeliness of response to requests for items and services. Streamline prior approval process for commonly approved items and services.

Improve Transparency around MA

Require Medicare Advantage (MA) plans to provide data on supplemental benefits, including optional long-term services and supports that plans may choose to offer in varying configurations, and on prior authorization. Annually publish specified prior authorization information, including the percentage of requests that are approved and the average response time.

Reform the Medicare Part D Prescription Drug Program

Protect and Improve on the Inflation Reduction Act to Allow the Government to Negotiate Lower Medicare Part D Drug Prices

Medicare Part D drug prices have historically been determined through a negotiation between the private drug plans that administer the benefit and the drug manufacturer. Until the Inflation Reduction Act (IRA) (P.L. 117-169) was enacted, the federal government could not, by law, negotiate Medicare drug prices. The Inflation Reduction Act gave the Secretary of Health and Human Services (HHS) the authority to negotiate some drugs used under Medicare Part B and D. The IRA should continue to be built upon to expand the number of drugs that can be negotiated and eliminate delays on when a drug becomes eligible for negotiation (9 years for pills, 13 years for biologics--drugs administered in a doctor’s office.)

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.

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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.

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 determine 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.

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 13 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 2023, income is limited to \$9,090 and assets to \$15,160 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.

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)

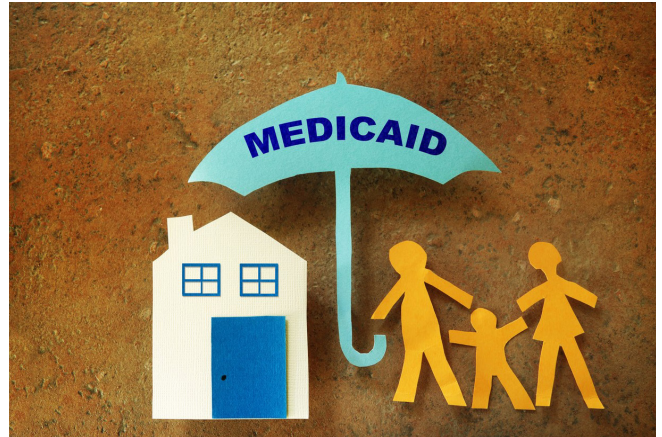
SHIPs assist Medicare beneficiaries with their enrollment decisions, offering local, unbiased, personalized counseling and assistance at no cost to people with Medicare and their families. They answer questions about benefits, coverage, and cost sharing. They can also help beneficiaries with enrolling 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.

Medicaid and Long-Term Services and Supports

Over 14 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-nine 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.

Reinvent Nursing Homes with Improved Transparency, Accountability and Bold Reform

There is an urgent need to overhaul the quality of care and the quality of life for the nation's 1.3 million nursing home residents. Leading this work, the Biden Administration issued a call in February 2022 ("Protecting Seniors by Improving Safety and Quality of Care in the Nation's Nursing Homes"), and the National Academy of Sciences, Engineering and Medicine issued a comprehensive blueprint for reform in April 2022 ("The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Family and Staff"). Part of this drive is to recognize that chronic staffing shortages mean that in many nursing homes, staffing levels are too low to assure reliable, consistent, safe care. Research has long established that staffing levels are fundamental to good care, and the Department of Health and Human Services (HHS) is expected to publish an updated analysis of safe national staffing standards that can be implemented over time, along with strengthened reporting requirements for nursing homes to reflect the many layers of ownership and financial relationships that characterize today's nursing home sector, and more detailed cost reports that reflect how Medicare and Medicaid dollars are actually being spent. Beyond these staffing and accountability standards, the National Committee supports expanded development of cottage-style "small homes" and renovation of larger buildings into small "household" suites with private rooms, which allow staff to get to know and provide individually tailored care for manageable numbers of older adults who are living with disabilities.

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Beyond nursing homes, the National Committee supports ongoing efforts to develop a continuum of better coordinated and integrated options for Medicare and Medicaid beneficiaries to be able to easily access long-term services and supports (LTSS). For example, expansion of PACE (Program of All-Inclusive Care for the Elderly), which is a provider-based model of care (capitated on both the Medicare and Medicaid side) that has the best record of serving individuals with very complex conditions and disabilities needs to be done expeditiously, so that more Medicare beneficiaries who wish to “age in place” can access this highly coordinated care model. Allowing Medicare’s home health benefit to better serve the needs of beneficiaries with chronic progressive illness is also sound policy, and taking steps to make enhanced home care more available to beneficiaries in traditional Medicare wishing to purchase such services as part of their supplemental insurance (Medigap) is worthy of careful consideration.

Adding LTSS to Medicare and the Possibility of a New Social Insurance Program

The goal of adding evidence-based, cost-effective LTSS to Medicare’s covered benefits can and should be a high priority for Congress and for the Administration. This can be done through analysis of what works and what LTSS services are most likely to reduce high-cost care in hospitals and long-stay placement in nursing homes. 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. A new federal social insurance program to finance LTSS should be discussed and considered, and efforts in Washington State and others to experiment with policy and enacting new public financing for benefits for state residents paying in should be supported. In general, Medicare beneficiaries should not have to impoverish themselves or their spouses, and policies that impact higher-income individuals’ access to Medicaid’s LTSS benefits should be done in the context of developing a coherent continuum of services and a long-term care strategy that works for individuals across income levels.

Eliminate the “Institutional Bias” in Medicaid

For Medicaid beneficiaries who require LTSS, institutional care is frequently their only option. Home- and community-based services (HCBS) are often provided only at state option, though there has been movement toward increasing access to these services as an alternative. However, during an economic downturn, states often have little choice but to cut back on services and optional state benefits get cut first. The American Rescue Plan (P.L. 117-2) created a temporary 10 percent Federal Medical Assistance Percentage increase for states to use for activities that enhance, expand, or strengthen HCBS services under their Medicaid programs. There needs to be both short-term increased federal funding for HCBS during the COVID-19 public health emergency and longer-term financing and other incentives to eliminate the institutional bias in Medicaid 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 (MFP)

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 over 100,000 people stay in their homes. While the Consolidated Appropriations Act of 2023 extended MFP for through September 2027, the program should receive a permanent authorization. Without a permanent authorization, the number of states that have participated in the program has dropped and the number of transfers outside of nursing homes and into the community has also declined.

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.

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The Affordable Care Act temporarily extended “spousal impoverishment protections” to people married to individuals receiving Medicaid home and community-based services (HCBS). Although the Consolidated Appropriations Act of 2023 extended Medicaid HCBS spousal impoverishment protections for four years, this safeguard 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. Social Security’s benefits are critical but modest, and should not be cut in the name of fiscal solvency. The 2022 Trustees Report states that Social Security is well funded, remains strong and as currently structured will be able to pay full benefits until 2035. In addition to over \$1 trillion in income received by the program in 2021, there is \$2.85 trillion in Social Security Trust Funds. Even the pandemic, with its associated economic devastation, had a minimal impact on the long-range financial stability of the program. Our nation’s rapid economic recovery helped replenish the Trust Funds and Social Security’s Actuary estimates the projected exhaustion date of the combined Social Security and Disability Insurance Trust Funds moved back from 2034, estimated last year, to 2035. 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

One of Social Security’s strengths is that it includes annual Cost-of-Living Adjustments (COLAs) that are intended to help beneficiaries keep up with increases in the cost of living over decades in retirement. Unfortunately, the current formula does not fully take into account the spending patterns of older Americans, who are more likely to purchase goods and services related to health care than the younger urban and clerical workers the formula currently uses. 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. The 2023 COLA was 8.7 percent, the highest annual increase since 1981. Although this historically high increase was good news for seniors, it does not speak well for Social Security’s ability to keep up with seniors’ ever-rising living costs over decades spent in retirement. The average COLA over the previous 10 years was only 1.88 percent, and there was no COLA at all for three of the past 14 years. Using the CPI-E to calculate future COLAs would help alleviate this problem.

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.

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

Seniors who live into their 80s 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 they first become eligible for Social Security benefits 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.

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 ten years spent providing care to certain dependent 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, but its value has deteriorated over time to the point of becoming entirely ineffective. It is unacceptable that seniors who have worked their entire lives should face retirement in poverty. For this reason, the Special Minimum Benefit should be set at a floor of 150 percent of the federal poverty line, thus restoring its ability to provide a safety net in retirement to those who spend their lives working. Other changes should include updating the method by which this benefit amount is calculated so that more individuals, many of them women, can qualify. This could be achieved by giving individuals credit for up to ten years spent outside the workforce providing care to family members. Additionally, wage growth should be adopted as part of the calculation for the PIA amount.

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.

Restore Protection from Garnishment of Social Security Benefits

Since the inception of the Social Security program in 1935, the Social Security Act provided strong protections against loss of retirement income through the garnishment or attachment of Social Security benefits for the purpose of recovering debts owed by retirees. For decades the law provided near iron-clad protection against impoverishment in old age due to debt collection.

Unfortunately, in 1996 the Congress reversed course by authorizing the garnishment of Social Security and other earned benefits for the purpose of collecting debts owed by seniors to the federal government. Congress must restore the historic protections that once were provided by Social Security against the spectacle of impoverishment in old age.

Providing Automatic Waivers for Overpayments of Social Security Benefits

When a Social Security or Supplemental Security Income (SSI) beneficiary's circumstances change, Social Security Administration (SSA) reduces or cuts off benefits if required by the programs' rules. Due to the pandemic, SSA suspended overpayment notification and collection and temporarily stopped most work related to reducing or cutting off benefits. As a result, some beneficiaries have been receiving extra benefits through no fault of their own, which SSA has signaled it will again begin collecting. The law allows SSA to waive repayment of overpaid benefits if the individual is without fault and cannot afford to repay them. The agency has begun streamlining the process for granting overpayment waivers but in practice this has serious shortcomings. The National Committee supports granting automatic waivers of repayments.

Raise Taxation Threshold for Social Security Benefits

In the early days after enactment of the Social Security Act, none of the benefits paid were subject to federal income taxation. As part of the 1983 Social Security Amendments (P.L. 98-21), a change was made and benefits over fixed thresholds were subject to income tax for the first time. The change was made to raise revenue for the program, but also to provide tax treatment of Social Security benefits analogous to that applied to private pensions, where a workers' contributions are not subject to federal income tax, but employer contributions and account earnings are taxable at the time of distribution.

At the same time, Congress acknowledged the uniqueness of Social Security as the bedrock of workers' retirement security by ensuring that only higher-income beneficiaries would be subject to the tax. At the time, the tax applied to about ten percent of beneficiaries. The thresholds set by the law were not indexed for inflation, however, so in the intervening years the percentage of beneficiaries who pay income taxes on their Social Security has risen to about one out of every two beneficiaries. Congress should enact legislation raising the tax thresholds so that middle-income beneficiaries are not subject to income tax on their Social Security benefits.

Increase the Administrative Budget

Restore SSA Infrastructure to Appropriate Levels

Over 69 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 over 500 days for a hearing decision. SSA's staffing is low relative to demand for service, which is increasing significantly with the aging 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 2023 and beyond. Unfortunately, funding provided in the Consolidated Appropriations Act of 2023 falls short of adequately addressing the continued growth in the demand for services and the cost of re-opening field offices safely in the face of continuing disruptions due to the pandemic. In future appropriations bills, SSA must be sufficiently funded if it is to serve the needs of both seniors and workers. Illustrating the importance of better agency funding is the fact that, sadly, almost 110,000 individuals died from 2008-2019 and 50,000 people filed for bankruptcy between 2014-2019 while waiting for a decision on their claim for disability benefits.

Program Improvements

Reinstate Production and Delivery of the Social Security Statement

Under current law, 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 previously provided services to seniors in more remote and sparsely populated areas. The result has been a significant deterioration in the level of service SSA 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; and the evaluation of pain when deciding whether an individual is disabled. While the overall effect of these rule changes is not yet clear, their general thrust appears to militate against the interests of claimants. The Biden Administration and congressional committees of jurisdiction must carefully review disability adjudication regulations proposed or promulgated by the previous Administration and withdraw, revise, or withhold funding for implementation, as appropriate, for any harmful program policy initiatives.

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. For this reason, we urge Congress to approve legislation requiring 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 2023, only the first \$160,200 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 could play a central role in strengthening Social Security's finances. However, raising the payroll tax cap – with the goal of eventually eliminating it – would also extend the program's solvency and help to pay for needed benefit improvements.

Increase the Social Security Tax Rate

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 8.1 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 50 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.

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.

No Privatization

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 proponents will never give up 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.

No Payroll Tax Deferrals or Elimination

The payroll tax, or FICA payment, is a contribution workers make with each and every paycheck in exchange for guaranteed benefits backed by the full faith and credit of the U.S. government. Eliminating this dedicated source of funding would end Social Security as we know it, converting the program into an unpredictable welfare benefit dependent upon the whims of future Congresses and Administrations, and forcing the earned benefits of millions of workers and their families to compete for funding with myriads of other national priorities. The National Committee strongly opposed former President Trump's initiative to defer payment of payroll taxes and ultimately repeal them, and we urge Congress to preserve this critical dedicated source of income for Social Security's future.

No "Fast-Track" or "Entitlement Commission" Approaches

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

These scenarios typically allow a very small group of legislators and administration officials to 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. Any changes to Social Security should go through the regular legislative process, with hearings and the opportunity for amendments in the Committees of jurisdiction and ample time for the American public to fully understand the impact of any proposed changes.

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 is 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. 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.

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According to the Centers for Medicare and Medicaid Services' Medicare Current Beneficiary Survey, out-of-pocket spending in 2017 for Medicare beneficiaries was \$6,175 for women compared to \$5,375 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:

- Women live longer than men and are more likely to suffer from three or more chronic conditions including arthritis, hypertension and osteoporosis.
- More than half of Medicare's over 61 million beneficiaries are women; for beneficiaries 85 and over, nearly 70 percent are women.
- More women than men suffer from physical limitations and cognitive impairments that limit their ability to live independently.
- Women have lower incomes than men.



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 are 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 84 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.

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Ensure that a Strong Fiduciary Standard Applies to Retirement Accounts

Workers trying to manage their retirement savings can find themselves confronting a complex set of investment choices, so they often turn to investment advisors for help making financial decisions. These advisors are not always required to act in their best interest when offering investment advice.

Advisors who are subject to a “fiduciary” standard are required to always act in the beneficiary’s best interest, even if doing so is contrary to the advisors’ interest. Advisors who are not fiduciaries are held to a lower standard – that of “suitability”. For advice to be considered merely “suitable,” the financial professional must only have an adequate reason to believe a recommendation fits the client’s financial situation, needs and other investments, nor must advisors avoid conflicts of interest. The suitability standard does not require advisors to put their clients’ best interests before their own.

The Obama administration’s Council of Economic Advisers estimated that advice from advisors with conflicting incentives costs IRA investors about \$17 billion per year. The council estimated that recipients of conflicted advice earned 1 percent lower returns each year. If conflicted advice is given when a 401(k) is rolled over into an IRA, it can cost the investor an estimated 12 percent of his savings over 30 years, with those savings running out more than five years sooner as a result.

The Department of Labor has been struggling to update the rules governing fiduciaries for years and has been repeatedly challenged in court. The National Committee believes a strong fiduciary standard rather than the lower suitability standard is essential for those providing advice related to retirement accounts as these assets are integral to workers’ retirement security.

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 Older Americans Act Funding

Substantial, across-the-board increases in 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 2023 increase of \$226 million, which brought National Institutes of Health (NIH) funding for Alzheimer's disease/dementia research to more than \$3.7 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. In addition to the financial and health challenges commonly associated with aging, older people have been the hardest hit by the coronavirus pandemic. The National Committee to Preserve Social Security and Medicare urges the 118th Congress to protect, improve and strengthen Social Security, Medicare, Medicaid and the Older Americans Act for current and future generations.

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**The National Committee to Preserve
Social Security & Medicare**

**Max Richtman, President/CEO
richtmanm@ncpssm.org
(202) 216-8383**

**Dan Adcock, Government Relations
& Policy Director
adcockd@ncpssm.org
(202) 216-8465**

**www.ncpssm.org
www.entitledtoknow.org
@ncpssm**

**111 K Street, NE
Suite 700
Washington, DC 20002
(800) 966-1935**

