Legislative Agenda

119th Congress, Second Session, 2026

National Committee to Preserve Social Security & Medicare®
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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 119th 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.

777 North Capitol St. N.E.
Suite 805
Washington, DC 20002
(202) 216-0420

Max Richtman, President/CEO

Support the Crucial Work of Federal Employees on Behalf of Seniors

The National Committee's overarching concern during the 119th Congress (2025-2026) is the Trump Administration's intent to arbitrarily layoff, fire and force into retirement massive numbers of the dedicated and talented federal workers that perform essential services to older Americans. Prior to the current administration, most federal agencies focused on seniors were underfunded and understaffed to serve the more than 10,000 older Americans turning 65-years-old every day. The actions of the so-called "Department of Government Efficiency" (DOGE) has only further debilitated the capacity of these agencies to serve the best interest of taxpayers. Although they are being promoted in the name of improving efficiency and cutting fraud, waste and abuse, the vast majority of DOGE's claims have been thoroughly disproven.

Mass reductions in the federal workforce have been particularly harmful at the Social Security Administration and the Department of Health and Human Services because they could undermine the public popularity of Social Security, Medicare and Medicaid. In fact, the National Committee is concerned that erosion of basic services could enhance the ability of opponents of our cherished programs to privatize the agencies that manage them and privatize and/or cut the earned benefits of current and future generations of seniors. We are also troubled by the significant staff reductions at the Administration for Community Living, the National Institutes of Health, the Food and Drug Administration, the Department of Treasury's Bureau of Financial Service, the Department of Labor, and the Department of Justice's Civil Rights Division. The National Committee condemns these ill-conceived personnel actions against federal workers and will join with other organizations in opposing them.

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 2025 Trustees Report states that Social Security is well funded for now, remains strong and as currently structured will be able to pay full benefits until 2034. In addition to almost $1.4 billion in income received by the program in 2024, there is $2.72 trillion in the Social Security Trust Funds. Congress has ample time to make reasonable changes to strengthen Social Security's long-term financing through the regular legislative process. At the same time, Congress must address the issue of benefit adequacy since a growing share of Americans depend on Social Security for all or most of their retirement income. As a result of wage stagnation for the middle class and rising wealth inequality, future generations can expect to also rely on Social Security as the bedrock of their families' financial security. 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 2026 COLA was 2.8 percent, while the Medicare Part B premium increased by 10 percent. With the exception of the 2022 and 2023 high COLAs, the current COLA formula has not led to an increase of over 3 percent for thirteen out of the last eighteen years. There was no COLA at all for 2009, 2010 or 2015, and the 2016 COLA was a mere 0.3 percent. 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.

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. They are less likely to be able to continue working, their health care costs are likely to be higher, and whatever private savings they may have accumulated for retirement are likely to be depleted. 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 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 practically 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, at a minimum, be set at a floor of 125 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 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 not only help the student, but also those who must defer saving for their own 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 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. This Offset Program with Treasury was suspended during the COVID-19 pandemic but recently restored by the Trump Administration. Congress must reverse this decision and restore the historic protections that once were provided by Social Security against impoverishment in old age.

Address Overpayments of Social Security Benefits

The Social Security Administration takes seriously its responsibilities to ensure eligible individuals receive the benefits they have earned and to safeguard the integrity of benefit programs to better serve its customers. While payment accuracy rates are high, both underpayments and overpayments do happen given the number of people the agency serves, the number of changes in their circumstances, and the complexity of the programs. When a Social Security or Supplemental Security Income (SSI) beneficiary's financial circumstances change so they are no longer entitled to the benefit amount they have been receiving, the Social Security Administration (SSA) reduces or cuts off benefits if required by the programs' rules, and implements procedures to recoup the overpayments. The agency has the authority to waive repayments in some cases, but that authority must be balanced with the agency's responsibility to safeguard the integrity of the benefit programs. Under the previous leadership, SSA had implemented a number of modifications to its recoupment process to make it easier for beneficiaries to address overpayment that have occurred through no fault of their own. The Trump Administration reversed some of these improvements. Congress and the Administration should restore the previous improvements in overpayment recoupments and continue exploring methods to further improve the process for beneficiaries.

Raise Taxation Threshold for Social Security Benefits

In the early days after the 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, a change was made so benefits over fixed thresholds were subject to federal income tax for the first time. The change was made to raise revenue for the program, but also to provide a mechanism for generating increased contributions to both Social Security and Medicare from higher income beneficiaries. Over time, the federal taxes raised have become an increasingly large revenue stream for both programs. In 2023, the tax raised almost $100 billion for the programs, revenue which is projected to total $1.6 to $1.8 trillion through 2035.

When the tax was established, 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 four 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 benefits has risen to about 40 percent of beneficiaries, and that number will only continue growing with time. President Trump has committed to eliminating the income tax on Social Security benefits but has not suggested how he would replace the revenue that would be lost. Without such a plan, repealing the tax would advance the Trust Fund depletion date for Social Security's retirement fund by over one year and the Medicare Hospital (HI) Trust Fund by six years. If Congress enacts legislation either repealing the tax or raising the tax thresholds so that middle-income beneficiaries are not subject to income tax on their Social Security benefits, it must ensure that the lost revenue is replaced by a dedicated alternative revenue source. For example, we support reducing the taxation of Social Security benefits by increasing the income thresholds below which benefits are not taxed and offsetting this revenue loss by raising the wage cap on Social Security payroll taxes.

Increase the Administrative Budget

Restore SSA Infrastructure to Appropriate Levels

Almost 73 million Americans are enrolled in programs administered by the Social Security Administration (SSA). Although the number of beneficiaries is at a record high and increasing, as over 10,000 baby boomers reach age 65 daily, SSA's operating budget has been essentially flat since 2018, the most recent year SSA received funding equal to 1.2 percent of the benefits it paid and the agency provided the level of customer service Americans have earned. If this history of underfunding continues, further deterioration of customer service is inevitable.

The agency is operating with the lowest staffing levels in 50 years, which will result in a reversal of the service improvements SSA has achieved in recent years. SSA instituted a hiring freeze in November 2024, and Elon Musk, through the operations of the so-called Department of Government Efficiency (DOGE) pressured an additional 7,000 employees, or about 12 percent, to resign or take early retirement. At the same time, SSA is planning field office closures, limiting access to Social Security services through the SSA phone service and providing a few hours of training to staff reassigned to answer beneficiary calls. The impact of these and other proposed changes is clear: many benefit payments may be delayed, wait times on the SSA national toll-free number will grow, as will service backlogs, especially in processing disability claims.

Benefits delayed become benefits denied. According to a report by the U.S. Government Accountability office (GAO) in 2020, almost 110,000 individuals died from 2008-2019, 30,000 in 2023 alone, and 50,000 people filed for bankruptcy between 2014-2019, all while waiting for a decision on their claim for disability benefits. The DOGE-driven staff cuts and policy changes affecting phone services have resulted in a significant deterioration in the level of service SSA provides in its field offices. Given the vital importance of local offices in providing the assistance that seniors and people with disabilities need to access benefits, maintaining fully functioning local offices is critical to the agency's ability to serve the public.

The ongoing funding shortfalls are especially frustrating when one considers that the source of funding for SSA's operations comes nearly entirely from the Social Security Trust Funds themselves, not general revenue – which means American workers have already paid for the services needed to access their benefits. Shortchanging the agency Americans rely on to receive their earned benefits is tantamount to cutting Social Security, and Congress must step in to reverse this history of underfunding. We urge the Administration and Congress to restore a level of funding for the Social Security Administration equal to 1.2 percent of benefits paid, helping to rebuild the agency's ability to provide the level of customer service the American public has earned.

Limit reliance on private contractors or Artificial Intelligence (AI)

Under its "digital first" agenda, the Trump Administration has begun replacing federal SSA employees with contractors or Artificial Intelligence in computer systems to provide services to the American public. While outsourcing SSA operations may be appropriate in some limited circumstances, any shift in this direction must be carefully investigated before it is implemented. SSA holds an extraordinarily wide range of personal, private information on virtually every American. Allowing contractors unfettered access to this information, without the privacy safeguards and legal limits that SSA employees must operate under, places at risk vast troves of personal information including Social Security numbers, banking information, employment histories, and in many cases, private medical records. This is especially true when security clearances are rushed and perfunctory, or if contractors are selected based on their ability to deliver cost savings rather than their capacity to protect Americans' personal data. Numerous claims have been made that the vast troves of American's data held by SSA has been inappropriately or illegally shared with others, or moved to unauthorized cloud storage with minimal controls over the data's access and use. If the claims are substantiated, this cavalier attitude toward American's personal data could leave millions exposed to identity theft and scam artists. It would also be extremely concerning if members of the Administration or their friends and associates are permitted to bid on any contract offered, thus profiteering from the privatization of functions better performed by government employees.

Those most likely to utilize SSA's services are older or disabled, and comprise the customers least able to conduct important financial business online, or to travel long distances to reach a field office. Restricting their ability to utilize phone systems to conduct business under the guise of reducing unsubstantiated claims of fraud will limit the ability of many to access their earned benefits. Considering the complexities of reviewing and responding to questions regarding benefit eligibility in programs administered by SSA, replacing trained, human employees with AI systems with any acceptable level of accuracy may not be possible, and at a minimum will require extremely high levels of competence to program and maintain.

Congress and the Administration must place the highest priority on protecting the privacy of Americans' financial and medical data.

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, who do not have an online My Social Security Account (MySSA), and who are not receiving Social Security benefits. 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.

Strengthen Social Security's Disability Program

It is important to remember that Social Security provides protection to workers and their families in the event of loss of income due to retirement, death or disability. Protection in the case of disability is a vital part of the program's compact with America's workers and should not be the subject of cuts – just as Social Security's retirement and survivors' programs must be protected. President Biden's Administration made improvements to the disability review process and advocated for SSA funding levels that began the process of reducing backlogs and making the claims process more efficient and less time consuming. Conversely, during the first Trump Administration, cuts to the disability program were included in every annual budget submitted to Congress. In addition, SSA issued several rule changes related to the adjudication of claims for disability benefits and considered numerous other operational changes that would have adversely affected the ability of many workers to qualify for disability benefits.

It is important that the Trump Administration and Congress not propose or implement cuts to Social Security's disability program, or advance policy initiatives that would undermine its mission of protecting workers and their families from the loss of income when disability strikes.

Increase Program Revenue

Oppose Tax Cuts that Increase the Debt and Disproportionately Benefit the Wealthy and Corporations

Some economists are legitimately concerned that our nation's gross federal debt of over $38.6 trillion is on a glidepath that is not sustainable over the longer term. Many fiscal conservatives insist on placing the blame for most of this growing debt on earned income programs such as Social Security and Medicare. While it is true that Social Security and Medicare total about one-third of the federal government's spending, many ignore the fact that these programs also bring in about 40 percent of the federal government's revenue. Neither Social Security nor Medicare's Hospital Insurance (HI) program contribute a single dime to the national debt.

While publicly lamenting our nation's finances, in July 2025, Congress enacted the so-called "One, Big Beautiful Bill Act" (P.L. 119-21) which included massive tax cuts that will cost $3.4 trillion over the next decade and will primarily benefit the wealthiest Americans and massive corporations. Enacting these tax cuts was partly paid for by cutting Medicaid by $1 trillion over ten years and the Supplemental Nutrition Assistance Program (SNAP) by $187 billion over ten years. Increasing the federal debt by this this magnitude poses an existential threat to Social Security, Medicare, and a wide variety of other programs important to the health and financial security of American families, as the debt that results would put even more pressure on future Congresses to slash these programs in order to balance the budget. In order to protect programs that are important to seniors and America's families, the National Committee adamantly opposes any benefit cuts that would pay for tax cuts that primarily benefit the wealthiest and large corporations.

Eliminate the Cap on Social Security Payroll Tax

The Social Security program was most recently modified in 1983, over 40 years ago. At that time, changes were made to the program that were expected to extend the solvency of the Trust Funds until 2063. The maximum amount of a worker's wages subject to the payroll tax was set at a level so that about 90 percent of all worker income would be subject to the payroll tax, and the maximum was scheduled to rise in the future at a rate that would maintain this ratio. Since then, wage levels have risen much faster than average for high earners. According to Social Security's Chief Actuary, between 1983 and 2000, average earnings for the top 6 percent of earners rose 62 percent more than price inflation, while average earnings for the other 94 percent of earners rose only 17 percent more than price inflation. Since 2000, the ratio has stayed at about 82.5 percent, except for temporary spikes during economic recessions. As a result, Social Security payroll tax income is about 8 percent less than it would have been if the taxable ratio had remained at 90 percent. According to the Actuary, this change, along with the effects of the deep recession of 2007-2009 and slow recovery, are primarily responsible for moving the expected year of OASDI Trust Fund reserve depletion from 2063 in the 1983 Trustees Report to 2034 currently.

In addition, the composition of American's income has significantly changed in the past 40 years. Today, most of the income of the wealthiest Americans comes from investments and business profits, neither of which is subject to payroll taxes, while virtually all of the average workers' income is in the form of wages. This income inequality has contributed to the shifting of the burden of financing Social Security toward middle-income workers.

In 2026, only the first $184,500 of a worker's wages and no investment income are subject to the Social Security payroll tax. Eliminating the wage cap and extending the Net Investment Income Tax (NIIT) that already applies to Medicare, so it also applies to Social Security payroll taxes would improve the fairness of how revenue for the program is raised. At the same time, providing modest benefits reflecting the additional contributions would retain the earned-benefit nature of the Social Security program. Providing this additional revenue could play a central role in strengthening Social Security's finance, extending the program's solvency and helping 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. This option should only be considered as a potential *addition* to other revenue proposals -- NOT *in lieu* of asking the wealthy to pay their fair share.

Strengthen and Restore the Supplemental Security Income (SSI) Program

The Supplemental Security Income (SSI) program provides vital and much needed economic security for 7.4 million low-income seniors and people with disabilities, including children with marked and severe functional limitations. Although it is funded through general revenue and not the Social Security Trust Funds, SSI is administered by the Social Security Administration. During the Biden Administration, SSA made a number of improvements to the SSI program designed to update SSI and make it easier for the vulnerable populations it serves to receive benefits. These improvements include: updating the definition of a public assistance household, excluding the value of food from SSI benefit calculations and expanding the rental housing subsidy exception.

Although these administrative actions are welcomed and should be retained by future administrations, much of the SSI program remains woefully inadequate. Over the years, 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 Benefit Rate and Repeal the Marriage Penalty

Current benefit levels are extremely low, and over one-half of those on SSI have no other source of income. Those who are able to work are faced with antiquated limits on the amount of income they can earn. This leaves many people with disabilities living in poverty. Congress should increase the benefit rate to 100% of the Federal Poverty Level and repeal the marriage penalty.

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. These levels must be increased to reflect economic growth during the past five decades.

Raise the Asset Limit and Repeal Marriage Penalty

SSI is a means-tested program which severely limits the level of assets an individual may accumulate and still remain eligible for benefits. Currently, the limits are $2,000 for individuals and $3,000 for couples, levels that make it extremely difficult for beneficiaries to set aside resources for emergencies or to save for retirement.

The current levels also discourage marriage as the limit for a couple is 50 percent lower than for two single individuals. At a minimum, these levels should be increased to $10,000 for singles and $20,000 for couples.

Eliminate Punitive Penalties

SSA has modified many of the penalties that reduce or eliminate SSI benefits when low-income persons receive non-cash in-kind assistance, such as food and housing support, from their families. These provisions were unfair to affected individuals and have proven to be enormously difficult for the Social Security Administration to administer, not only consuming disproportionate amounts of staff time and resources but also often resulting in overpayments or underpayments that must be recouped by the agency. Congress should codify the improvements SSA has implemented to make them permanent and continue expanding improvements in the future. This 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. They must be rejected by Congress, just as they continue to be rejected by the American public.

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. During President Trump's first term, payroll taxes were deferred during the pandemic, and the President expressed support for ultimately repealing these essential sources of Social Security's revenue. The National Committee strongly opposes initiatives such as these because retaining a dedicated source of income for Social Security is essential to the program's future and to retaining the earned-income nature of the program.

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. In addition, any changes to Social Security should be designed to improve the program and enhance financial security for America's families, not to achieve budgetary savings or goals. Social Security does not contribute one dime to the federal debt and it should not be targeted for cuts as part of a budget-cutting exercise.

Medicare

Medicare and Social Security are the bedrock on which the economic and health security of today's seniors -- and tomorrow's older adults -- stands. Medicare helps prevent poverty and promotes greater access to health care for more than 73 million people 65 years of age and older and people with disabilities. Even though half of all Medicare beneficiaries in 2024 had incomes below $43,200, 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.

Strengthen Traditional Medicare

Reject Calls to Privatize Medicare

For several years, some in Congress have attempted to replace traditional Medicare with the "premium support" or voucher system 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.

Where a private Medicare voucher system has failed in Congress, more than 54 percent of all beneficiaries have voluntarily enrolled in private Medicare Advantage (MA) plans (also known as Medicare Part C) as of 2024, representing nearly 34.1 million enrollees. At current enrollment growth rates, MA is projected to cover 69 percent of the Medicare population by 2030. While MA plans and privatization advocates have used misleading information to enroll more individuals in the private plans, the Trump Administration and congressional majority is interested in more aggressively increasing MA enrollment by making the private plans the default option when beneficiaries first enroll in Medicare. The NCPSSM opposes efforts by the federal government and insurers to manipulate Medicare beneficiaries into joining MA plans without knowing the limitations of the private option.

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. Despite opposition from MA plans, the Affordable Care Act (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, concerns persist as MA plans continue to receive larger reimbursements than justified through practices such as inappropriate diagnostic coding for enrollees' medical conditions.

In addition, MA 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 and hospitals. The Department of Health and Human Services' Office of Inspector General have repeatedly found that improper denials through prior authorization requirements is a persistent problem in MA plans, potentially delaying or preventing necessary care for beneficiaries.

Recent studies have shown that MA plans experience higher disenrollment rates among beneficiaries with chronic conditions and higher health needs, rather than healthy beneficiaries.

Build on Medicare Provisions in the ACA That Extend Program Solvency.

Development of Accountable Care Organizations (ACO), and medical homes that strive to coordinate care for beneficiaries with multiple chronic conditions, are two primary strategies that contain costs and promote access to high-quality care. These and multiple other innovations championed by the Center for Medicare and Medicaid Innovation (CMMI) should be broadened. In addition, multi-payer models of care that focus on coordinating existing programs offering Long-Term Services and Supports (LTSS) should be developed as a matter of priority for the tens of millions of older adults who wish to age in place.

Combat Waste, Fraud and Abuse

The ACA expanded initiatives to prevent, detect and recover improper payments, with an emphasis on preventing the payment of improper claims in order to avoid the costlier process of trying to recover payments from Medicare's hundreds of thousands of providers. These should be continued, and the Department of Health and Human Services (HHS) should also employ a data-driven approach to proactively monitoring and overseeing LTSS and health care providers on a routine, ongoing basis, thereby ensuring more consistent performance and lowering the prevalence of improper payments and fraud.

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

Medicare beneficiaries with annual incomes above $109,000 for individuals and $218,000 for couples are paying higher Part B and D premiums (the "Income-Related Monthly Adjustment Amount" -- IRMAA) 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 $171,000 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 9.2 percent in 2024. 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 2030. 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 of this important social insurance program.

Private Equity Encroachment on Accountable Care Organization (ACO)

The Centers for Medicare and Medicaid Services (CMS) is continuing a controversial program started under the first 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, approximately 7% 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 $109,000 for an individual and $218,000 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. The standard monthly premium for Medicare Part B is $202.90 for 2026, an increase of $17.90 from 2025. While the hold harmless provision helps many beneficiaries, its limited application remains a topic of ongoing debate regarding equity in Medicare premium adjustments.

Reduce the Late Enrollment Penalty

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

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

The National Committee believes the penalty is too severe. To mitigate the penalty, individuals delaying Part B enrollment should be treated like those who delay Part A enrollment for at least 12 months beyond their initial enrollment period. In other words, late enrollees should be subject to a 10 percent premium surcharge regardless of the length of the delay, but the surcharge should only apply for a period equal to twice the number of years (i.e., 12-month periods) during which the late enrollee delays their enrollment.

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.

Medicare benefits should be expanded to cover vision, dental and hearing health services and equipment because they are important for healthy aging.

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

There are various deductibles and copayments for Medicare-covered services. The Part A deductible and other cost-sharing requirements are quite high. With the exception of the Part D prescription drug program, 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.

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 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.

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 of any pre-existing conditions they may have. 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 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

The Affordable Care Act (ACA) made significant progress in reducing plan overpayments to Medicare Advantage plans relative to traditional Medicare. However, MA plans continue to receive larger reimbursements than they should due to 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.

CMS rules require that MA plans must notify enrollees of changes in their provider network resulting from contract terminations at least 45 days prior for primary care or behavioral health providers, and at least 30 days prior for specialist providers.

An additional CMS rule aims to improve the prior authorization process and increase consumer protections. This rule took effect on January 1, 2026, and applies to Medicare Advantage organizations, Medicaid and CHIP programs, and qualified health plans on the federal ACA marketplace. The rule requires payers to send prior authorization decisions within 72 hours for urgent requests and send prior authorization decisions within 7 calendar days for standard (non-urgent) requests. Payers must provide a specific reason for denying a prior authorization request and publicly report prior authorization metrics.

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.)

Stop "Pay-for-Delay" Agreements that Delay Generics Entering the Market

Pay-for-delay agreements occur when brand-name drug manufacturers compensate generic drug manufacturers to delay the introduction of less expensive generic drugs. These agreements extend the profitability of brand-name drugs, limit consumer access to affordable medications, and increase costs for taxpayers and government programs. The Federal Trade Commission (FTC) estimates that such agreements cost consumers and taxpayers $3.5 billion annually in higher drug costs. Prohibiting pay-for-delay agreements is projected to save Medicare $11.5 billion over 10 years. The National Committee supports legislation to make these agreements presumptively illegal, empowering the FTC to take legal action against violators. Unfortunately, the Trump Administration has rescinded President Biden's Executive Order 14036 which had encouraged stricter enforcement to end these anticompetitive practices.

Promote Faster Development of Generic/Biologic Drugs

Reducing the exclusivity period for biologic drugs would accelerate the development of biosimilars, potentially lowering pharmaceutical costs. Currently, brand-name biologic manufacturers enjoy a 12-year exclusivity period, which is significantly longer than the 5-year period granted to small-molecule drugs. Shortening this period to 7 years and prohibiting additional exclusivity for minor formulation changes could improve consumer access to affordable biosimilars. According to the Office of Management and Budget, reducing the exclusivity period for biologics to 7 years is estimated to save Medicare $6.96 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 nearly 14 million seniors with limited income and assets to help them pay for out-of-pocket drug expenses. Sadly, the One, Big Beautiful Bill Act (P.L. 119-21) imposed a nine-year moratorium (through 2034) on a Biden-era Center for Medicare and Medicaid Services rule intended to automatically enroll more low-income beneficiaries in LIS by aligning eligibility criteria with Medicaid's Modified Adjusted Gross Income (MAGI) methodology and simplifying applications. The law prevents an estimated 1.3 million additional people from gaining access to LIS assistance with Part D premiums and cost-sharing. The National Committee supports ending this moratorium.

Eliminate the Part D Low-Income Subsidy Asset Test

The amount of Low-Income Subsidy (LIS) assistance depends on beneficiaries' income and assets. For 2026, the income limit is $23,940 annually for an individual ($34,460 for a married couple living together), and the asset limit is $16,590 for an individual ($33,000 for a married couple), including allowances for burial expenses. The LIS asset test should be eliminated because it penalizes low-income seniors who have saved modest amounts 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 Pharmacy Benefit Managers (PBMs) to administer their pharmacy benefits. PBMs' duties include creating and managing formularies, processing prescription drug claims, 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. Increased transparency and regulation of PBM practices are necessary to ensure that formulary placement decisions are based on the best available clinical evidence, drugs chosen are cost-effective for the Medicare program, and savings are passed along to both the Medicare program and beneficiaries.

While the Consolidated Appropriations Act of 2026 (P.L. 119-75) addressed some PBM reform -- including Medicare rebate retention, spread pricing transparency, and some compensation rules -- it did not eliminate several major abuses. The remaining issues are pharmacy steering, affiliated-pharmacy conflicts, restrictive formularies and utilization management, and non-transparent contracting practices in the commercial and Medicaid markets.

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.

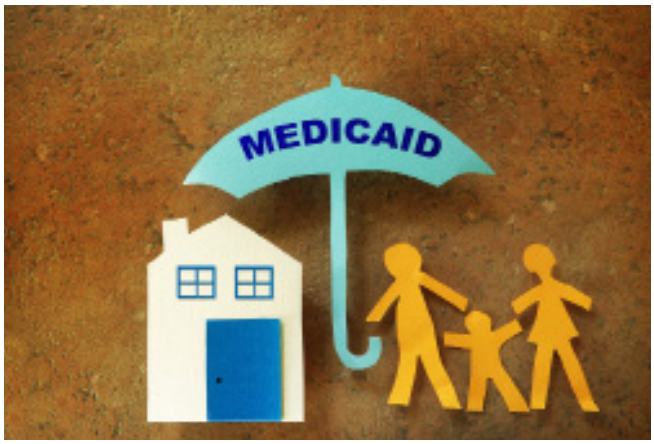
Provide Additional Funding for State Health Insurance Assistance Programs (SHIPs)

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



Medicaid is important to seniors for two reasons. First, 7.8 million low-income older Americans receive their health care through both Medicaid and Medicare (e.g. dually eligible). Second, over 14 million seniors and people with disabilities 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. 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. Regrettably, the 119th Congress cut Medicaid by $1 trillion in the One, Big Beautiful Bill Act (OBBBA) (P.L. 119-21) which will shrink state Medicaid program budgets for long-term care, make it difficult for states to maintain optional home and community-based services and result in nursing home closures.

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

Forty-one 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 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").

As part of this effort, the Biden-Harris Administration addressed chronic staffing shortages in nursing homes by issuing final rules in April 2024 to establish minimum staffing standards for nursing homes. These new regulations would have required that Medicare- and Medicaid-certified nursing homes provided a staffing equivalent of 3 hours per resident per day (PRPD), with 0.55 hours of care from registered nurses (RNs) and 2.45 hours of care from nurse aides. Non-rural nursing homes would have had 3 years, and rural nursing homes would have had 5 years to meet these standards. The rules also would have required facilities to have an RN on staff 24 hours a day, daily. Unfortunately, OBBBA effectively scrapped the nursing home staffing minimum rule by imposing a 10-year moratorium on it. The National Committee strongly supports the nursing home staffing standards particularly since many for profit nursing homes have sharply cut nursing staff, which has endangered patients.

Unlike staffing standards, the current administration left in place a new rule to promote public transparency related to Medicaid payments spent on compensation for direct care workers and support staff. This aligns with the goal of strengthening reporting requirements to reflect the complex ownership and financial relationships in today's nursing home sector.

The National Committee's support for the expanded development of cottage-style "small homes" and renovation of larger buildings into small "household" suites with private rooms remains relevant. These models allow staff to provide individually tailored care for manageable numbers of older adults living with disabilities. Regarding long-term services and supports (LTSS) beyond nursing homes, the focus on developing a continuum of better coordinated and integrated options for Medicare and Medicaid beneficiaries remains important. The expansion of PACE (Program of All-Inclusive Care for the Elderly) and efforts to allow Medicare's home health benefit to better serve beneficiaries with chronic progressive illness continue to be sound policy directions.

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, like contributions made by state residents to the program. 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 requiring long-term services and supports (LTSS), institutional care has historically been the primary option due to Medicaid's "institutional bias". However, there has been a shift towards increasing access to home and community-based services (HCBS) as an alternative. The American Rescue Plan Act of 2021 (ARP) (P.L. 117-2) provided a temporary 10 percentage point increase in the federal medical assistance percentage (FMAP) for certain Medicaid HCBS from April 1, 2021, through March 31, 2022. This funding boost, estimated at nearly $37 billion, allowed states to enhance, expand, or strengthen HCBS under their Medicaid programs. While this represents the largest infusion of federal resources into the HCBS system in 30 years, challenges remain. Most notably, since OBBBA cut Medicaid by $1 trillion, cash-strapped state Medicaid programs may be forced to cut optional state benefits, including HCBS. To fully eliminate the institutional bias, Congress must restore and enhance federal Medicaid funding in general and HCBS in particular. This would ensure that more individuals needing LTSS can receive care in their preferred setting – their own homes – rather than in institutions.

Money Follows the Person (MFP)

The Money Follows the Person (MFP) demonstration program in Medicaid continues to play a crucial role in helping seniors and individuals with disabilities transition from institutional care to community-based settings. The program provides federal grants to states, enabling them to offer Medicaid-funded services and supports for up to 365 days following a participant's transition to community living. MFP has successfully assisted over 107,128 long-term residents in transitioning from institutions to the community by the end of 2020. While the Consolidated Appropriations Act of 2021 extended MFP funding through December 31, 2023, the Omnibus Appropriations Act of 2022 extended funding through September 2027.

This extension has provided some stability, but challenges remain. Despite these extensions, the lack of permanent authorization has impacted the program's reach. The number of participating states has fluctuated, with 34 MFP grantee states active as of Spring 2022. This variability, coupled with potential waitlists in some states due to limited funding or HCBS Medicaid Waiver slots, has affected the program's ability to consistently facilitate transitions. To ensure the program's long-term viability and maximize its impact, MFP should have a 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). Although the Consolidated Appropriations Act of 2023 extended Medicaid HCBS spousal impoverishment protections for four years, this safeguard should receive a permanent extension.

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.

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 73 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. Almost one-half of elderly unmarried women receiving Social Security rely 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 and the "Lilly Ledbetter Fair Pay Act of 2009" 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.

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, and they are not required to 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 most recent regulation proposed by the Trump Administration would severely weaken the protection provided to workers seeking advice on their retirement savings. The Administration, in response to an Executive Order by President Trump, has also proposed allowing "alternative assets" such as cryptocurrency, private equity, hedge funds and venture capital to be offered through employer-sponsored 401(k) plans, thus exposing workers to risky, expensive and difficult to value investment products for the savings in their retirement nest eggs. Congress should legislatively enact a strong fiduciary standard, thus permanently resolving the questions of administrative overreach and Congressional intent.

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. OAA service include home delivered meals (also known as "Meals on Wheels") and congregate meals, senior centers, in-home services, transportation, legal services, elder abuse prevention and caregiver support. 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 its economic impact on families and government programs requires continued investment in research to find a cure and/or slow down disease progression. Building on previous funding increases, the National Institutes of Health (NIH) is now investing as much as $3.8 billion annually in Alzheimer's and dementia research. This substantial increase from under $500 million annually when the National Alzheimer's Project Act (NAPA) was passed has accelerated progress in understanding the disease, developing new biomarkers for early diagnosis, and exploring potential treatments. By maintaining and expanding this investment, we can save millions of lives and potentially curb the 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 programs that have protected generations of seniors, workers with disabilities, survivors and children. However, never in the 44-year history of NCPSSM have our social insurance programs been under greater threat by an administration that has significantly downsized the federal workforce that manages them. In addition, the congressional majority significantly undercut health and food security by slashing Medicaid and SNAP to pay for tax cuts that mainly benefited the wealthy and large corporations. The $3.4 trillion added to the federal debt by the One Big Beautiful Bill Act also threatens Social Security and Medicare. No serious consideration should be given to cutting earned benefits in the face of growing income inequality and declining employer-sponsored retirement and health benefits. Protecting and improving these social insurance programs continues to be essential to keeping middle- and working-class Americans out of poverty. The National Committee to Preserve Social Security and Medicare urges the 119th Congress to restore Medicaid funding and protect, improve and strengthen – not to cut or privatize - Social Security, Medicare and the Older Americans Act for current and future generations.

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

777 North Capitol St. N.E.
Suite 805
Washington, DC 20002
(800) 966-1935