NRLN Legislative Agenda 2024

Preamble

The following 2024 NRLN Legislative Agenda is a set of legislative proposals developed to address concerns of retirees who retired from more than 400 U.S. companies and public entities. The full agenda focuses on retirees and on Income Security (including Social Security) and Healthcare Security (including Medicare). The agenda is revised annually and as new issues arise.

Each year, agenda proposals are fully reexamined and prioritized and the top proposals are supported by detailed White Papers and brief Executive Summaries and/or Position Papers that are posted on the NRLN website at www.nrln.org. A set of one-page Talking Points is also developed for each of the top priorities and they are used as a lobbying aid in Washington, D.C. and throughout our Grassroots Network in all 50 states.

Annual preparation, prioritizing of objectives and grassroots lobbying has proven to be an effective and economical way to represent retirees and has earned recognition for the NRLN as an effective retiree advocacy organization.

We find that retiree issues we address mirror issues like the high cost of healthcare and income security issues tied to savings and overall preparation to retire, that affect many Americans under age 65 today.

To learn more about legislative issues important to America's retirees, please contact Alyson Parker, NRLN Executive Director, at executivedirector@nrln.org, or at 813-545-6792.

NRLN
NATIONAL RETIREE
LEGISLATIVE NETWORK

NRLN Legislative Agenda – 2024

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PROTECTION AND ENHANCEMENT OF RETIREE INCOME

Pension De-risking by Companies *(See White Paper at www.NRLN.org)*

There are a variety of ways in which pensions can be de-risked (also known as Pension Risk Transfers) and the list is growing as more companies are lining up to shed pension plan liabilities. Financial institutions are looking to takeover plan assets in exchange for annuity payments and consulting groups are aggressively encouraging companies to shed pension plan liabilities in creative ways in order to enable propping up company balance sheets. Additional protections are proposed by the NRLN that would make de-risking in the form of buying annuities more secure for plan participants:

If the plan is not terminated pursuant to ERISA Section 4041, after review and approval by PBGC, the plan has a fiduciary duty to continue to hold the annuity contracts as a plan asset, so that retirees do not lose PBGC or other protections.

- **Alternatively, the plan sponsor can choose to permanently transfer its liability for individual retirees to a qualified annuity provider, as if the plan were terminated, but only if it complies with one of the following safe harbor requirements:**

    - **the plan obtains the affirmative consent of individual retirees**.

  or

    - **the plan can purchase reinsurance from a separate, highly rated insurer that guarantees the payment of benefits, in case of default, of each individual participant's loss to the extent it is not covered by state insurance guarantee associations (SGAs).**

- **As part of either safe harbor, two additional protections should be required**:

    - **the purchase of the annuity contract – and any reinsurance purchased to satisfy the safe harbor above –must be reviewed and approved by the Department of Labor (DOL) based on the criteria in the safe annuity rule adopted in DOL's Interpretive Bulletin 95-1.**

    - **the plan sponsor must send a formal notification to all plan participants at least 90 days prior to the transaction, with specific disclosures about the impact on participants and on the plan's funding status, as well as any alternatives available to the participant (such as choosing not to participate).**

If the agencies do not act, Congress must at a minimum require plan sponsors to maintain back-up insurance, either from the PBGC or a highly rated reinsurance carrier.

- **In addition, the agencies must require that following any transfer of assets to settle liabilities for a subgroup of plan participants – whether by group annuity purchases or by lump sum buy-outs – the on-going plan must be at least as well funded as it was prior to the transaction.**

Social Security Protection

The NRLN advocates legislation that will make Social Security financially sound without reducing current and future retiree benefits. The view of the NRLN is that the Social Security system is not broken. Threats to the system can be averted without dismantling the program. Current and future retirees and their employers have paid taxes to fund this benefit and the annual inflation adjustment.

The NRLN supported the **Social Security 2100 Act** that was introduced in the 116th Congress and advocated its re-introduction in the 117th Congress (2021-22). However, when Representative John Larson (CT-01) introduced the **Social Security 2100 Act: A Sacred Trust** on October 26, 2021, and reintroduced the bill on July 12, 2023, the NRLN did not consider them as strong as the original Social Security 2100 Act. The NRLN wants Social Security legislation that would accomplish the following:

- Ensure the solvency of the program for the next 75 years, the only bill to do so.
- Change the annual Cost-of-Living Adjustment (COLA) from the current CPI-W index pegged to urban wage earners' living expenses to CPI-E (Elderly) based on older Americans' spending patterns, including high medical costs.
- Cut federal income taxes on Social Security benefits for middle-income Americans and raise the limit for non-Social Security income before benefits begin to be taxed. The new limits would go to $50,000 for individuals and $100,000 for couples, up from the current $25,000 and $32,000.
- Raise the payroll tax rate starting in 2024 so that by 2043, workers and employers each would pay 7.4% toward Social Security, instead of the 6.2% each worker and employer pays today.
- Impose payroll tax rate to the current earnings amount above $400,000. While there appears to be a doughnut hole between the $160,200 taxable limit for 2024 and the new $400,000 limit, this doughnut hole will shrink annually as under existing law the current maximum earnings amount subject to the payroll tax increases each year.

Annual increases in Social Security benefits should equal or exceed the percentage of any congressional pay raise.

Limit Social Security Claw Backs

The Inspector General's report in November 2023 on the Social Security Administration stated: "According to SSA, in FY [Fiscal Year] 2023, it recovered over $4.9 billion in overpayments…Still, at the end of the FY, SSA had a $23 billion uncollected overpayment balance."

When a federal agency has made a massive blunder impacting Americans, such as the Social Security Administration's (SSA) gigantic overpayment to Social Security beneficiaries, the NRLN believes that Congress has the duty to rectify the action by not holding beneficiaries accountable for the SSA's mistakes.

During a Subcommittee on Social Security hearing on October 18, 2023, SSA *Acting Commissioner Kilolo Kijakazi* said that the agency is required by law to recover over payments and has been sending about one million people a year notices that they were over paid and need to return the money to SSA. A December 6, 2023, article reported that SSA has demanded money back from more than two million people a year, according to a document obtained through a Freedom of Information Act request by Kaiser Family Foundation News and Cox Media Group.

Read the September 15, 2023 article *Social Security Overpays Billions to People, Many on Disability. Then It Demands the Money Back* by Kaiser Family Foundation News and Cox Media Group for examples of the hardships that recovering over payments are causing. The article also quoted Rebecca Vallas, a senior fellow at the Century Foundation, as saying that the SSA overpayment situation amounts to a crisis. "Overpayments push already struggling beneficiaries even deeper into poverty and hardship, which is directly counterproductive to the [SSA] goals"

NRLN's Proposed Change to Future Overpayment Recovery

The NRLN proposes that the existing SSA overpayments be waived and the current Social Security Code of Federal Regulations be replaced with statutory language similar to the NRLN's proposal on pension recoupment that was enacted in the SECURE 2.0 Act of 2022.

Prior to the new law, a company could "recoup" or recover pension overpayments made to a retiree when it discovered them, no matter how long it had been. With the new law, the Company doesn't have a fiduciary
obligation to recoup; but if it does recoup it must be done within three years of initial overpayment and may not recoup more than 10% of overpayment per year. The same rules should apply to Social Security overpayment recovery. In addition:

- Not only should SSA not collect overpayment after the three-year lookback period but SSA needs to fix its system so it is not overpaying to begin with – wasting dollars that workers have contributed toward their retirement.
- If a beneficiary has provided erroneous information that caused the SSA to request repayment of an overpayment, the beneficiary should not be entitled to keep the overpayment.
- There should be no recovery action by SSA if it will cause the Social Security beneficiary to be at or below the Federal Poverty Level. (The Federal Poverty Level for an individual in 2023 is $14,580.)
- When a Social Security beneficiary is sent a notification letter requesting payback of overpayment, information must be provided on how the calculations were made.
- The notification letter must inform beneficiaries about how to request a waiver.
- The SSA's waiver process must be streamlined.

Adjust Tax on Social Security Benefits for Inflation

Many retirees have to pay federal income taxes on Social Security benefits. This usually happens when there is other substantial income in addition to Social Security benefits (such as wages, self-employment, interest, dividends and other taxable income that must be reported on your tax return).

The Internal Revenue Service (IRS) rules on taxing Social Security benefits are if you:

- **file a federal tax return as an "individual"** and your combined income is
    - between $25,000 and $34,000, you may have to pay income tax on up to 50 percent of your Social Security benefits.
    - more than $34,000, up to 85 percent of your Social Security benefits may be taxable.
- **file a joint return**, and you and your spouse have a combined income that is
    - between $32,000 and $44,000, you may have to pay income tax on up to 50 percent of your Social Security benefits.
    - more than $44,000, up to 85 percent of your Social Security benefits may be taxable.

Most parts of the tax code automatically adjust for inflation, such as the progressive income levels for tax brackets. The NRLN believe that Congress should pass legislation applying the same concept to Social Security benefits income.

Protection of Retirees in Mergers, Acquisitions and Spin-offs
(*See White Paper at www.NRLN.org*)

The advent of globalization and attendant behavior of U.S. firms in forming joint ventures and engaging in mergers, acquisitions and spin-offs involving foreign and U.S.-owned corporations has added complexity to the determination of how U.S. retirees' pension and welfare benefits are protected from being reduced or eliminated as a result of change in ownership.

Mergers and acquisition activity can ultimately result in dissolution of a corporation, loss of jobs and loss of retiree pension and welfare benefits. Consequently, the involvement of Bankruptcy Courts and the PBGC are always possible outcomes of M&A efforts done badly. Thus, pension plan asset protection issues mentioned in the NRLN's PBGC and Bankruptcy Reform in other sections of this agenda may be the direct result of M&A activity.

In some cases, it is clear that the ERISA provisions apply. Alternatively, it is also unclear what the rights of retirees, the PBGC and bankruptcy courts are in some situations. The NRLN has prepared a white paper describing the foundation for determining which U.S. statutes must be modified or created to better protect retirees. The paper includes proposed legislative solutions and/or regulatory rule changes that are required to protect U.S. plan participants.

The NRLN recommends five changes for legislation, regulatory reform and stepped-up enforcement:
1. Congress needs to clarify that the PBGC has the authority to enforce a lien against all U.S.-based assets of the parent company of a foreign-owned plan sponsor even if those other assets or subsidiaries are not considered part of the controlled group sponsoring the plan.

2. The Department of Labor should revise its regulations related to breaches of fiduciary duty to **clarify that fiduciaries under ERISA – at a minimum contributing sponsors and named fiduciaries – must be subject to the jurisdiction of federal district courts with respect to the enforcement of judgments for potential breaches of fiduciary duty**.

3. **Congress should give regulators broader and more flexible authority under § 4042(a) to negotiate or seek court approval for a more tailored remedy, short of plan termination**, to address spin-offs, mergers, or other transactions that greatly increases the risk of future loss to the PBGC and participants.

4. **Congress should expand the events that trigger immediate liability for pension under-funding pursuant to Section 4062(e), calculated on a termination basis, to include transactions that pose even greater risk to *all* plan participants.** Triggers should include spin-offs, control group break-ups and takeovers by foreign firms that transfer more than 20% of a firm's under-funded plan liabilities, or which transfer more than 20% of the plan sponsor's assets or revenues without obligation for funding plan liabilities.

5. **The PBGC should add foreign ownership, and proposed sales or spin-offs to foreign owners, along with such transactions among U.S. corporations, to the list of transactions triggering special**

scrutiny under the PBGC's Early Warning Program and, if possible, to the list of transactions requiring an Advance Notice of Reportable Events.

Protecting Vested Pension Benefits from Plan Asset Transfers
(*See Position Paper at www.NRLN.org*)

Nearly 40 million U.S. retirees depend upon company fiduciaries and the rules of ERISA to protect their accrued pension benefits since they do not own their assets. Insolvency and bankruptcy can lead to distress terminations – which result in the permanent loss of vested benefits for many retirees and other participants under the PBGC's priority category system.

The rules require funding at 100% of accrued liabilities but no action is taken until a plan reaches the 80% level, after that most sponsors only pay the Minimum Funding Requirement.

Plan sponsors have the ability and incentive to merge plans in ways that may reduce costs and risks for companies but may increase the risks for permanent retiree pension benefit losses.

Fiat Chrysler (now Stellantis) combined two U.S. management pension plans and the successor combined plan was underfunded whereas participants in the better funded plan lost 6% of its funding level because of the merger.

CenturyLink (now Lumen) merged three dissimilar plans resulting in 81,000 participants in a Qwest plan funded at 91% merging with two plans with over 50,000 funded below 75%. Re-engineering the merger of these plans obscures the true funding levels of all three plans and exposes the 81,000 Qwest plan participants to a greater risk of a plan termination.
There is no review and approval by any agency of pension plan mergers. PBGC protection is weak and can still leave retirees with benefits less than under their pre-merger plan.

NRLN Proposed Changes to ERISA:
1. Pre-Approval Process: Plan sponsors should be required to submit the proposed merger (combination) of two or more qualified plans to the PBGC, DOL and IRS for review and approval. Avoidance of funding of underfunded plans, or any substantial reduction in the funding level of a merged plan, shall be a reason for denial.
2. Distress Termination: For a period of at least five years after a qualified plan merger, the PBGC should be required to oppose any proposed distress termination of the merged plan unless the plan sponsor can establish, to the satisfaction of the agency or a court in bankruptcy, that a distress termination would have been justified at the pre-merger funding level.
3. Hold Harmless Provision: For a period of at least five years following a qualified plan merger, the PBGC should ensure that, in applying its Priority Category allocation of benefits, retirees and other plan participants do not lose any vested benefit that would have been funded based upon the pre-merger asset and funding level of their plan, or the current termination funding level of their plan, whichever is higher. PBGC insurance should guarantee the priority claims of participants who would lose vested benefits due to the merger's reduction of plan funding levels, if necessary.

Bankruptcy Reform
(*See White Paper at www.NRLN.org*)

Current bankruptcy laws do not offer clear rules that assure equal treatment to retirees that lose their pension and healthcare benefits that are afforded to otherwise secured creditors. Bankruptcy courts have stymied retirees from making claims under Section 1114 rules by ruling in favor of companies because they can establish the existence of a Reservation of Rights (ROR) clause which are often not easily discernible to laypeople.

Proposed Changes to Status of Retirees in Bankruptcy Law:

- Disallow company Reservation of Rights (ROR) clauses as reason for denying retiree's rights to the establishment of a Section 1114 Committee.
- Require that companies provide **a retiree advocate contact** with an updated list of all retirees, and that such a list must be updated in a timely way throughout bankruptcy proceedings, **giving the advocate permission to advise and solicit all retirees to join a representative organization.**
- Mandate Section 1114 Committee within 60 days of a Chapter 11 filing date.
- Raise retiree claims to "Administrative Status" in bankruptcy filings.
- Require pension plan sponsors to fund underfunded plans after passage of 365? days from date of filing for bankruptcy.
- A retiree who has suffered the loss of non-taxable healthcare benefits should not be subjected to taxation (as well as Social Security and Medicare taxation) on any settlement received in bankruptcy court for the loss of healthcare benefits. The NRLN supports legislation that would designate as non-taxable income any bankruptcy claims and settlement for reduced or eliminated retiree-earned healthcare or other welfare benefits.

Pension Benefit Guarantee Corporation (PBGC) Reform
(*See White Paper at www.NRLN.org*)

The PBGC currently treats changes in the annual earnings limits, mandated by Congress, as modifications to the pension plans themselves, and has applied the lowest annual earnings limit during the five–year look-back period when calculating retiree benefits. These changes result from applying IRS code changes under Sections 401(a) and 415(b).

Current PBGC practices permit the disqualification of certain retiree vested pension benefits if granted within a five-year window prior to pension plan termination. The result has been loss of retiree vested benefits that should be protected by ERISA.

Proposed PBGC Rules and Regulation Changes**:**

- The PBGC should use the defined benefit plan income and pension benefit limitations defined in IRS codes 401(a) and 415(b) in effect on the date of the plan termination when calculating the pension benefits payable under Priority Category Three (PC3).
- PBGC rules should be modified to require the PBGC to include the retiree's age and length of service, used to determine his/her benefit at retirement or termination, whichever is higher, when calculating and determining the PBGC pension benefit.
- PBGC rules used to calculate or otherwise determine PBGC pension benefits (4010 filings) should include those used to determine the termination values of plans and those accounting assumptions between ERISA fund reporting and the PBGC plan-termination-funding calculations as well as full disclosure of 4010 filings and calculations. Section 4010 of ERISA requires certain underfunded plans to report identifying financial and actuarial information to the PBGC. Calculation of

termination value by the PBGC should use the same discount rate called for under ERISA and used by the company to calculate the pension obligation of the terminated plan.

- Amend the PBGC reporting structure so it is accountable to the Department of Labor (DOL) as opposed to the current three agencies.

Pension Asset Protection (PAP) Proposal
(*See White Paper at www.NRLN.org*)

- The NRLN urges Congress to pass legislation that would limit the ability of a company to tap pension assets to pay for what properly should be considered restructuring expenses. Such new legislation, likely an amendment to the Employee Retirement Income Security Act (ERISA), would stop company use of pension assets to pay lump-sum severance or layoff payments and/or other enhancements to selected defined benefit pension plan participants.
- Plans bargained for by unions and subject to the terms of a collective bargaining agreement would be exempt from this legislation.
- Such lump sum severance or layoff payments are typically granted to 10% or fewer of the total plan participants and dilute defined benefit pension plan assets. These often take the form of incentives designed to get workers to retire early, in exchange for a waiver of rights by older workers which limits the company's age discrimination liability. Use of pension plan assets in this fashion benefits shareholders, not plan participants, and should not be paid out of pension trusts.
- It is pivotal to note that non-union plan participants have no bargaining power to counter perilous corporate actions affecting pension plans and should be entitled to this proposed ERISA protection. This practice has led to under-funding of defined benefit pension plans and thus directly increases the risk of under-funding and triggering PBGC takeover where plan liabilities have outgrown assets and/or where decline in equity markets have caused a loss in value of plan assets. The merging of pension plans by merged companies has been abused to avoid funding one or more of them with protections lost by retirees.
- The IRS and Federal courts have allowed companies to hide behind current pension law to use defined benefit pension plan assets to pay such lump sum bonuses and, to date, Congress has allowed this practice to continue. This sacred-cow type of thinking is not in keeping with the intent of ERISA, the 2006 Pension Protection Act or the vested rights of defined benefit pension plan participants.
- Additional amendments to the Pension Reform Act of 2006 must (a) Protect defined benefit pension fund assets from being bought out by management firms, hedge funds, or other high risk third parties; (b) Must protect the integrity of Defined Benefit Pension funds against schemes designed to enhance corporate profits.
- Congress must codify IRS rules that state that defined benefit pension plans must not discriminate in favor of highly compensated employees. If a company wishes to provide enhanced supplemental deferred compensation (QSERPs), it must do so without any tax advantages gained through defined benefit pension plans.
- The use of plan assets as indicated above effectively constitutes reversions that place pension assets at risk and deny participants the opportunity to benefit from IRS Sec. 420 which allows for transfers to pay for healthcare and precludes COLA consideration.

PBGC and Pension Plan Asset Protection During Plan Terminations
(Also see page 6 on Mergers and Acquisitions)

The NRLN advocates for legislation that clarifies a parent foreign owner's pension plan obligations to plan participants and that the foreign owner must abide by ERISA rules should a U.S. subsidiary be spun off or dissolved. All U.S. based assets under control of a foreign owner must remain within the legal jurisdiction of U.S. courts in order to satisfy ERISA funding obligations. Pension plan fiduciaries would be required to be American citizens. Clarifications must address situations where foreign corporations that own U.S. subsidiaries are also acquired by a third party, foreign-owned corporation.

Pass Susan Muffley Act to Restore Pensions for Delphi Salaried Retirees

The federal government picked winners and losers in the General Motors and Delphi auto industry bankruptcies of 2009. The Delphi salaried retirees were singled out to have their pension plan terminated and taken over by the Pension Benefit Guaranty Corporation (PBGC). Actions taken by the Federal Government's Auto Team, which intervened in the bankruptcies, assured certain union-represented GM and Delphi workers and retirees received their full earned pensions. This resulted in 20,000 Delphi salaried retirees losing up to 70% of earned and promised pensions.

The NRLN supports passage of the Susan Muffley Act (H.R.735 and S.2277) - supported by Republicans and Democrats in the U.S. Senate and House of Representatives - would restore the terminated pensions, making the retirees whole.

PROTECTION AND ENHANCEMENT OF RETIREE HEALTHCARE BENEFITS

Protecting Medicare from Privatization (Medicare Vs. Medicare Advantage and Rebates, Accountable Care Organizations (ACOs) and ACO REACH). Definitions: **Accountable Care Organizations (ACOs)** are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated care to the Medicare patients they serve. The ACO Realizing Equity, Access, and Community Health (ACO REACH) model provides novel tools and resources for health care providers to work together in an accountable care organization (ACO) to improve the quality of care for people with traditional Medicare and possibly Medicare Advantage.

Time to End Taxpayer Rebates to Healthcare Insurance Industry
(White Paper at www.NRLN.org)

The National Retiree Legislative Network (NRLN) and most Americans support competition from private healthcare plans and the NRLN understands the financial challenges ahead for Medicare and the federal budget. However, we do not support Medicare Advantage (MA) taxpayer bonuses and rebate subsidies, or anti-competitive restrictions placed on original Medicare Fee-for-Service (FFS) just to preserve the notion that private insurance plans may be more cost effective or provide better care than FFS, when the record shows they are not and do not.

Congress' efforts to privatize Medicare with MA has increased costs, income taxes, and jeopardizes our children's and grandchildren's healthcare futures. MA rebate payments were $76 billion ($2572/yr./enrollee) in 2023 and $263 billion total from 2018 – 2023. Rebates were 16.4% of CMS payments to MA plans in 2023. CMS payments to MA plans cost 9% more / enrollee than CMS pays FFS traditional Medicare per enrollee. **MA HEALTHCARE COSTS PER ENROLLEE ARE OUT OF CONTROL!**

-- MA plans hold a 53% Market Share (30.8 million enrollees) – THERE'S NO JUSTIFICATION FOR REBATES!

-- The healthcare insurance industry promised it could compete if subsidized enough to get a head start. Instead, fat rebates fund MA marketing expense – TV "there free" ads that undercut America's Medicare! It is time to cut the umbilical cord!

-- "Annual increases in per capita rebates are projected to be in the mid to high single digits for years 2025 through 2032 due to assumed increases in quality bonus payments and increases in benchmarks." (*Source: 2023 Annual Trustees Report, page 164*)

-- Rebates are denied to 27 million traditional FFS Medicare A&B (class) enrollees who need the same Chronic healthcare subsidized benefits that Medicare A&B MA enrollees enjoy.

To place in perspective the $76 billon given in rebates to private insurance companies in 2023, the federal government could have funded, for example, all of the following programs for $75.54 billion in the Fiscal Year 2023 budget:

- **National Institute of Health** – The bill provided the NIH with **$49.2 billion** for biomedical and behavioral research.
- **Food and Drug Administration** – The bill provided the FDA with **$3.5 billion** to protect public health by ensuring the safety, efficacy, and security of our food supply, human and veterinary drugs, biological products, medical devices and cosmetics.
- **Centers for Disease Control and Prevention** – The bill provided the CDC with **$9.2 billion** to protect the health of Americans.
- **Centers for Medicare & Medicaid Services** – The bill provided CMS with **$4.1 billion** for administrative expenses.
- **National Science Foundation** – The bill provided NSF with **$9.54 billion** to promote the progress of science, advance our national health, prosperity and welfare, and secure our national defense.

The number of over-age 65 U.S. retirees will grow 25%, from 62 to 77 million between now and 2030 and to 100 million by 2060. We are an aging country. Baby boomers are a small piece of the puzzle; they will all be over age 65 by 2030 and by 2060 only 3 million will remain. Medicare healthcare costs will grow 101%, from $796 billion to $1.7 trillion from 2019 to 2030. Medicare Trustee and Medicare Payment Advisory Commission (MedPAC) reports show that healthcare costs are rising 101% four (4) times the rise of Medicare enrollees (at 25%) from 2019 to 2030. **– MEDICARE HEALTHCARE COSTS PER ENROLLEE ARE OUT OF CONTROL!**

Facts that can't be denied: **1)** healthcare costs are rising four times faster than Medicare enrollees**, 2)** private plan Medicare **market share rose by 2% to a 46% (27.4 million enrollees)** in 2023; **revenue was $350 billion, 3)** after 37 years (1985-2022) of dolling out over **$450 billion in rebates,** the Committee for Medicare and Medicaid Services (CMS) payments per Medicare Advantage (MA) plan enrollee increased to **103% of payments** made per enrollee for Medicare Fee-for-Service (FFS) enrollees in 2020 and **to 104% in 2022, 4)** it's time to realize that subsidized growth can no longer be justified, Congress, CMS and Insurers must be held accountable!

Exposing the cause and effect of the facts is very revealing. In 2019, payments to MA plans per enrollee were 2% higher than for Original Medicare FFS. This **102%** performance was treated as insignificant by

CMS, the industry lobby and some prestigious think-tanks, proving that averages can deceive. MA plan **Part A results were 91%** or 9% under original Medicare cost. However, the **Part B score was a pathetic 118%.** The combination of the two **was 102%.** The Medicare Trustee and MedPac reports cited that MA plan new enrollees are much younger (ages 65 – 70) and don't often go to the hospital but as they age to match the profile average of older original Medicare enrollees, Part A costs for MA plan enrollees will **skyrocket**!

On September 8, 2023, Rep. Bill Huizenga (MI-04) introduced **H.R.5779, Fiscal Commission Act of 2023** and on November 8, 2023, Senators. Joe Manchin (WV) and Mitt Romney (UT) introduced **S.3262, Fiscal Stability Act of 2023**. Should one or both bills pass it would establish a 16-member "Fiscal Commission" appointed by congressional leaders. Twelve members of the commission would be members of Congress and the other four would be "outside experts." The Commission would make recommendations on how to balance the federal budget to address the growth of direct spending and to improve the solvency of Federal trust funds, including Social Security and Medicare, for at least 75 years.

There is no requirement that the Commission's deliberations be open to the public. The Commission's recommendations would then be delivered to Congress immediately following the November 2024 elections, with the requirements that each chamber conduct an immediate up or down vote on the recommendations without any opportunities for changes or amendments. These types of commissions give cover to members of Congress for making tough decisions themselves.

If members of Congress were honest, it would acknowledge that with costs rising 7% a year, the cost of government is going to double every ten years – even without adding any new expense items. WHY are they adding to the problem - by not disclosing that they legislated and have approved spending over $70 billion in rebates or that they look the other way at another $40 billion for healthcare insurance company upcoding, and in addition not disclosing they are getting back negative results from the Medicare privatization scheme.

Taxpayers are kept in the dark and duped into paying insurers for extra MA plan benefits worth **$70 billion in 2023 to entice new MA plan enrollees**. They call these extra benefits "free" on TV commercials, flyers and postcards. In fact, they are unjustified subsidies that enable privatization.

Congress authorized rebates to fund MA dental, vision, hearing and prescription drugs and much more, and "cost sharing" but has repeatedly **denied these same benefits to 27 million beneficiaries in original Medicare**; a slap in the face to them and breech of moral and ethical character by Congress.

MedPAC' s 2023 Annual Report States: "Aggregate Medicare payments to Medicare Advantage plans have never been lower that FFS Medicare spending." "Medicare payments for extra benefits have increased by 53% since 2019." Further, "indirect subsidies," "account for 15% of payments made to MA plans, yet we have no data about their use nor information about their value." MA payments per enrollee in 2023 were 109% of FFS.

Privatization works only because bonuses of 5-10%, or more inflate FFS benchmarks that MA plan insures bid against. When insurer bids are lower than FFS benchmarks, they win and become eligible for huge unjustified rebates of 50%, 65% and 70% of the gap between inflated benchmarks and low-balled bids. If bids are over benchmarks (rare), insures may add or increase premiums

Astonishingly, this 1-5-star Quality Bonus Plan (QBP) awards 1-star rated plans a 50% rebate! The Health and Human Services (HHS) Inspector General Office calls rebate payments "Wrong and Improper Payments".

MA QBP doesn't measure consumer healthcare product or service quality well. MedPAC's 2022 report condemned the MA QBP…With 46 percent of eligible Medicare beneficiaries enrolled in MA plans…, "The current state of quality reporting is such that the Commission can no longer provide an accurate description of the quality of care in MA."

The original intent behind bonuses and rebates was to give private (MA) plans time to demonstrate they could reduce Medicare costs per enrollee and improve the quality of care. After 35 years and after achieving at 53% market share and with MedPAC' s condemnation of the QBP, it is time to eliminate all taxpayer subsidies associated with MA plans, and ACO, DCE and ACO REACH private equity-based plans.

NRLN Opposes ACO REACH Effort to Destroy Medicare:

In addition to Medicare Advantage plans, Congress authorized innovations like Accountable Care Organizations (ACO), Direct Contracting Entities (DCEs) and ACO Realizing Equity, Access, and Community Health (ACO REACH) private equity-based plans to address improvements (innovations) that would improve original Medicare beneficiary access and cost for those not covered by Medicare Advantage plans.

Under lobbying pressure from the NRLN, some other retirement advocacy groups and a few members of Congress, the Centers for Medicare and Medicaid (CMS) announced on February 24, 2022, it would end DCEs and transition to ACO REACH. For the federal government's fiscal year 2023 the ACO Reach Model had 132 ACOs with 131,772 healthcare providers and organizations providing care to an estimated 2.1 million beneficiaries. The NRLN opposes the ACO Reach effort to destroy Medicare.

CMS has boldly predicted that all traditional Medicare enrollees will be assigned to an ACO by 2030. At that time, Medicare would be comprised of Private Medicare C (Medicare Advantage) enrollees and ACO REACHs controlled by private equity under lucrative profit-sharing agreements.

WHAT DOES ALL THIS MEAN?

Rather than retract subsidies and require that insurance companies compete on a level playing field, Congress is funding CMS to double down. They created a new Accountable Care Organization (ACO), called ACO REACH. It will receive even more subsidies; doctors can be paid increased salaries and bonuses. ACO REACH private ownership can keep up to 100% of savings generated. Outside investors can control 25% of an ACO REACH but inside physicians own buildings staff, cost and overhead and are effectively private investor owners operating as enterprise (LLCs', Sub-S corps etc.) today - there will be 100% private control.

Today our Supplemental Insurers (Medigap Plans) advise enrollees of the quarterly cost of Medicare (Medicare payments on the enrollee's behalf) on the Explanation of Benefits (EOB) form. Here is an example of what is reported: total bill or Provider Charged $369.22, Medicare Approved Amount $124.36, Medicare Paid $97.50 (at 80% of Approved Amount), Your Plan Paid $24.87 (medigap G paid.

TODAY, MEDICARE SETS MEDICARE APPROVED AMOUNTS (DOLLAR PAYMENTS) FOR SERVICES PERFOMED BY HEALTHCARE PROVIDERS, BASED ON MARKET STUDIES. WHO WILL DO THAT WHEN MEDICARE IS PRIVATIZED? WHILE PROVIDER CHARGES MAY BE INFLATED, DO WE REALY BELIEVE THAT PROVIDER CHARGES WILL BE REDUCED BY MORE THAN 67 % TO MEET $124.36 (SEE THE EXAMPLE ABOVE)? ARE THERE ANY INCENTIVES OTHER THAN SUBSIDIES (REBATES) THAT WOULD INFLUENCE REDUCTIONS? SO FAR, IT SEEMS THAT COMPETITION IS A RACE TO SEE WHO CAN RAISE HEALTHCARE PRICES FIRST.

What is Congress suggesting? It appears that Romney and Manchin are politically shortsighted – they want to leave us current and prospective retirees alone (if we vote for them) but then sucker punch our children, grandchildren, and others among the 100 million over age 65, starting a few years from now into poverty.

ACO REACH is for those in original Medicare only and includes those who are also covered by a Supplemental or Medigap plan that covers the 20% that Medicare does not pay. A peculiar and unexplained feature is that while an ACO REACH is supposed to serve non-MA plan retirees, they can and are selling MA plans. The NRLN expects ACO REACH enrollees to experience service delays, closure of rural care hospitals and clinics, benefit denials, even more private networks, and ultimately total privatization of Medicare.

There is evidence that ACOs benefit from about 11-12% in benchmark increases and expenditure reduction adjustments combined, and that again, Congress, CMS and the healthcare industry are reinventing another loser and reproving that private insurers can't compete without taxpayer subsidies.

Medicare Advantage, ACO1 and ACO GenX, DCE Geographic, DCE Global, DCE Professional, DCE Global-Professional, and ACO REACH plans have proven that privatization of Medicare has already failed. A grand experiment that has cost over $500 billion. Members of Congress who support it are fools.

NRLN Proposal #1

The current ACA statute should be amended to eliminate the non-conforming elements of this subsidization scheme and be replaced by a product and service bid plan where price includes expected quality and service performance. The reward for the expected performance? Continued opportunity. Any new plan structure should encourage non-subsidized private plan competition with traditional Medicare on a level playing field.

NRLN Proposal #2

New MA so called Chronic benefit rebates are denied to Traditional FFS (class) enrollees who are older and have the same needs for Chronic disease and other illness benefit coverage.

These 27 million traditional Medicare enrollees should be covered by all Medicare Part A & B benefits currently available to MA plan only enrollees and be eligible for new Part A & B benefits as approved by Congress. See details on table below.

Protection of Medicare/Medigap/Advantage Benefits
(See White Paper at www.NRLN.org)

The NRLN advocates that Congress must guard against reductions in Medicare expenditures that negatively impact the care that retirees receive from doctors, hospitals and other healthcare service providers.

- Eliminate waste, cut back federal budgets for projects, non-strategic grants and planned budget expenditures and stop authoring wasteful preferential bills and amendments.
- Congress must enact laws that contain stiffer federal penalties for defrauding the Medicare system. Annual savings accrued should be applied to reduce and eliminate the 75-year Medicare funding gap.
- Pass legislation that would compel Medicare to do safe importation of prescription drugs, competitive bidding, funding to accelerate generic drug sales and eliminate non-competitive practices in the prescription drug industry.
- Set fair and equitable rate formulae for determining physician fees and make adjustments up or down annually. Examine costly referrals and redundant visit practices and disallow them.
- Medicare should allow individuals receiving outpatient observation services in a hospital to be an inpatient with respect to satisfying the three-day inpatient hospital requirement in order to entitle the individual to Medicare coverage of any post-hospital extended care services in a skilled nursing facility (SNF) or for therapy. While extending Medicare, it should also help in reducing unnecessary hospital stays to qualify for such services and is in the direction of preventive medicine.
- Congress must honor its covenant with the American people. The effect of unemployment on payroll tax revenue, the surge in baby-boomer eligibility and rising healthcare costs cannot be offset by slashing Medicare benefits without regard for this covenant.
- The NRLN advocates that adequate compensation be provided to medical providers to assure availability of Medicare accepting physicians. Any revised formula should assure that physicians are obligated to reduce the cost of healthcare.

Medicare-eligible retirees on fixed incomes often elect to purchase Medicare Advantage plans because of lower premium costs and/or enhanced benefits created by subsidies authorized by Congress in the 2003 Medicare Modernization Act. The Centers for Medicare and Medicaid Services rules do not protect guaranteed issue rights of those affected where they have exceeded a twelve-month coverage time limitation period. As a result, Medigap insurers may not allow retirees to buy into Medigap plans due to pre-existing medical conditions, many of which may have developed while covered by a Medicare Advantage plan, nor can retirees freely switch to plans annually.

The Affordable Care Act established several rules for Medicare Advantage plans, with similar rules for plans through the new state insurance exchanges:

- Pre-existing conditions cannot be considered when changing insurance during the annual enrollment period and
- 85% of premiums must be spent on benefits (whereas Medigap plan insurers need only cover 65%).
- Community/regional versus age related policy pricing applies to all policies.

These same rules need to be applied to all Medigap policies which currently are governed by prior federal regulations. Currently, seniors cannot shop for lower priced Medigap plans without undergoing evaluation for pre-existing conditions. Consequently, seniors are effectively locked into increasingly more expensive policies.

Legislation Necessary to Reduce the Cost of Prescription Drugs and Other Cost Reductions for Retirees *(See Position Paper at www.NRLN.org)*

- **Importation/Re-importation** - Importation involves foreign-manufactured prescription drugs imported into the U.S. Most U.S. companies manufacture offshore and are de facto importers. Re-importation involves U.S. manufactured drugs sold at discounted prices in other countries and then resold in the U.S. NRLN supports legislation to amend the Federal Food, Drug, and Cosmetic Act and Homeland Security regulations with respect to the safe importation of prescription drugs.
- **Generic Drugs** - The NRLN supports legislation to provide equal funding and staffing of the FDA to both brand name and generic drug manufacturers.
- **Generic Drug Restraint of Trade** - Patent settlements between brand name manufacturers and generic drug manufacturers – often called "pay-for-delay", "reverse payments" or "exclusion payment settlements" – keep generic drugs off of the market in violation of anti-trust laws. The NRLN supports legislation to prohibit brand name drug companies from compensating generic drug companies to delay the entry of a generic drug into the market. The Supreme Court ruled on June 17, 2013, that brand-name drug makers can be sued for violating antitrust laws if they make a deal to pay a potential competitor to delay selling a generic version of a brand-name medicine. Legislation is needed to make pay-for-delay and other agreements that withhold generic drugs from the market illegal so cases are not dragged through the courts for years while Americans are denied cheaper generic drugs.
- In August 2022 Congress passed the *Inflation Reduction Act* which included prescription drug legislation that the NRLN supported. The bill included:
- Beginning in 2024, copays for a 30-day supply of any insulin that a Medicare drug plan covers will be capped at $35. Part D plans will be required to adhere to the $35 copay limit even if an enrollee has not met their annual deductible. As of Jan. 1, 2024, Medicare enrollees won't have any out-of-pocket costs for vaccines that the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices recommends for adults.
- Beginning in 2025, the amount of out-of-pocket money that Medicare Part D beneficiaries will have to pay each year for their prescriptions will be capped at $2,000. This out-of-pocket limit will apply to prescription drugs through a stand-alone original Medicare Part D plan or a Medicare Advantage plan for prescription drugs. If a Part D plan or MA plan has a prescription drug deductible, that will count toward the cap. Also beginning in 2025 is the requirement that Part D plan offer the option for "smoothed cost-sharing". This means Part D participants can opt to have their out-of-pocket costs spread out over the year. This is designed to protect from being hit with a big drug bill at one time that may discourage filling prescriptions.
- In 2024, the year before the out-of-pocket cap takes effect, Medicare beneficiaries will no longer have any out-of-pocket costs for drugs if they reach Medicare's catastrophic coverage. The way catastrophic coverage works in 2022 is that once an enrollee's out-of-pocket costs reach $7,050, they pay 5% of their prescription drug costs, with no limit. In 2024, the 5% coinsurance requirement will be gone, and enrollees won't have to pay anything for their prescription drugs for the rest of the year. Also beginning in 2024 and continuing through 2029, Part D premiums cannot increase by more than 6% a year.

- Although the NRLN would have preferred that Medicare be required to use the competitive bidding (business) model that it had proposed to members of Congress, it is historic that the new law will allow Medicare to eventually negotiate the price on some expensive prescription drugs. However, Medicare will not begin negotiating drug prices until 2026. Even then, Medicare will only negotiate the price for 10 drugs that it spends the most on; that have been on the market for at least nine years, and that do not have generic equivalents. By 2028, the number of eligible drugs will increase to 20.
- **Encourage Retention of Company-Provided Healthcare for Retirees** - The NRLN advocates legislation that would increase the Medicare Part D prescription plan subsidy paid to employers who offer better coverage than required for equivalent coverage in Part D, if they agree to maintain their current plans.
- **Company Benefits Bundling** - The NRLN urges legislation to prohibit companies from forcing retirees to choose between company pre-determined bundles of plans or none of their sponsored Healthcare or Prescription Drug Plans. This bundling practice holds retirees hostage to company plans and makes it impossible for plan participants to make free choices.

Health Coverage Tax Credit Should Be Made Permanent

The NRLN advocates making the Health Coverage Tax Credit (HCTC) permanent to help Americans ages 55-64 cover the cost of health insurance if they are retired and their pensions have been taken over by the Pension Benefit Guaranty Corporation (PBGC), or if their job was outsourced abroad and they qualify for Trade Adjustment Assistance (TAA).

Unless HCTC is made permanent, or at least reauthorized annually, thousands of retirees will lose health insurance coverage through no fault of their own. Currently HCTC reimburses 72.5% of health insurance costs. The NRLN continues to lobby Congress to increase reimbursement to 80%.

The NRLN advocates passage of **H.R.3912, Bob von Schwedler Permanent Health Coverage Tax Credit Expansion Act**, which would make HCTC permanent or at least pass **H.R.2914, Health Coverage Tax Credit Reauthorization Act of 2023**, which would reauthorize HCTC through 2027. Either bill would help retirees under age 65 cover their health insurance costs.

Original Medicare Merits Out-of-Pocket Cap

It is well understood that health care costs are out-of-control in America. Older and disabled Americans are hit hardest because they use three times more healthcare services than working people. Congress can and should make healthcare more affordable to them through a reasonable Medicare out-of-pocket cap.

Original Medicare works well for many who can afford supplemental coverage that picks up most of Medicare's out-of-pocket costs. They can buy great health care protection and they don't have to decide between their rent and a hospital procedure.

But millions of people with Medicare cannot afford private supplemental coverage. They have no guaranteed right to buy it, after their initial enrollment period in Medicare. And people with disabilities under 65 have no right to buy supplemental coverage until they turn 65. Insurers may deny this coverage because selling them coverage could jeopardize their profits.

Original Medicare enrollees who do not have supplemental coverage are at financial and health risk because Medicare does not have an out-of-pocket cap. A single chronic illness or catastrophic health event can destroy their economic survival and too often leads to personal bankruptcy. With the Affordable Care Act (ACA), Congress ensured that everyone under age 65 with private health insurance had an out-of-pocket limit for their health care. However, people ages 65 and older and disabled with Medicare are not covered by the ACA.

As it is, private Medicare Advantage (MA) plans, which offer Medicare benefits are required to provide out-of-pocket financial protection to their enrollees. (That said, the limit is exorbitant, as much as $7,550 in 2022 for in-network.) Congress should ensure that everyone with Medicare has a reasonable limit on financial liability for their care.

A low out-of-pocket cap in Medicare would save lives. After paying deductibles, copays and coinsurance, out-of-pocket costs for hospital inpatient and outpatient care can easily be hundreds or thousands of dollars and more. This situation is causing millions of lower and middle-income people with original Medicare to skip needed care.

Importantly, a reasonable out-of-pocket cap in Medicare would ensure that everyone has access to alternative choices. Whether they choose to enroll in original Medicare and a private supplemental (Medigap) plan or Medicare Part C (Medicare Advantage) plan, they could. Right now, people with complex health conditions, people under 65 with disabilities, people who live in rural communities and people who move throughout the year, among others, need access to unrestricted choices.

The last published U.S. Census projected that by 2060, when our grandchildren and greatgrandchildren will need affordable health care coverage in retirement, that there will be 100 million Americans, nearly 25% of the U.S. population over age-65.

Giving people a meaningful choice of original Medicare insures cost advantages as well as health benefits. Since its inception, Medicare Advantage costs the Medicare Trust Fund significantly more per person than original Medicare. Medicare Advantage also drives up Part B premiums. Original Medicare is far more cost-effective.

Now is the time for Congress to set forward-looking health care policies, a time to start by adding an affordable out-of-pocket cap to Medicare at an optional premium set at 95% of lowest Fee-for-Service (FFS) benchmark rates.

This proposal will afford all Medicare plan beneficiaries a meaningful baseline and choice among original Medicare supplemental (aka medigap and catastrophic) benefit coverage and pricing available. Further it will level the playing field with Medicare Advantage plans and allow Congress to set healthcare policy that is the best deal for beneficiaries and taxpayers.

Further, the NRLN proposes that Congress pass legislation that differential individual cost risks associated with the state health of the age of individuals (insurability risk) be reflected in premiums of all healthcare policies – eliminate age-related pre-existing condition risk disparities in premium pricing (see NRLN Drop Pre-existing Conditions white paper).

Protect Against the Loss of Medicare Guaranteed Issue Rights

Healthcare insurance providers have traditionally denied healthcare policy coverage to applicants who admit to a pre-existing condition on their policy application. This denial due to pre-existing condition has resulted in some applicants not being able to find an insurer who will insure them at all or commonly results in their having to accept policies where the combination of premium, deductible, copay and coinsurance costs are prohibitively expensive. This problem is particularly acute where applicants are retired and living on a constantly eroding fixed income, including Social Security income.

Original Medicare beneficiaries ages 65 and older have the right to purchase a Medicare Supplement plan (Medigap) or Medicare Advantage (MA) policy sold in their state when they become Medicare eligible at age 65. The Guaranteed Issue Right (GIR) for a Medigap policy extends for the first six months.

As part of the Affordable Care Act (ACA) insurers in the individual and group markets were precluded from applying any pre-existing condition exclusions starting in 2014. It also provided this protection to MA plans but did not apply that same protection to those who purchased Medigap Plans to supplement Original Medicare.

The Centers for Medicare and Medicaid Services (CMS) rules do not protect GIRs of those affected where they have exceeded a 12-month coverage time limitation period from the date of plan enrollment. As a result, Medigap insurers may not allow retirees to buy into Medigap plans due to pre-existing medical conditions, nor can retirees freely switch to plans annually, once this 12 month limit is exceeded.

The ACA protects MA plan enrollees from having to meet the pre-existing conditions at the time of enrollment but excludes retiree enrollees in Medigap plans from the same protection. This precludes retirees from being able to purchase similar coverage at equal or lower cost and leaves them with the personal financial risk of having to pay out of pocket catastrophic costs.

Enrollees in Medigap policies who have exceeded the Medicare GIR period (12 months) are subject to losing the right to coverage or to choose freely in the healthcare insurance market without paying extremely high premiums.

Medigap GIR rules define (1) who is eligible for Guaranteed Issue Rights and (2) requirements for notifying those eligible persons of their specific Guaranteed Issue Rights. This table from the 2023 Medicare and You booklet highlights the various situations under which GIRs apply to, what you can buy and when:

Guaranteed Issue Right situation...	You have a right to buy...	When to apply for Medigap policy...
#1: You joined a Medicare Advantage or PACE program when you 1st enrolled in Medicare - within the 1st 12 months you want to leave	ALL MEDIAGAP PLANS	Within the 1st 12 months after joining the Medicare Advantage program.
#2 Your employer group health plan coverage ends through no fault of your own	A, B, C, F, F High, K, or L	No later than 63 calendar days from the date your coverage ends.

#3 You terminated a Medigap policy to enroll in a Medicare Advantage plan, Medicare Select policy, or PACE program for the 1st time, now you want to terminate the MA plan after no more than 12 months of enrollment	Original; Plan. If not available, then A, B, C, F, F High, K, or L	Within the 1st 12 months after joining the Medicare Advantage, Medicare Select policy or PACE program.
#4: You are in a Medicare Advantage (MA) Plan, and your plan is leaving Medicare or stops giving care in your area, or you move out of the plan's service area.	Medigap Plan A, B, C, F, K, or L sold in your state. You only have this right if you switch to Original Medicare rather than joining another MA plan.	No later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your M A Plan coverage ends.
#5: You have Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. Note: You may have additional rights under state law.	Medigap Plan A, B, C, F, K, or L sold in your state. You only have this right if you switch to Original Medicare rather than joining another MA plan.	No later than 63 calendar days after the latest of these 3 dates: Date the coverage ends. Date on the notice you get telling you that coverage is ending (if you get one) Date on a claim denial.
#6: You have Original Medicare and a Medicare SELECT policy. You move out of the Medicare SELECT policy's service area. Keep Medigap policy, or switch to another Medigap policy	Medigap Plan A, B, C, F, K, or L that is sold by any insurance company in your state or the state you are moving to.	No later than 63 calendar days after your health care coverage ends.
#7: (Trial Right) You joined a Medicare Advantage Plan or Programs of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.	Any Medigap policy that is sold in your state by any insurance company.	No later than 63 calendar days after your coverage ends. Note: Your rights may last for an extra 12 months under certain circumstances.
#8: (Trial Right) You dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time; you have been in the plan less than a year, and you want to switch back.	The Medigap policy you had before joining the MA Plan or Medicare SELECT, if the same insurance company still sells it. If it isn't available, you can buy Medigap Plan A, B, C, F, K or L sold in your state.	No later than 63 calendar days after your coverage ends. Note: Your rights may last for an extra 12 months under certain circumstances.
#9: A Medigap insurance company goes bankrupt and you lose coverage, or your Medigap policy coverage ends through no fault of your own.	**Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.**	**No later than 63 calendar days from the date your coverage ends.**
#10: You leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled you.	**Medigap Plan A, B, C, F, K, or L that is sold in your state by any insurance company.**	**No later than 63 calendar days from the date your coverage ends.**

The NRLN is pursuing individual cases where our members in Associations and Chapters may have been denied GIRs covered under situations shown in #9 and #10 in the left column of the table above. These cases include situations where TVA, AT&T, IBM, Century Link, and other member's healthcare plans contained some or all of the supplemental coverages (see Medigap Plans) that pay part or all of the 20% not covered by traditional Medicare A & B, a.k.a. or referred to as Catastrophic coverage.

Companies are increasingly dropping company plans and replacing them with MA plans that offer out of pocket coverage but not all coverages in Medigap plans A-N, shown in the Medicare and You Handbook.

We believe companies are being persuaded by Private Medicare Exchange Providers (PMEs) to switch to government subsidized MA plans to shed Supplemental benefits liabilities and simultaneously benefit from rebates and / or other deals offered by PMEs.

We have already pursued case particulars with one or more of the companies mentioned above, in the states in which they operate, the Center for Medicaid and Medicare Services (CMS) and the relevant congressional committees in both Chambers of Congress.

Healthcare Access for Older Adults – Medicare Buy-In Option
(See Position Paper at www.NRLN.org)

Retirees faced with high total healthcare costs who are between ages 55 and 65 often can't find employment sufficient to pay exorbitant private insurance premiums, co-pays and co-insurance, especially if they lose employer group coverage during employment or after, before reaching age 65. Medicare costs and expenses and thus Medicare premiums, co-pays and co-insurance are very predictable and more representative of healthcare service and product costs than private insurers who receive federal subsidies and must recover a minimum of 10% to cover profit and overhead whereas Medicare overhead is 3-4%.

Access to Medicare should be made available to seniors ages 55 to 65 on a buy-on basis that would absorb the full cost of coverage. Doing so would further lower the cost of Medicare per enrollee served and would enable reductions in federal private insurance subsidies.

Medicare Parts B and D Means Testing Should be Eliminated

Currently Means Testing can double monthly Medicare B and D premium deductions from Social Security checks and can effectively double taxation (IRMAA tax) for those over age 65 based on Modified Adjusted Gross Income (MAGI).

Instead, all MAGI taxable income should be reflected as an adjustment to federal taxable income Tax Rate Tables and should not reduce Social Security payments.

PROTECTING BENEFICIARIES - OTHER

Notification of Beneficiaries by Financial and Life Insurance Companies

Often individuals, especially seniors, neglect to notify or make a list for their heirs that they are designated beneficiaries for accounts in financial institutions and for life insurance policies. The NRLN advocates that Congress enact statutes requiring insurance companies and financial institutions to notify account holders once each year who their beneficiaries are. Also require financial institutions and life insurance companies to notify survivors that they have been designated by a deceased person that they are a beneficiary.