NRLN Legislative Agenda 2022

Preamble

The following 2022 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 Health Care Security (including Medicare) 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 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 health care 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 Legislative Agenda – 2021

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PROTECTION AND ENHANCEMENT OF RETIREE INCOME

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 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. 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 health care, and precludes COLA consideration.

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.

PBGC and Pension Plan Asset Protection During Plan Terminations *(See also p. 6 discussion 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.

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 health care 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.
- The NRLN supports legislation that would prohibit unions from negotiating or approving the reduction or termination of collectively-bargained benefits of retirees including the plans that govern those benefits in bankruptcy proceedings.
- Require pension plan sponsors to fund underfunded plans after passage of 386 days from date of filing for bankruptcy.
- A retiree who has suffered the loss of non-taxable health care 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 health care benefits. The NRLN supports legislation that would designate as non-taxable income any bankruptcy claims and settlement for reduced or eliminated retiree-earned health care or other welfare benefits.

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 is 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 recently 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 (CTL) 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. <u>Hold Harmless Provision</u>: 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.

<u>Pension Annual Funding Notices (AFNs) – Disclosure Improvements</u> (*See White Paper and the NRLN's proposed AFN at <u>www.NRLN.org</u>)*

Through congressional legislation, the Department of Labor (DOL) regulatory process or a combination of these two, the following changes to the Annual Funding Notices should be made to provide more useful and timely pension fund disclosure to plan participants.

AFN Timeliness and Layout:

AFNs should disclose plan valuations effective on December 31 of the plan year. Currently plans are valued as of the 1st day of the plan year but AFNs are not received until 120 days after the end of that plan year, 16 months later. This delay causes untimely reporting and risk disclosure.

The 2006 Pension Protection Act (PPA) mandated reporting of AFN data that was constrained by the inability to compute and report data on a timelier basis at that time. Advances in computing and data management technology as well as financial and actuarial software systems improvements since 2006 have eliminated most if not all of these constraints. Therefore, the sixteen 16 month delay between the plan valuation date and the AFN disclosure date is no longer acceptable.

The valuation and reporting dates for pension plan assets and liabilities should be made based on a year-end market valuation of pension plan assets and the actuarial value of plan liabilities and should coincide with SEC mandated corporate 10-K reporting requirements for the reporting of all other corporate assets and liabilities. While this would require adjusting pension plan dates to coincide with corporate fiscal year dates, it would be relatively easy to accomplish and would enable reporting of more timely and added relevant plan data to AFNs that could be in the hands of plan participants within 180 days, no later than June 30, from the end of every plan year.

Data currently scattered in the AFN should be reported in table format, not in a narrative form and clear definitions of tables should be provided. Tables should display the current and previous two years histories of relevant data so that plan participants can view changes in the number of plan participants, plan assets and liabilities, company funding obligations and contributions,

interest rates used to calculate funding levels and the rate of return on plan investment, over a three (3) year period.

AFN tables should clearly display data over time and should be clearly and concisely explained in layman's terms and the AFN layout must be standardized to prevent self-interested verbiage.

Proposed AFN reporting Tables:
The NRLN has proposed a six-page standardized AFN that would replace today's six to eight page AFN with more visible and well explained information. This proposed AFN incorporates straight forward definitions for each of seven (7) data tables used to disclose plan information:

Table I – is new and discloses changes in the number of active employees, retirees receiving benefits and separated employees who may hold vested pension rights. Comparing participant data across three years with the corresponding changes in plan asset and liability values and with company contributions made to plans will aide participants in better understanding causes for increases or decreases in Funding Target Attainment Percentage (FTAP) calculations over time.

Table II - would replace the current format and would disclose plan FTAP data on a 2006 PPA basis only for the current and previous two plan years. Plans benefiting from MAP 21, Airline industry or other temporary rate relief would have to report here (without rate relief) and also on Table III. Requiring all plans to report on the same basis on this table establishes a baseline for participants to compare with Table III FTAP calculations that are invariably inflated.

Table III - discloses pension plan funding for all plans that benefit from temporary or intermediate Rate Relief. Data for the current and previous two plan years are reported. Plans that are required to report on Table III must also report 2006 PPA data on Table II.

Note: Minimum Funding Requirements, company Contributions made to the plan, Effective Interest rates used to make calculations and At-Risk Liabilities are new disclosure requirements. This data must be reported on Tables II and III by all plan sponsors.

Table IV - discloses the End-of-Year, Fair Market Value (FMV) of Assets and Estimated Liability FTAP for the current and previous two plan years in table format. The current AFN includes FMV asset and estimated liability data in the AFN text but does not require a disclosed FTAP calculation using this important data and reporting is limited to the current year only.

Table V - discloses the PBGC Termination Liability as a FTAP calculation. The PBGC uses a significantly lower discount rate than required by the 2006 PPA, resulting in an overstatement of plan liabilities and lower FTAP. Participants are currently unaware of the plan termination risk they are exposed to. Plan sponsors would acquire this discount rate from PBGC's website.

Table VI - is a comparison table that provides side by side comparisons of FTAP calculations from Tables III – V so that plan participants may view the differences between reported FTAPs with and without rate relief, with the FTAP calculated using the timelier End-of-Plan-Year FMV basis as well as with the a projected FTAP predicated on the lower PBGC liability discount rate.

Table VII - the Asset Allocations Table is modified to require disclosure of annual rates of return and the unbundling of investments. Master Trust assets would be listed by-line whereas today a one line reference that 100% of a plan's investment are in a Master Trust is all that may be disclosed. These changes will enable scrutiny of how Liability Driven Investment (LDI) de-risking strategies and third party asset managers are affecting asset values.

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 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.**

Protect Retirees from Pension Plan Recoupment

When retirees receive their first pension check, they trust the amount shown on the check will be what they should receive monthly. Far too often, pension plan sponsors later find an error in the pension payment calculation and force retirees to pay back thousands of dollars and suffer a large cut in benefits as well.

Over the years, retirees from companies such as AT&T, FCA/Chrysler, General Motors, and Lucent Technologies, have been victimized by pension plan overpayment recoupment and have had to pay back millions of dollars.

Barring gross negligence, recoupment dollars in a single case may amount to less than a 0.5% change in plan liabilities. In the FCA/Chrysler recoupment case, liabilities changed less than $1 million on $6.5 billion asset base (less than 0.1%), and AT&T's overpayments affected "significantly less than 1/10th of 1%" of its retirees.

Current ERISA and Department of Treasury guidance mandates that plan sponsors recover overpayments, but rules are vague in deciding a dollar amount and reasonable time required to recoup overpayments. There have been incidents where plan sponsors have hired collection agencies to recover overpayments to retirees. On the other hand, rules have been relaxed for some plan sponsors to pursue recoupment, but no statues exist for this.

On October 27, 2020 during the 116th Congress Ways and Means Committee Chairman Richard Neal and Ranking Member Kevin Brady introduced **H.R. 8696, the Securing a Strong Retirement Act.** The NRLN supported the bill and has requested its re-introduction early in the 117th Congress (2021-2022).

The NRLN advocated for Section 301 in the bill that particularly important to millions of retirees with pensions. It clarifies that a pension plan does not have a fiduciary duty to recoup

overpayments, but if it chooses to do so, it must be done within three years of the initial overpayment. Further, the company may not recoup more than 10% of the amount of the overpayment per year, and it may not recoup against a beneficiary of a participant.

The bill also includes important provisions for future retirees including, automatically enrolling in their company's saving plan; financial incentive for small businesses to offer retirement plans and providing federal tax credit for contributions to a retirement plan.

Amending Section 420 Surplus Transfer Rules to Protect Welfare Benefits

NRLN Association and Chapter retired members worry about losing unprotected welfare benefits, such as, health care and/or life insurance benefits. In many cases their pension plans are comfortably funded and hold surplus assets that plan participants and companies would like to use to help sustain these benefits. Unfortunately, Internal Revenue Code (IRC) Section 420 prohibits the use of plan asset surplus unless a plan is funded at 125% or higher.

Pension plans funded above 110% but under 125% are well protected but companies may need plan assets to extend or virtually save welfare benefits, that IRC Section 420 was created to protect. The Section 420 outdated threshold of 125% indirectly places welfare benefits at risk.

The NRLN supports an amendment that would amend the Employee Retirement Income Security Act (ERISA) and IRC Section 420 to reduce the Section 420 surplus transfer limits from 120% and 125% to a lower level of 110%, subject to the requirement that annual plan surplus transfers may not exceed the combined annual life insurance and health insurance benefits or 1.75% of plan assets whichever is lower.

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 **H.R. 860 / S. 269, the Social Security 2100 Act** that was introduced in the 116th Congress and advocates its re-introduction and enactment in the 117th Congress (2021-22). This bill comes the closest to the NRLN's 2017 "Grand Bargain" proposal to make Social Security financially strong for our generation, our children, grandchildren and great grandchildren.

Passage of the Social Security 2100 Act would:

- 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.
- Provide an across-the-board benefit increase equivalent to about 2% of the average Social Security benefit.
- Increase the minimum benefit to ensure that workers with many years of low earnings do not retire under the poverty line.
- Cut federal income taxes on Social Security benefits for about 12 million 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.

To pay for the benefits the Social Security 2100 Act would:

- Raise the payroll tax rate starting in 2020 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 current $137,700 taxable limit 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 raises for that year.

PROTECTION AND ENHANCEMENT OF RETIREE HEALTH CARE BENEFITS

The NRLN supports any bill that protects Medicare and Medigap benefits, lowers Medicare costs for the government that does not negatively impact the insured, and increases the quality of service and delivery.

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 health care 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.

Significantly reduce the $140 billion of annual improper and wrong payments of which $85 billion is attributable to Medicare and Medicaid.

- . 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 health care costs cannot be offset by slashing Medicare benefits without regard for this covenant. Congress must increase the Medicare tax on workers and employers until such time as taxes can again fund 60-65% of the Medicare budget.

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 health care.

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 polices 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.

Time to End Taxpayer Rebates to Health Care 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 bonus 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.

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 / ENROLLEE ARE OUT OF CONTROL!**

Four realities 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 43.1% (27.4 million enrollees)** in 2021 and generated **revenue of $370 billion, 3)** after 24 years, despite gobbling up over **$450 billion in rebates, t**he 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 2021, 4)** MA plan market share is at 43.1% and revenue is $370 billion; it's time to realize subsidized growth can no longer be justified!

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 recruits are much younger and don't often go to the hospital but as they age to match the profile average of original Medicare enrollees, Part A costs for MA plan enrollees will **skyrocket**!

Taxpayers are kept in the dark and duped into paying insurers for extra MA plan benefits worth **$41.8 billion in 2021 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 40 billion beneficiaries in original Medicare**; a slap in the face and breech of moral and ethical character.

CMS paid MA insurer rebates of **$81 a** month per enrollee in 2016. In 2021**,** rebate payments rose 14%, above 2020 to the highest level in history, **$140 monthly ($1,680 / yr.)** paid to insurers directly for 27.4 million MA enrollees. Total payments were up 19.1% from **$35.1 in 2020 to $41.8 billion** this year and the **2021 Medicare Trustee report warns us to expect 6-10% annual increases per enrollee, growing to $100.8 billion in 2030 ($668 billion 2021-2030)**.

Privatization works only because bonuses of 5-10% or larger are awarded and are applied to boost benchmarks in combination with insurer plan bids used to determine rebates, that are paid under terms of a customized formula contrived in 2010, implemented in 2012 and revised in 2015.

This scheme uses a 5-star rating plan The plan is called the Quality Bonus Plan (QBP). Close examination shows it is vehicle used to grease the skids, enabling rebate payments to private plan insurers.

The Medicare Advantage Quality Bonus Plan (QBP), doesn't measure consumer healthcare product or service quality well. **Astonishingly, this 1-5-star plan awards 1-star rated plans a 50% rebate!** The Health and Human Services (HHS) Inspector General Office calls rebate payments "Wrong and Improper Payments".

<u>The NRLN PROPOSES "Exposing the Truth and Holding People Accountable":</u>

Obtain Majority Political Support to Save Medicare – a symbol of American Democracy

Grandfather Benefits for all Current MA Plan Holders

Eliminate Bonuses and Rebates

Use Quality Control and Innovation to Reduce Costs and Award Contracts Using Competitive Bids.

Removing Original Medicare Competitive Barriers – Creates a Level Playing Field for Competing Plans

Working to Stop Direct Contracting from Destroying Medicare

The Centers for Medicare and Medicaid Services (CMS) under President Biden's administration is moving ahead with Direct Contracting (DC), an ill-conceived plan announced, but not fully implemented by December 2020 under President Trump's administration. The NRLN is demanding that President Biden and Congress kill the program.

The DC plan is **aimed at the 41 million in original Medicare** who would be auto-enrolled in a private plan. Furthermore, investor-backed startup so-called Direct Contracting Entities (DCEs) can be Accountable Care Organizations (ACOs), commercial insurers, and even Medicare Advantage (MA) new or existing MA plans. This could mean that **the 24.9 million enrollees in MA plans** might be converted to original Medicare to come under DCEs. The Health Affairs publication reported that already the pilot program includes 53 DCEs in 38 states and that 23 of them are investor owned. More DCEs are expected to be rolled out 2022.

While seniors can switch from an MA plan to original Medicare by their decision, they will be involuntarily placed into DCEs without their knowledge or permission.

DCEs will be paid monthly by the CMS to cover a specified portion of a patient's medical care. This is a terrible shift from original Medicare's direct reimbursements to healthcare providers. DCEs are allowed to pocket the funding they don't spend on healthcare. **This is a prescription for private insurers to skimp on healthcare for original Medicare patients.**

Maintenance of Cost Protections ("MCP") *(See White Paper at www.NRLN.org)*

In the event that a corporation cancels or reduces all or part of a retiree's health care benefits, including those that are ancillary such as life insurance, prescription drugs, long term care and other benefits, the employer would be required to pay to the retiree the amount the corporation had been paying on behalf of the retiree and eligible dependents, adjusted for retiree participation in Medicare, at the time of a partial or full cancellation. Companies would be entitled to tax credits as an offset against dollars paid. Retirees could use such funds to purchase supplemental

insurance from employers or third-party providers but employers would be required to continue to make available and pay administrative costs for self-insured or contracted group plans.

Provisions in statutes such as in Sec. 720 of ERISA which permit the denial of protections otherwise enacted by Congress must be stricken from such statutes. Denying enacted benefit coverage to retirees, simply because retirees are members of retiree-only plans, where such protections are otherwise afforded to younger active employees or retirees is discriminatory, unjust and patently bad policy.

The NRLN advocates that Congress enact legislation in order to rectify the carve-outs of benefits currently excluded from retiree-only group plans resulting from the Patient Protection and Affordable Care Act of 2010. These include but are not limited to: 1) Prohibition of pre-existing conditions exclusion or other discrimination based on health status; 2) Prohibition on excessive waiting periods; 3) No lifetime or annual limits; 4) Prohibition on recessions (cannot drop coverage for high claims or health conditions); 5) Extension of dependent coverage until age 26; 6) Development and utilization of uniform explanation of coverage documents and standardized definitions; 7) Bringing down cost of health care coverage (for insured coverage).

Inclusion of Catastrophic Coverage in Medicare *(See Position Paper at www.NRLN.org)*

There are a rapidly increasing number of bankruptcies among retirees who have either been uninsured or underinsured against health care cost liabilities. Many retirees suffer because catastrophic illnesses that are covered by out-of-pocket maximum limits written into employee and retiree company-sponsored plans are not covered when the retiree becomes Medicare-eligible. Currently, Medicare does not provide out-of-pocket maximum coverage. The NRLN advocates that Congress should extend protection against catastrophic medical costs to the Medicare population by setting a reasonable maximum limit on out-of-pocket costs.

One of the landmark achievements of the Patient Protection and Affordable Care Act of 2010 is that it prohibits insurance plans from imposing any annual or lifetime limits on the dollar value of covered benefits. The legislation also caps the amount individuals and families must pay out of their own pocket each year, setting an out-of-pocket limit that varies by income, but in no case is higher than the current law limit for Health Savings Accounts ($7,000 for individuals and $7,200 for families in 2021).

Unfortunately, the protection against ruinous health costs that Congress will guarantee as a right to nearly all Americans under the age of 65, Congress denies categorically to those who are most vulnerable: senior citizens on Medicare.

Health Care 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 age 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.

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 off-shore 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.

- **Competitive Bidding** - NRLN supports legislation to allow competitive bidding for prescription drugs under any federally-supported health programs.

- **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.

- **Medicare Part D Prescription Drug Plan "Donut Hole"** - The NRLN advocated for the closing of the "donut hole." Although Medicare and insurers say the "donut hole" closed

on January 1, 2020 and the 50% payment obligation was eliminated, the new 25% coinsurance requirement is just a reduction from 50% to 25% under updated entry and exit points.

Once a senior and his/her prescription drug plan spends $4,130 combined on drugs (including deductible) the individual pays 25% of the cost for prescription drugs until his/her out-of-pocket spending is $6,550 under the standard drug benefit. At this point he/she automatically gets "catastrophic coverage" and pays no more than 5% of the cost for covered drugs for the rest of the year.

Even with the 25% discount often seniors can't afford the out-of-pocket cost for expensive Tier 3 and higher drugs and many stop taking their medicines. The NRLN is lobbying to remove the "noninterference" clause in the Medicare Modernization Act of 2003 (MMA) which stipulates that the HHS Secretary "may not interfere with the negotiations between drug manufacturers and pharmacies, and may not require particular formulary or institute a price structure for the reimbursement of covered Part D drugs." In other words, the government can have no role in negotiating or setting drug prices in Medicare Part D.

We advocate that Medicare should do competitive bidding (the business model) wherever two or more FDA approved generic drugs, or two or more brand drugs, or a generic and brand drugs (upon patent expiration) treat the same medical condition.

- **Encourage Retention Of Company-Provided Health Care 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 Health Care or Prescription Drug Plans. This bundling practice holds retirees hostage to company plans and makes it impossible for plan participants to make free choices.

RETIREE INCOME AND HEALTH CARE BENEFIT TAX REFORM

Taxes Affecting Retiree Income Sources

Taxing Social Security Income:

Support legislation to amend the tax code to eliminate federal and state taxes on all Social Security income and/or allow a tax credit for taxes withheld. These taxes on Social Security income

constitute a reduction of benefits which were supposed to be temporary when passed in 1993 to balance the budget. Reductions on Social Security taxes should have priority over any other tax cuts including the extensions enacted in 2003. In doing so, we stop penalizing fixed-income seniors.

Alternate Minimum Tax:

Support legislation to raise the threshold level and indexing to inflation.

Taxes on Dividends and Capital Gains

Taxation on dividends and capital gains for retirees with under $200K-$250K annual income should be kept at the same 2012 rates.

(401)k / IRA Mandatory Distribution Requirement From 70 ½ to age 72:

The NRLN Supported legislation that passed in the CARES Act 2020 to change the age from 70 ½ to 72 for Required Mandatory Distribution (RMD) from retirement savings accounts. The NRLN advocatess that individuals should be given the choice of not taking an RMD in years when equity markets decline. This was the case in 2020 during the COVID-19 pandemic.

Taxes Affecting Retiree Health Care Benefits

The Health Coverage Tax Credit

The Health Coverage Tax Credit (HCTC) is a refundable tax credit for individuals, between the ages of 55 - 64, receiving certain Trade Adjustment Assistance benefits or individuals receiving pension plan benefits that have been taken over by the PBGC. Pass legislation to permanently provide HCTC rather than having to lobby Congress annually to re-introduce and vote on passing an extender. Currently, the tax credit is for 72.5% of the premium amount paid by an eligible individual for health insurance coverage. The tax credit should be increased to 80% of the premium.

Taxing Health Care Benefits

The NRLN advocates that the portion of premiums paid by employers that is currently treated as a tax-free benefit to employees and retirees should remain tax free.

Deductibility of Health Care Costs

Support new legislation that enables health care premiums (including Medicare premiums) to be tax-deductible, similar to the way health insurance premiums for self- employed individuals are deductible. Such deductions would be exempt from the 7.5% (AGI) limitation.

Health Savings Accounts (HSAs)

Change IRS Code of 1986 to allow HSA funding beyond age 65 and directly from IRAs for all years not one year without tax penalties and reasonable annual contributions.

Withdrawals To Pay Retiree Health Premiums

Support new legislation that enables penalty- free withdrawals from 401k, IRA, SEP and other qualified accounts to pay for retiree health care premiums.