



# Alliance for Retired Americans Legislative Agenda 2009-2010

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The **Alliance for Retired Americans** is a nationwide organization of over three million union retirees and other older and retired Americans working together to make their voices heard in the laws, policies, politics and institutions that shape our lives. The Alliance’s mission is to advance public policy that protects the health and economic security of older Americans.

## OVERVIEW

Older Americans in 2009 face challenges on several fronts. Health care costs continue to rise dramatically and outpace general inflation. Seniors increasingly use more of their income for out of pocket health care costs. In addition, the economic downturn, which began in 2008, threatens seniors' financial security. Social services, on which millions rely for basic needs, are severely strained. Basic energy and food costs have risen dramatically. This all has come at a time when the oldest members of the Baby Boom generation are beginning to retire in large numbers, the start of a wave of retirements that will nearly double the number of older Americans. The need for health care services, long-term care, economic security, and housing will grow increasingly urgent as the American population ages.

Current and future retirees, and their families, will need strong Social Security and Medicare systems, access to affordable long-term care, and strong pension systems in order to attain a comfortable quality of life. However, structural changes to the Medicare program and attempts to cut Social Security benefits, as well as current tax policy, which is skewed toward the wealthiest Americans, represent major threats to the security of today's and tomorrow's retirees.

The 2008 elections have given the nation a great opportunity to fundamentally change how Americans pay for and receive their health care. The country today has a once-in-a-generation opportunity to create lasting, positive change.

The Alliance for Retired Americans believes that thoughtful and effective legislative policies enacted in the 111th Congress will protect and enhance the quality of life for America's retirees for years to come.

### Prescription Drugs

#### Background

Older Americans spend more out-of-pocket on prescription drugs than the rest of the population because they have more acute and chronic illnesses, need more drugs for treatment and, in the case of retirees under age 65, are less likely to have insurance coverage. Rising medical expenses consume 15 percent of a typical retiree's budget and prescription drugs outlays represent a big portion of these out of pocket costs. Moreover, retirees are increasingly being left without employer-sponsored health coverage as the number of large employers providing such coverage has dwindled down today to only one in three, as compared with two in three in the 1980s. Meanwhile, Medicare's prescription drug benefit, as described below, has barely dented seniors' out-of-pocket spending.

The Medicare Modernization Act (MMA) of 2003 created a prescription drug benefit (Medicare Part D) provided through stand-alone drug plans or Medicare Advantage managed care plans both administered by private insurers and not the Medicare program. The MMA benefit, which began in 2006, is doing little to alleviate the difficulties that seniors with high drug costs experience. In 2009, Part D premiums will jump by 30 percent for the 10 most popular prescription drug plans. After spending \$2,700 in total drug costs, Part D beneficiaries reach the "doughnut hole" and are responsible for all prescription drug costs until they have spent \$4,350 total out of pocket. This gap in coverage is forcing seniors who lack coverage in the doughnut hole to reduce their monthly prescriptions by 14 percent once they enter the doughnut hole. Along with cutting back on medications in an effort to avoid reaching the doughnut hole, Part D beneficiaries stop using an average of one in five prescriptions once in the coverage gap.

Likewise, Part D's low-income subsidy (LIS) program continues to see a decline in the number of plans that can enroll LIS beneficiaries for no monthly premium from year to year; variations in plan availability across regions; and a continuing lower-than-expected enrollment of eligible enrollees. The most recent data available indicate that approximately 2.3 million eligible low-income beneficiaries (19%) are not receiving the LIS subsidy.

Even with the MMA benefit, drug costs for seniors will continue to increase. The federal government is explicitly prohibited from using its purchasing power on behalf of 45 million beneficiaries to negotiate lower drug prices with drug companies. The MMA also continues the ban on re-importation of safe, affordable drugs from countries such as Canada and other advanced countries, thus protecting drug companies from price competition. Drug costs are further inflated by "sweetheart" deals, in which pharmaceutical companies pay generic drug companies to keep their generic alternatives off the market. In 2006, a federal appeals court allowed drug maker Schering-Plough to pay \$90 million to two generic drug manufacturers. In return, they agreed not to market generic versions of Schering drugs.

Since then, Federal Trade Commission officials estimate that nearly half of all legal agreements between brand-name and generic drug makers have involved payments to the

manufacturer of generics in return for an agreement to stay out of the market. In the outline for his 2010 budget, President Obama offered two measures to halt these “sweetheart” deals from occurring by: “prohibiting anticompetitive agreements and collusion between brand name and generic drug manufacturers intended to keep generic drugs off the market” and by prohibiting drug manufacturers from reformulating existing products into new products to restart the exclusivity process, a process known as “evergreening.”

President Obama’s FY 2010 budget proposed means testing of Part D premiums. Beneficiaries with pre-tax incomes greater than \$85,000 (\$170,000 per couple) would pay a larger share of the overall Part D premium costs. Faced with higher premiums for Part D as well as the means testing of Medicare’s Part B premiums, wealthier and healthier beneficiaries may decide to opt out of Medicare in favor of private insurance. Means testing undermines the social insurance nature of the Medicare program and could lead to increased costs for middle- and lower-income seniors if higher-income seniors, who are often younger and healthier, are driven away by increased cost sharing. It also raises premiums for those who have paid the most into the program through Medicare payroll taxes, harms seniors and their families regardless of their financial obligations, and puts the burden on seniors to demonstrate that their premiums should not be increased if their income is reduced. Given Medicare's current unresolved problems with premium processing, the means testing of premiums is extremely difficult to implement and administer.

### **The Alliance Position**

The Alliance for Retired Americans believes that Part D should be overhauled.

- Older Americans should have a nationally available Medicare-administered drug program, following these guiding principles:
- Comprehensive benefits available to all Medicare beneficiaries, which includes no gap in coverage, voluntary enrollment, affordable premiums, and low-co-payments.
- No means testing of benefits.
- Strong, enforceable provisions to bring down the costs of prescription drugs.
- Negotiation for lower drug costs for Medicare beneficiaries by the federal government, and the re-importation of prescription drugs from advanced countries.

The Alliance supports legislation that addresses these principles, including bills that would lower prescription drug costs for all Americans by allowing the importation of drugs with appropriate safeguards, even though this is only a preliminary step in taking on the problem of high drug costs. The Alliance also supports legislation that requires the federal government to negotiate lower drug prices on behalf of Medicare beneficiaries, expands availability of generic drugs, prevents agreements between brand and generic companies to keep generics off the market, and promotes the ability of the states to use the power of bulk purchasing in order to reduce costs. Punitive features of Part D, such as the asset test for low-income recipients to receive help should be eliminated. The late enrollment penalty should also be eliminated until the problems with Part D are fixed.

# Medicare

## Background

Medicare is the nation's largest and most successful health insurance system, serving the health needs of nearly 45 million senior and disabled beneficiaries. It is an operating model of an effective universal health system in the United States.

Costs of health care for Medicare beneficiaries, however, have risen since the program's inception. Medicare beneficiaries spend on average of about 23 percent of their income for health care related needs. This is much higher than younger age groups, in part because of the additional costs to beneficiaries for services that Medicare does not cover and the need for expensive supplemental insurance due to Medicare's significant co-pays and lack of annual out of pocket spending limits. Medicare originally covered approximately 85 percent of beneficiaries' health care costs; currently it covers only about 50 percent.

The MMA included other changes undermining the Medicare program, including means testing of Part B premiums and setting reimbursement rates for Medicare Advantage plans that average 14 percent higher than the reimbursement rates for traditional Medicare. Every Medicare beneficiary pays an extra \$3 per month to subsidize these overpayments.

Legislation is needed to address two specific parts of the MMA that are designed to ultimately privatize or threaten traditional Medicare. These two measures have been halted by Congress, but need to be officially eliminated. First, in 2010, the MMA required the Medicare program to compete with heavily subsidized private insurance plans in an experiment that would advance the effort to privatize Medicare.

Second, the MMA also imposed an arbitrary cap of 45 percent on general revenue financing of the Medicare program. The MMA designed the trigger to "go off" if the Medicare trustees reported two times in a row that in the following six years Medicare spending would use more than 45 percent of funding from general revenues. The President is then required to propose legislation to reduce Medicare spending. There is no basis for the 45 percent figure; it is entirely arbitrary. Medicare's "solvency" is not measured by the 45 percent trigger because the trigger has nothing to do with the size of the Trust Fund.

The MMA increased spending by overpaying private health plans and drug manufacturers without an offsetting increase in revenues, in the process penalizing all beneficiaries to subsidize private plans used by only one in five beneficiaries. Ironically, the MMA then set a limit (the 45 percent trigger) on that spending, creating an artificial crisis that could result in benefit cuts or increased premiums.

## The Alliance Position on Medicare

The Alliance for Retired Americans supports:

- A Medicare program with expanded benefits, including a comprehensive prescription drug benefit under the Medicare program, and affordable home and community-based long term care;
- Eliminating the current two-year waiting period for receiving Medicare for Social Security Disability Insurance beneficiaries;
- Providing early retirees, 55-64, health care coverage; either through buying into Medicare at affordable premiums or through a national health care plan that is at least equivalent in cost and coverage;
- The inclusion of annual physical exams, dental health, vision services and eyeglasses, hearing services and hearing aids, foot care, extended preventive services and PET scans with little or no co-payments.
- Coverage for care in the most appropriate and cost effective setting.
- A specific, affordable limit on annual out-of-pocket spending by beneficiaries.
- Repeal of: the Part B premium means-testing provision; the 2010 demonstration project; and the 45% Trigger.
- Medicare reimbursement levels sufficient to strengthen the provider base and to ensure access.
- Providers should be held accountable for how funds are spent with an emphasis on quality standards and regulations.
- Eliminating the asset limits for the Medicare Savings Program (MSP) and Part D Low-Income Subsidy (LIS) programs. Additionally, allow “cross-deeming” for the MSP and LIS so that if an individual is eligible for one program, they may be deemed eligible for the other.
- Making the Qualified Individual (QI) program permanent, and align income eligibility should with the Part D LIS program at 150 percent of poverty.
- System-wide use of health care IT, with appropriate privacy protections, and increased funding for comparative effectiveness research.
- Care coordination should be provided to older adults and people with disabilities with complex chronic conditions, disabilities, or dementia. Care coordination can improve the quality of and access to health care for older adults and may reduce costs by helping to prevent unnecessary hospitalizations and nursing home placements.
- Sufficient funding to reduce waste, fraud, and abuse in the Medicare program.

- Authorizing nationally available standard benefit design packages for Part D and Part C to minimize confusion and make comparisons easier.
- A universal health care program that covers all Americans with comprehensive benefits and includes strong cost-containment mechanisms. This is the only true solution to the growing cost of the Medicare program and the need to improve Medicare coverage.
- Any reform must protect benefits currently offered, to ensure that an individual's quality and access to care will not be diminished.

The Alliance for Retired Americans opposes:

- The provisions in the MMA that restructure the Medicare program and undermine federal administration of Medicare by turning it, or parts of it, over to private insurance companies and managed care plans.
- Shielding saving and investment income from taxation through HSAs and MSAs, which provide greater benefits for those with greater wealth while at the same time reducing federal revenues and providing inferior health care coverage.

## Medicaid

### Background

The Medicaid program, a joint federal-state program, provides health care to 55 million Americans, including 7 million Medicare beneficiaries. Medicaid participants include low-income children, parents, pregnant women, people with disabilities and seniors. Eligible low-income Medicare beneficiaries can receive assistance with their Medicare premiums and cost sharing from Medicaid. These beneficiaries, known as “dual eligibles” receive their Medicaid benefits through the three Medicare Savings Programs: the Qualified Medicare Beneficiary (QMB) program, the Specified Low-Income Benefit (SLMB) program, and the Qualified Individual (QI) program. Unlike the QMB and SLMB programs, however, the QI program is not permanent.

Medicaid accounts for nearly half of all formal long term care expenditures. While more than half of Medicaid long term care spending goes toward institutional services, home and community-based services account for a growing proportion of Medicaid spending on long term care. Medicaid, however, is not a comprehensive base for long term care protection: recipients must spend down their assets to qualify. Prior to the Medicare Modernization Act of 2003 (MMA), Medicaid played a fundamental role in the provision of prescription drugs for low-income seniors. Now many older Medicaid beneficiaries are enrolled in Medicare Part D plans and subject to co-payments for their medications for the first time.

Over the past few years, some states have used Medicaid waivers as vehicles for establishing cost containment measurements in Medicaid, the State Children's Health Insurance Program (SCHIP) and other health coverage programs, including new eligibility restrictions, reduced benefits, and increased cost-sharing.

The Deficit Reduction Act (DRA) of 2006 fundamentally alters many aspects of the Medicaid program. Some are mandatory changes that states must enact, making it more difficult for individuals to qualify for or enroll in Medicaid. Optional changes allow states to alter Medicaid through state plan amendments increasing cost-sharing and changing benefits packages. The penalty period specified under the DRA for Medicaid eligibility for long-term care should start regardless of care setting and should keep running if there is a break in use of Medicaid by the beneficiary. Additionally, “innocent transfers” should be exempt from DRA’s transfer penalty provisions if the gifts were made by people who did not anticipate they would need nursing home care.

The current economic downturn, with over half the states facing budget shortfalls, continues to put pressure on state budgets to cut Medicaid. As a result states are already beginning to curb Medicaid services, such as those that keep older Americans out of nursing homes. Congress must prevent harmful Medicaid spending cuts that would reduce home and community based services for the elderly and people with disabilities. States considering drastic cuts to Medicaid should receive fiscal relief by temporarily augmenting the current level of federal support for state Medicaid programs (FMAP) in order to stave off the counter-cyclical cuts to this safety net program. Increases to FMAP included in the American Recovery and Reinvestment Act of 2009 were a positive step, but the pressures remain.

During economic downturns the Medicaid program in states is financially stressed by the influx of new participants. The federal government should address these stresses by ensuring permanent counter-cyclical funding mechanisms, which would create an automatic increase in FMAP provisions during an economic recession.

Finally, an expanded and improved Medicaid program that extends health insurance coverage to low income people who currently are uninsured should be a core component of health care reform.

## **The Alliance Position**

The Alliance for Retired Americans supports adequate Medicaid funding for the following:

- Improvements that protect “dual eligibles” from increased cost-sharing and ensure coverage of essential medications;
- Permanent authorization of the QI program;
- Stepped-up enforcement of the Nursing Home Reform Act of 1987 to ensure institutional settings comply with federal standards of care;
- Expanded Medicaid to cover low-income people who currently do not qualify due to family status (for example, adults under 65 without dependent children);
- A permanent system of counter-cyclical funding, in which federal matching rates (FMAP) are increased automatically during a downturn;
  - Waivers approved only for new, innovative means of providing services and not merely for the shifting of funds to other existing services; and
- Increased levels of care management for patients with chronic diseases and other high-cost conditions.

# Long Term Services and Supports

## Background

Long term services and supports (LTSS) cover a range of services in a variety of settings. About 10 million Americans of all ages, including almost 5 percent of the total adult population living in communities and in nursing homes, have significant limitations in more than one activity of daily living (ADL), such as bathing, dressing, eating, and walking, and instrumental activities of daily living (IADLs), such as preparing food, and managing medication. These people require personal assistance or long term services and supports.

The cost of LTSS falls heavily on individual recipients and their family caregivers, accounting for 22 percent of spending on such services and more than half of all donated care. Nursing home care averages \$70,000 per year, assisted living facilities average \$36,000 per year, and home health services average \$29 per hour. Medicaid is the primary source of funding, paying for 40 percent of LTSS. While the majority of funds goes to nursing home care, Medicaid expenditures for home and community-based care is increasing. Individuals must spend down their assets to qualify for Medicaid. Medicare accounts for slightly less than one-quarter of long term services and supports spending. It only covers nursing home care costs for up to 100 days following three days of hospitalization or part-time skilled nursing or therapy services at home for the same period. Medicare's services are designed to help beneficiaries recover from acute illness rather than provide long term services and supports for those who have chronic problems with ADLs.

Private long term care insurance is not a viable solution for financing LTSS as it is beyond the financial reach for most Americans. According to a 2008 study by Fidelity Investments, a couple that is 65 years old will need \$85,000 to insure against the expense of long-term care in the future. . Additionally, it is not available to both older and younger people who already have the need for long term services and supports. All policies currently exclude those with pre-existing conditions. By themselves, tax credit and tax deduction proposals for long term services and supports are insufficient to address the need and the tax advantage would accrue primarily to higher income Americans. The United States needs a multigenerational, national, social insurance program for those who become functionally disabled that will help pay for the services and supports they need to stay functional and independent, and to have choices about community participation, education and employment.

## Long Term Services and Supports Workers

Certified nursing aides provide 90 percent of direct care in nursing homes, and home health and personal care workers provide the vast majority of paid direct care in the home and community. Low levels of pay, limited opportunity for advancement and lack of benefits result in high annual turnover rates among long term services and supports workers.

Nursing homes and other providers cannot deliver quality care until there are vast improvements in staffing and training, and adequate compensation and benefits as well as safety protections for LTSS workers.

## **Family Caregivers**

There are an estimated 34 million adults (16% of population), who provide health care for adult family members and friends over 50. LTSS issues are multi-generational and disproportionately affect women because they have longer life expectancies and have traditionally filled the role of caregivers. An estimated 59% to 75% of caregivers are female., as are three-fourths of nursing home residents, and two-thirds of recipients of home health care.

## **The Alliance Position**

The Alliance for Retired Americans supports:

- A social insurance model for long term services and supports
- The CLASS Act (S. 697 and H.R. 1721) as a step toward comprehensive long term services and supports coverage;
- Affordable care for all those who need it, based on their health conditions;
- To the extent possible, ensuring the individual's independence and right to choice of provider and care environment, including one's own home;
- A range of quality care services including, but not limited to, the following services and settings that enhance the physical and mental well-being of recipients and their caregivers: skilled nursing care; rehabilitative services; respite care; personal assistance with activities of daily living such as bathing, toileting, dressing; congregate living arrangements; adult-day-care services; home care; and hospice care;
- Enforcement of quality assurance measures, improved data collection, and public disclosure of staffing levels;
- Educational efforts to promote informed decision-making by individuals and families including an examination of available options for types of care and settings, as well as financing resources and eligibility criteria;
- Recognition of the essential role of front line long term-care workers in ensuring quality care through improvements in nursing home staffing ratios; staff and management training; and fair pay, benefits, incentives, and safety protections for all health-care workers; and
- The right of all long term-care workers to organize and bargain collectively, with provisions for effective enforcement.
- Transparency laws so that consumers can easily understand the chain of ownership of nursing facilities.

- Expanded funding for the National Family Caregiver Support Program and funding for Lifespan Respite Care programs, as well as national enactment of financial and other supports for family caregivers. These should include, but not be limited to, affordable health insurance, funding for caregiver assessments, adequate provisions for respite, and guaranteed Social Security credit protections for the women and men who leave the workforce to care for a loved one.

The Alliance opposes:

- Pre-entry arbitration agreements, forcing residents and families to forfeit their rights as consumers upon entering a facility.

## **Universal Health Coverage**

### **Background**

It is a national outrage that early 47 million Americans, including 9 million children, did not have basic health insurance in 2008. More than 8 in 10 uninsured individuals are in working families. The numbers of uninsured are rising largely because of the decline of employer-sponsored coverage—either because employers do not offer health care benefits or workers cannot afford their share of premiums. The cost of family health insurance is approximately one-third of the gross earnings of the average full-time wage worker. Tens of millions of employees worry about losing the coverage they have. As a result of a large uninsured population, public facilities providing health care face an increasing burden of uncompensated care. As these costs grow, they are shifted to those who have coverage – driving up insurance costs for individuals and employers.

America now stands at a crossroads for universal coverage. The current system, with a large and increasing number of uninsured Americans, cannot sustain itself. Health care costs outpace general inflation by two or three times. The main reason for the large number of uninsured Americans is the cost of health insurance. Universal coverage for all Americans is both a health care and economic necessity.

Workers who retire before age 65 have few affordable options for health care coverage. Many cannot buy insurance at any cost, due to their age or pre-existing health conditions, and must wait until they reach the age of Medicare eligibility. As a result, many retirees do not receive basic and preventive health care services, which increases the cost burden on Medicare once those retirees become eligible. Only a third of large employers now offer retiree health care benefits, a precipitous drop from two-thirds in 1988.

Health care spending in the United States in 2008 was \$2.4 trillion. That's nearly four and a half times the amount spent on national defense. According to the National Health Statistics Group at the Centers for Medicare and Medicaid Services, health care spending in the United States is expected to experience its largest one-year increase in 2009. The 2009 estimate for health care as a percentage of GDP is 17.6% and is projected to reach 20.3 % in 2018.

Medicare's costs are tied directly to the soaring costs in the entire health care system. Until overall costs are reined in, it will be impossible to contain costs in Medicare. The same is true for the cost of Medigap plans and employer-sponsored retiree health benefits.

Unfortunately, the current high cost of our overall health system is not reflected in the quality of care. For example, according to a February 2009 study in the *New England Journal of Medicine*, program spending varies dramatically by region because individual physicians increase costs based on the quantity of medical services they provide in the area. However, patients do not necessarily receive better quality care. The findings suggest that in 2023, an estimated \$660 billion deficit in Medicare could become a \$760 billion surplus if physicians were more conservative with their treatments. Further, patients in the United States get appropriate treatment only about half of the time and, according to a study by the Harvard Medical School, 100,000 die each year as a result of medical errors.

### **The Alliance Position**

The Alliance for Retired Americans believes that health care is a fundamental human right and an important measure of social justice. The Alliance supports a universal health care system with coverage that is comprehensive, affordable and accessible for all. Individuals should be able to choose their health care providers. Financing should be a shared responsibility, with employers paying their fair share. Effective quality and cost control mechanisms are a necessity. The Medicare program, with low administrative costs, is a prime model for a universal health care system with these features.

Achieving universal health care will require coverage for all, not just many. Benefits must cover a broad array of health services—from preventive to long term services and supports—in order to address all situations and the health needs of all age groups. Health care reform must include large risk pools in order to make costs affordable and available to all Americans. No one should be denied coverage or priced out of the market due to pre-existing health conditions, or age. Basing premiums on community rating will achieve this goal.

The reduction of health care costs globally will benefit all Americans, including retirees. Such reductions in costs will sustain and strengthen the Medicare program as well as private plans that millions of retirees receive through their former employers. A public plan option, available to all Americans as part of health reform, would help reduce overall health care costs by providing competition to private plans with traditionally high advertising and marketing costs. Such a plan, along with the use of community rating, would be a first step toward a national single payer health care system.

Until such a system is in place, health reform efforts should not undermine existing coverage or place individuals at risk of unmet health care needs. To that end, the health benefits of workers and retirees must be protected from unilateral actions by employers. Also, the Alliance strongly opposes proposals to tax the value of employer-paid health care coverage, which would unfairly penalize low- and middle-income workers, as well as retirees.

The Alliance for Retired Americans calls for the enactment of universal health coverage that is accessible, affordable, and maintains quality coverage during the 111<sup>th</sup> Congress. The current patchwork system, leaving 47 million Americans uninsured, is unsustainable and detrimental to the American economy.

# RETIREMENT SECURITY

## Social Security

### Background

Social Security is the foundation of America's retirement security and provides critical financial protection for survivors of deceased and disabled workers and their families. Two-thirds of older Americans rely on Social Security for half or more of their income.

Despite the recent rhetoric that Social Security is "in crisis," the Social Security Trustees estimated in 2009 that the Social Security Trust Fund has adequate resources to pay full benefits through 2037 and, even if no changes are made, the system will be able to pay nearly 75% of benefits thereafter.

The Alliance was a national leader throughout 2005 and 2006 in opposing President Bush's and congressional Social Security privatization proposals. The 2008 downturn in financial markets clearly showed the folly of workers investing even a portion of their Social Security contributions in private accounts.

The increased use and substitution of defined contribution plans for defined benefit pension plans and the greater risks inherent in these plans magnify the importance of Social Security's role in providing the bedrock of retirement security for all Americans. Of workers who have access to any retirement plan, only 21% have access to a traditional defined benefit plan. Only half of families have any kind of retirement savings, and the average amount is just \$29,000. The 2008-2009 downturn in the financial markets demonstrated that defined contribution plans cannot be a substitute or a model to replace the guaranteed benefits of Social Security.

### The Alliance Position

Social Security is not "in crisis." Opponents of the program have created a mythical world that belies the reality of Social Security financing, which will be sound for many years to come. The time is approaching, however, when Congress will need to take action to extend the solvency of Social Security into the distant future. One simple solution is to restore the earnings cap to the historical level of 90% of all wages earned. The erosion to current levels of approximately 82% of wages has deprived the Social Security Trust Fund of funds that can be deposited and compounded for payments to future beneficiaries.

The Alliance supports:

- Strengthening and improving the financing and benefits of the current Social Security system, including the Social Security Administration.
- Addressing long-term solvency by making Social Security's financing more equitable and stable by raising or eliminating the cap on wages covered by Social Security.

- Increased benefits for single older women and others who do not spend full careers in the paid workforce because of their care of children and other family members.
- A general benefit increase at age 85 for all Social Security beneficiaries to improve the adequacy of benefits.
- The establishment of a minimum Social Security benefit so that those most dependent on Social Security get benefits at least at 100% of the poverty level.
- Basing cost-of-living adjustments on the true cost-of-living of Social Security beneficiaries derived from a determination of the actual living costs for seniors and persons with disabilities.
- Taking the Social Security Administration's administrative expenses off-budget and out from under congressional discretionary spending caps because the agency's operating costs are funded through the payroll tax.
- Education efforts by the Social Security Administration on the importance and benefits of the Social Security program including the old age, survivors, and disability programs.
- Repeal by Congress of the Social Security Government Pension Offset and Windfall Elimination Provision, which unfairly penalize public sector employees by reducing Social Security benefits in direct proportion to their public sector pensions.

The Alliance opposes:

- Any plans to privatize Social Security by diverting Social Security revenues into individual accounts subject to investment and market risks.
- Any increase in the early retirement age or any further increase in the normal retirement age.
- Changing the Social Security benefit formula to either increase the number of years of earnings counted or to index benefits entitlement to prices instead of wages.
- Closing local Social Security offices and reducing Social Security Administration staff and forcing claimants to use electronic filings without the option of seeing Social Security personnel.

# **Pensions and Savings Protections**

## **Background**

Just half of private sector workers participate in an employer-sponsored retirement plan. Many employers do not offer a retirement plan, and even when a plan is offered, too many workers do not participate. Of all workers in both the private and public sectors with access to any retirement plan, only 21 percent have access to a traditional pension plan. Traditional defined benefit pensions are in decline, falling from 112,000 plans in 1985 to 28,769 in 2005. These trends have created the potential for economic hardship for millions of Americans during their retirement years.

The retirement security of millions of retired and working Americans has been threatened by the steep decline in the stock market and an increasing number of corporate bankruptcies. In addition, tens of millions of retirees and workers, including many Alliance members, have lost their 401(k) retirement savings because of reckless speculation, corporate corruption, and improper auditing and accounting practices. Many retirees and workers who had investments in 401(k) and similar plans were unable to reallocate their assets because of lockdowns and other barriers while the value of their savings declined. In addition, many employers have stopped making contributions to their 401(k) plans and even withdrawn funds to meet day-to-day expenses.

A major factor in declining retirement security over the last 20 years has been the replacement of defined benefit pension plans with uninsured retirement savings plans such as 401(k) plans, which are often minimally or poorly regulated. The growth in retirement savings plans at the expense of defined benefit pension plans has forced retirees and workers to take on more risk, potentially jeopardizing their retirement incomes. The federal government insures defined benefit pension benefits in the private sector while retirement savings plans have no such protection.

The Pension Benefit Guaranty Corporation (PBGC), while not only underfunded by \$11 billion because of the recent economic downturn, invested premium dollars in the stock market. The results were disastrous. Shortly before the stock market collapse of late 2008, the agency invested \$64 billion, an astonishing 55% of its funds, in equities and real estate. The pension security of 45 million Americans is now at risk because of this reckless action. All taxpayers could suffer should a bailout become necessary.

Conversions to the so-called hybrid or cash balance defined benefit plans by employers have frequently resulted in reduced benefits for older workers. Such plans diminish the value of career employment and significantly reduce the retirement income of such employees, while discouraging others from long-term commitments to an individual employer. Such conversions, which may be economically necessary at times for a firm, should protect older workers who will not have sufficient time remaining in the workforce to make up for lost retirement income.

All of these events underscore the importance of maintaining Social Security's guarantee of risk-free, inflation-adjusted lifetime protection. Social Security remains the only retirement security program that is not subject to the risks of stock market volatility, poor investment decisions, and corporate fraud and abuse.

### **The Alliance Position**

The Alliance for Retired Americans supports:

- Federal legislation that will encourage employers to maintain and start defined benefit pension plans in order to expand pension coverage to workers who do not have coverage in the workplace.
- Federal protections for public sector pension plans that create minimum standards at least as good as ERISA and allow states and cities to go beyond such minimums. Public employees and retirees should not be abandoned to the risks and uncertainties of personal retirement accounts.
- Representatives elected by workers and retirees to the boards of trustees of defined benefit pension plans, 401(k)s and similar retirement savings plans. All trustees should be insured in case they are found to have acted unlawfully; plan participants need to be made whole in such cases of fiduciary malfeasance.
- A national ombudsman to protect the rights of plan participants established within the United States Department of Labor and adequate funding for enforcement agencies to protect retirees against wrongful practices. Corporate officers must be held accountable for their actions regarding retirement savings plans and plan sponsors should be held accountable for adequately funding their plans.
- Independent investment advisers and accounting firms. Investment advisers must not have any conflict of interest in stocks or other investment instruments they recommend to plan participants. Accounting firms must not receive consulting fees from the firms that they audit.
- A refundable Savers Credit with a higher income limit in order to provide a more attractive incentive for low and middle-income workers to contribute to retirement savings plans.

The Alliance opposes the excessive investment of PBGC premiums in the stock and real estate markets, as well as the conversion of defined benefits plans to any other plan type—including cash balance and defined contribution plans—without adequate protections for older workers. The Alliance also opposes the diversion of payroll contributions from Social Security to private investment accounts.

# Supplemental Security Income

## Background

Supplemental Security Income (SSI) is a federal income-supplement program funded by general tax revenues (not Social Security taxes) that provides monthly benefits to more than 7.2 million low-income individuals, couples, or children who are blind, disabled or age 65 or older. Over one-quarter of SSI recipients are age 65 and older, with approximately 863,000 persons in this age bracket receiving SSI benefits..

In 2009, to be eligible for SSI, monthly unearned income cannot exceed \$699 for an individual or \$1,031 for a couple. Furthermore, a qualifying individual's assets cannot exceed \$2,000 for an individual and \$3,000 for a couple. The maximum dollar amount one can receive in Federal SSI cash benefits on a monthly basis is \$679 for individuals and \$1,011 for couples. Few seniors on SSI, however, actually receive the maximum amount. In fact, the average monthly SSI federal benefit for a senior is merely \$341.20. This discrepancy is attributed to the program's benefits calculation formula, wherein once an individual is enrolled in SSI, their countable income is then subtracted from the maximum payment amount to determine the actual SSI benefit amount.

Though SSI is an important source of income for those most in need, its current benefit level is extremely low and its outdated eligibility requirements have made it less and less effective in alleviating poverty than originally intended.

## The Alliance Position

The Alliance supports modernizing the Supplemental Security Income program with the following recommendations:

- Increase the general income and earned income exclusions as well as the assets/resources limits. If the general income exclusion were adjusted to account for inflation since its launch, the updated amount would be over \$80.00. Likewise, the asset limit should be increase each year based on the change in the consumer price index. This is consistent with the treatment of SSI benefits, which are updated using CPI;
- Discontinue counting in-kind support and maintenance as income;
- Index increases to inflation;
- Develop and fund an effective outreach program;
- Increase Social Security Administration staffing to administer the current program more efficiently and to make the proposed improvements; and
- Simplify the application and appeals process.

## **BUDGET AND TAX POLICY**

### **Background**

In March 2009, the Congressional Budget Office (CBO) announced a fiscal year 2009 deficit of \$1.7 trillion, well more than triple the 2008 deficit of \$459 billion. In addition, CBO projected a deficit of \$1.1 trillion in 2010. The economic downturn of late 2008 and 2009, combined with stimulus measures to stabilize and revive the economy, have caused these record breaking numbers.

The Congressional Joint Economic Committee (JEC) has estimated that the federal government has borrowed \$1.6 trillion through 2008 to pay for the Bush tax cuts. Should Congress extend those tax cuts, the JEC estimates that the federal government would have to borrow an additional \$3.4 trillion over the next decade.

Budget and tax policy over recent years have resulted in dramatic cuts in domestic programs. The tax cuts disproportionately benefited the wealthy, financed by steep cuts in basic health, retirement, and other benefits for low- and moderate-income Americans. In recent years, Congress had also ignored prior budget rules by applying spending caps and pay-as-you-go procedures to discretionary and entitlement programs only while exempting tax cuts from the same restrictions.

Over the long term, the impact of such tax cuts and budget deficits will diminish or destroy programs vital to most Americans including: Social Security, Medicare, Medicaid, and other domestic programs that benefit children, those with disabilities, and millions of other average Americans. These programs are essential to the economic and health security of America's seniors and the vast majority of low- and moderate-income Americans— now and for generations to come.

There is mounting concern over the negative economic circumstances currently facing the nation. This anxiety, accentuated by the recent campaign to erode public support for social insurance programs, has served to confuse and generally misinform the public. Many now erroneously believe that it is time to diminish these cornerstone programs. They fail to see that reversing budget and tax spending that benefits the wealthy, and redirecting monies to programs vital to most Americans, go a long way toward improving the economic viability of our nation.

As the nation reforms health care delivery, payment, and benefits, some have proposed taxing existing employer-based health insurance benefits or creating an additional tax structure (including employers and individuals) to support the cost of health care reform.

## **The Alliance Position**

The Alliance for Retired Americans supports:

- Tax and budget policies that restore fiscal discipline and balance. These policies must reduce deficits in the long run and generate jobs and growth in the near term. Such policies should increase progressivity in the tax code, foster fairness and benefit most Americans, not just the wealthy.
- Ensuring that tax code changes do not undermine high quality health benefits. Even limited taxation of health benefits could undermine employer coverage. Until we have a proven and sustainable alternative to employer coverage, we should not diminish incentives for employers to offer coverage.
- Directly taxing the income of high earners to help finance health care reform, not the value of workers' employer-sponsored health benefits.

The Alliance opposes:

- Extending the regressive 2001 and 2003 tax cuts or making them permanent as well as any other tax cuts that benefit the wealthy at the expense of low- and moderate-income Americans and threaten the financial stability of the Social Security and Medicare Trust Funds.
- Creation of a commission on entitlement spending. This action undercuts Congress's responsibility to protect and improve social insurance programs in the larger context of budget and tax reform.

## **HOUSING**

Affordable, supportive housing is a key part of the continuum of care and critically necessary to prevent premature institutionalization of some older adults. The number of low-income renter households that paid more than half of their income for housing increased by 2 million, or 32 percent, between 2000 and 2007. Among senior renters, 1.29 million spend over 50% of their income on housing.

The Section 202 Supportive Housing for the Elderly program has provided safe, decent, affordable housing and coordinated services to very low-income seniors since 1959. Throughout the country, however, housing costs have increased and affordable housing units have been lost, leaving seniors on fixed incomes with few or no options. According to a recent study, there are 10 seniors waiting for every Section 202 unit that becomes available and a waiting list of at least one year. The Elderly Housing Development and Operations Corporation (EHDOC) dramatically demonstrated the reality of this statistic when over 1,000 seniors stood in line for days to get an application for EHDOC's new 110-unit building in Miami, while it was still under construction. At least 10,000 units of Section 202 Supportive Housing for the Elderly should be built each year over the next 10-15 years to meet the escalating demand.

Notwithstanding this need, actions taken by Congress and the Bush Administration weakened these programs considerably, just as the need was rising. Instead of focusing on affordable housing initiatives, the Bush Administration's annual budgets gave priority to deep tax cuts and increases in defense and homeland security funding. Funding for federal low-income housing assistance programs fell by \$2 billion between 2004 and 2008.

Since 1990, the HUD Service Coordinator program has provided federal funds to owners of federally assisted senior housing projects to hire service coordinators to assist frail residents in obtaining supportive services in the community. These services are intended to help seniors live independently and to prevent premature and inappropriate institutionalization. In 2006, service coordinators were serving more than 250,000 units in senior properties. Despite the critical role of this program, federal funding is very limited and uncertain, and in recent years primarily available only when current contracts are extended.

### **The Alliance Position**

The Alliance for Retired Americans supports:

- The recommendation of the minority report of the Elderly Housing Commission for annual construction of at least 60,000 units with appropriate supportive services.
- Preservation of existing public and private assisted housing, in current locations or in other locations that will better serve families, specifically, a federal commitment to:
  - Restore full operating funding for public housing;
  - Address the substantial backlog of capital repairs in public housing;
  - Re-establish reliable renewal funding for project-based Section 8 contracts;
  - Provide incentives and assistance to encourage private owners to renew their participation in the Section 8 project-based rental assistance program; and
  - Improve energy efficiency in public and private assisted housing.
- Increased funding for all necessary services to meet the varied needs of elderly households at different stages of their lives as well as substantially increased funding for service coordinators and congregate services, and the development and expansion of new technologies and exemplary models.
- Congressional oversight of the recently created federal interagency committee on aging services to assure progress in implementation including the appointment of an executive director. The committee should hold regular meetings to coordinate and maximize program efficiency and to monitor the availability and impact of housing and other services for older Americans.
- The recommendation of the bi-partisan Housing Commission to strengthen and enforce the requirement that owners of housing produced with federal assistance must accept households with Section 8 vouchers and must not raise rents to the market level; also, the recommendation for substantial additional funding for Section 8 to help meet the urgent need of low-income families for affordable housing.

- Full consideration by Congress and the Administration of potential new sources of funding for non-profit housing and services for the elderly. These would include a national housing trust fund that would use surplus funds in the Federal Housing Administration and the Government National Mortgage Association, possibly supplemented by funds from state housing finance agencies.
- Development of long-term strategies to ensure that adequate federal, state and local resources are directed to building, preserving and renovating housing for older Americans.
- Passage of legislation such as the Section 202 Supportive Housing for the Elderly Act of 2009 (S. 118), which would promote the construction of new senior housing facilities, as well as preserve and improve existing facilities. The bill would also support conversion of existing facilities into assisted-living facilities that provide a wide variety of additional supportive health and social services.

## **COMMUNITY SERVICES**

### **Background**

#### **Older Americans Act (OAA)**

Since its enactment in 1965 the Older Americans Act has served as a major national resource for the planning, organization and provision of community-based services to millions of older Americans. OAA services fall into five broad categories: information and access services; community-based services; in-home services; housing; and elder rights. These services include: senior centers, congregate and home-delivered meals, transportation, information, advocacy assistance, adult day care, home repair, health promotion, homemaker services, legal assistance, training and education; long term care ombudsman and employment services.

The OAA was reauthorized in 2006. The reauthorization allows new grants to improve transportation services for older adults, deliver mental health screening and treatment services, plan for long term care in home and community-based settings, promote multigenerational and civic engagement volunteer activities, and improve elder abuse prevention and services. For the past several years federal funding for OAA services has failed to keep pace with inflation and has not expanded adequately to support the growing aging population. Inadequate funding has resulted in premature institutionalization of older Americans and waiting lists for many supportive services. As the aging population continues to grow and more people are living longer and experiencing illness and frailty that require chronic care, the demand for increased services is likely to go unmet without significantly enhanced funding. OAA programs need at least a 12 percent annual increase in appropriations in order to continue to provide the multiple services under the Act. Otherwise, OAA programs will continue to serve fewer older Americans each year.

#### **Social Services Block Grant Program (SSBG)**

Title XX of the Social Security Act authorizes reimbursement, distributed through the SSBG, to states for social services provided to a diverse population, including children and younger

adults as well as seniors. For older adults, the services include home care, protective services to prevent neglect and abuse, congregate and home-delivered meals, adult day care, and transportation. The President's FY 2010 budget would reduce funding for SSBG by nearly one-third. Without an adequate level of funding, the above critically needed services will have to be cut back for seniors who are in greatest economic and social need.

### **Low-Income Home Energy Assistance Program (LIHEAP)**

LIHEAP is a Federally funded block grant program that is implemented at the state level to assist eligible households in meeting home heating and cooling costs, to provide energy-related crisis intervention aid, and to help pay for low-cost weatherization of homes.

LIHEAP assistance is targeted to help the most vulnerable Americans -- the elderly, disabled and households with young children -- pay for vital heating and cooling fuels. Older Americans are disproportionately affected by higher energy costs. As a share of income, households headed by a person age 65 or older spend more on energy-related expenditures than their younger counterparts. In addition, low-income households (those with less than \$15,000 in household income) spent nearly 20% of their household income on energy-related expenditures in 2006 (the latest year for which data are available). This compares to 7.3% spent by older households with incomes above \$15,000. As a result of rising energy costs and decreased funding, many families to be placed on waiting lists for supportive services, adding to their emotional, physical and financial hardships. Inability to pay for heating or air conditioning makes seniors susceptible to hypothermia and results in severe reactions to excessive heat such as heat exhaustion, heat stroke, and heart failure. As a proportion of total income, low-income households pay three to four times what all households combined pay for residential home energy costs.

Due to rapidly rising energy costs, the number of households qualifying for LIHEAP assistance has risen dramatically since 2003, but funding for the program has lagged. A significant infusion came in the 2009 Continuing Resolution (HR 2638, funding for LIHEAP at the fully authorized level of \$5.1 billion), and another infusion in the American Recovery and Reinvestment Act, but the program has not seen increases in the normal budgeting process. As a result, more needy and elderly seniors who qualify for the program are forced to make difficult decisions between essentials and heating their homes.

### **Transportation**

Finding necessary transportation between home and community is difficult for many seniors, and a challenge to fulfill their most basic needs: obtaining food, commuting to work or volunteering, visiting friends, or attending worship. It is particularly so for those who live in suburban or rural communities, home to nearly 80 percent of the older adult population, where destinations are too far to walk, public transit is non-existent or focused on traditional commuter routes, and private transportation is limited or unavailable and often prohibitively expensive. Less than half of households in urban and suburban areas are within a half-mile of a transportation stop or station. In rural areas, the situation is more difficult, with only one in eight households being within a half-mile of public transportation. Currently, there is an estimated \$1 billion per year in unmet senior transportation needs.

## **The Alliance Position**

The Alliance for Retired Americans supports:

- Increased funding for the Home and Community Care Block Grant which funds home and community-based services for people 60 years of age and older;
- Increased funding for the LIHEAP program;
- Additional permanent funding for essential community service programs. These programs not only contribute to the quality of life of those serve, they also are often a life-line for millions of Americans;
- Increased funding of vital services for the following and similar social service and benefit programs:
  - The Older Americans Act
  - Social Services Block Grant (Title XX) Program
  - The Low-Income Home Emergency Assistance Program (LIHEAP)
  - Transit Acts Programs, including:
    - Increased funding for the Federal Transit Agency’s Section 5310 program, which funds transportation programs for older adults and persons with disabilities in the reauthorization of the Transportation Equity Act for the 21st Century (TEA-21) in 2003;
    - Expanding existing public transit systems to improve accessibility and availability to older adults especially in suburban and rural communities where fixed route services are less accessible;
    - Including provision of non-emergency medical transportation as an allowable expense under Medicare.

## **WORKERS’ RIGHT TO ORGANIZE**

### **Background**

Joining together in a union to bargain for health care, pensions, fair wages and better working conditions has offered the best opportunity for working people to get ahead. Union workers earn 30 percent more than nonunion workers, are 63 percent more likely to have medical and health insurance through their jobs and four times as likely to have guaranteed pensions. . Since World War II, most employees and retirees receive health and pension benefits through union-negotiated contracts or as an employer-provided fringe benefit. These benefits are critical as retirees are likely to require more medical care and incur higher medical costs as they grow older. Workers represented by a union are nearly twice as likely to have a pension and retiree medical benefits as those without a union.

Unions continue to defend their retired workers. Whenever employers try to cut the pensions and health care benefits of retirees, active workers can take action to protect those who earlier fought on their behalf. Current labor laws however, do not effectively protect workers who want to form a union. Employers engage in unfair labor practices with impunity because the penalties under the 1935 National Labor Relations Act are weak and infrequently enforced.

Today:

- Ninety-two percent of private-sector employers, when faced with employees who want to form a union, force these employees to attend closed-door meetings to hear anti-union propaganda; 80 percent require supervisors to attend training sessions on attacking unions; and 78 percent require that supervisors deliver anti-union messages to workers they oversee.
- Half of employers threaten to shut down partially or totally if employees choose union representation
- In 25 percent of organizing campaigns, private-sector employers illegally fire workers seeking to form a union.
- Even after workers successfully form a union, in one-third of the instances, employers do not negotiate a contract.

Such actions come at a time when American workers have articulated clearly that they need, and desire union representation in the workplace. A reported 60 million U.S. workers say they would join a union if it were possible. However, only 12.5 percent of U.S. workers belong to a union. The fate of workers and retirees is undeniably linked. We cannot have a solid, stable retirement unless we have a solid, stable middle class.

### **The Alliance Position**

American workers must have the freedom to form unions and bargain for a better life. The Alliance for Retired Americans supports H.R. 1409 and S. 560, the Employee Free Choice Act of 2009. This legislation represents a critical step forward in rebuilding the middle class in this country.

The legislation will:

- Give employees the choice of seeking union representation either through a secret-ballot election or once a majority of workers sign cards authorizing union representation;
- Provides for first-contract mediation and arbitration if the parties to the negotiations cannot reach agreement within 90 days; and
- Establishes stronger penalties against employers who violate employees' rights during an organizing campaign.

## STATE ISSUES

- The Alliance recognizes the importance of efforts to reduce the price of **prescription drugs** by legislative action in several states, and encourages Alliance state affiliates to give full support to such campaigns. The Alliance supports efforts at the state level to control the costs of prescription drugs through: legal action against drug companies for anti-competitive practices and illegal inflation of prices; bulk purchasing alliances; and importation from Canada.
- The Alliance supports state efforts to provide all citizens of the state with high quality **comprehensive health coverage** that is affordable and provides a choice of providers. Financing should be a shared responsibility and reforms should include effective cost controls and do no harm to existing coverage.
- The Alliance supports state **voting laws** that expand early voting, vote by mail, and use of absentee ballots without restrictive identification requirements; promote language accessibility; provide special ballots, polling places and other resources for those with disabilities or visual impairments; and ensure the availability of paper records to verify electronic votes
- The Alliance supports state **tax laws** that are progressive and protect the interests of seniors as well as low and moderate-income people.
- State and local governments have used **public pension funds** as a means to balance their state budgets and some jurisdictions are moving to change their employee pension plans from defined benefit to defined contribution. The Alliance believes that governments must not raid or underfund public pension plans in order to pay for other government activities, thereby threatening the retirement security of public employees. Also, any change from defined benefit to defined contribution pension plans must be strongly opposed because it would leave public employees at risk for greatly reduced retirement incomes. The Alliance supports the strengthening of protections for public sector pension beneficiaries.
- The Alliance opposes state **medical malpractice and tort reform** proposals that limit damages to economic harm and income, as these are particularly unfair to retired Americans who have little or no earned income.
- The Alliance supports the efforts of state and local affiliate organizations to participate in the development of state **long term-care policies** and programs that incorporate the Alliance's long term care principles.
- The Alliance supports "**lifeline**" **provisions** for seniors and low-income consumers in public utility regulated power, communications and heating sectors.

- The Alliance supports public employee **collective bargaining** in all states and deplors revocation of such rights by governors, such as the governor of Indiana. Collective bargaining is a crucial right to ensuring the economic and health security of public employees and retirees and should be extended to all public employees
- A new accounting rule imposed on public employers by the **Governmental Accounting Standards Board (GASB)** requires them to include long term liabilities for retiree health care coverage in their financial statements. The large estimates, based on benefits scheduled for the next 30 years, has prompted calls for cuts in state and local government retiree health benefits. The Alliance opposes these attempts to cut benefits and supports efforts to fight the negative effects of GASB. These include measures to protect benefits, such as the establishment of pre-funding mechanisms. The Alliance also supports public campaigns that promote the importance of employer-sponsored retiree health coverage for everyone and insure adequate funding for such coverage.