



**STATEMENT FOR THE RECORD**  
**SUBMITTED TO THE**  
**Committee on Ways & Means**  
**on**  
**Proposals to Reform the Health System**

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**AARP**  
**601 E Street, N.W.**  
**WASHINGTON, D. C. 20049**

**WITNESS: JENNIE CHIN HANSEN**  
**AARP BOARD DIRECTOR**

For further information, contact:  
Nora Super or Ahaviah Glaser  
(202) 434-3770  
Government Relations & Advocacy

Chairman Rangel, Ranking Member Camp, and other distinguished members of the Committee, I am Jennie Chin Hansen, President of AARP. I want to thank you for your leadership on comprehensive health reform to ensure that all Americans have quality, affordable coverage options. This is AARP's top priority this year. Today, I am proud to represent nearly 40 million members of AARP – half of whom are over age 65 and therefore participate in the Medicare program, and half who are under age 65. Both age groups face serious problems in today's health care system, especially the 7 million of all persons age 50-64 who are uninsured today. Thank you for inviting me to here today to discuss your draft legislation.

### **AARP Health Reform Priorities**

AARP has identified six priorities for our members that we believe must be included in comprehensive reform legislation.

1) Guaranteeing access to affordable coverage for Americans age 50 to 64: To make coverage affordable for people in this age group, health reform must bar insurers from denying coverage and charging unaffordable rates based on age or health status and provide sliding-scale subsidies for those who need help to make coverage affordable.

2) Closing the Medicare Part D Coverage Gap or "Doughnut Hole": The Medicare Part D "doughnut hole" is a major reason why nearly 20% of people who get drug coverage through Medicare delayed or did not fill a prescription because of cost – higher than any other insured group. Under current law, the hole keeps getting larger each year and will double by 2016. AARP is calling on Congress to close the doughnut hole so people are not forced to pay premiums while at the same time paying full cost for their drugs.

3) Lowering Drug Costs through Generic Biologics: Biologic drugs treat serious conditions like cancer and multiple sclerosis but can cost several thousands of dollars per month. Currently, there is no FDA process to approve less expensive generic versions of these drugs. AARP is calling on Congress to include the "Promoting Innovation and Access to Life-Saving Medicine Act" (H.R. 1427) in health reform to make these life-saving generic biologic drugs much more available and affordable.

4) Reducing Costly Hospital Re-Admissions through a Medicare Transitional Care Benefit: Health reform should include a Medicare transitional care benefit that would help people safely transition to home or another setting after a hospital stay and prevent costly, unnecessary hospital readmissions. AARP strongly supports the "Medicare Transitional Care Act" (H.R. 2773/S. 1295), as it should improve care and save money by providing for appropriate follow-up care to prevent avoidable re-hospitalizations.

5) Long-Term Care (LTC): Health reform should support people with chronic conditions who need long-term care. This will save money, improve quality of life, and help people live at home. AARP supports the "Empowered at Home Act" (H.R. 2688/S.434) to expand eligibility and give states incentives to help people receive care at home, and the "Retooling the Health Care Workforce for an Aging America Act" (H.R. 468/S. 245) to provide training and support for family caregivers and an improved workforce to care for older adults.

6) Helping Low-Income Americans in Medicare: Health reform should include the “Medicare Savings Program Improvement Act” (H.R. 716) and the “Prescription Coverage Now Act (H.R. 1536)” to improve access to Medicare programs that help those with limited incomes pay premiums and out-of-pocket costs. These bills increase asset limits so people who did the right thing and saved a small nest egg can still get help, and raise income eligibility standards so more people qualify.

### **Making Affordable Coverage Available to All**

There are few issues of greater concern to AARP’s membership than improving health insurance markets across the United States to ensure that all Americans have access to affordable, high quality coverage choices. Many older Americans, especially those aged 50-64 who are not yet eligible for Medicare and those with pre-existing chronic conditions, often cannot secure health coverage, at any price. Industry data show that insurers reject between 17% and 28% of applicants aged 50-64.<sup>1</sup> Those who can find individual coverage tend to receive less generous benefits than those with employer coverage, yet on average pay three times more in premiums and over twice the out-of-pocket costs of those with employer coverage.<sup>2</sup> The AARP Public Policy Institute estimates that 13% (or 7.1 million) adults aged 50-64 were uninsured in 2007 – 36% higher (or 1.9 million more) than in 2000 – and this figure is growing rapidly in our current difficult economy.

AARP believes the best way to make coverage affordable for everyone is by:

- Guaranteeing that all individuals and groups wishing to purchase or renew coverage can do so regardless of age or pre-existing conditions;
- Prohibiting higher premiums based on age, health status, or claims experience;
- Providing a choice of qualified plans through an Exchange or “Gateway” with adequate subsidies based on income and the actual premiums each individual faces in the market so coverage is affordable for everyone;
- Addressing costs system-wide through prevention and wellness, better care coordination, fighting fraud, waste, and abuse, and rewarding quality rather than quantity of care; and
- Ensuring that any cost-sharing obligations do not create barriers to needed care

We are pleased that many of these issues have been addressed in the Tri-Committee’s health care reform discussion draft (Draft) released last week.

Exchange: The intent of the Exchange is to facilitate the purchase of coverage and products at an affordable price by qualified individuals and employer groups. AARP embraces the establishment of an Exchange, including the option for states to create their own or regional Exchanges. As described, the Exchange construct would provide balance and flexibility – clear federal guidelines and standards to assure affordable coverage while maintaining the traditional state role in the oversight of insurance.

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<sup>1</sup> AHIP, “Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits,” December 2007.

<sup>2</sup> AARP Public Policy Institute, Health Care Reform: What’s at Stake for 50- to 64-Year-Olds? March 2009.

Policymakers have learned much by observing and studying the laboratory of Massachusetts and its successful health coverage experiment. The Federal Employees Health Benefit Program has also been successful in providing meaningful choices to consumers, and we support both as a model for the structure outlined in the House health reform draft legislation.

We are also pleased that the Draft increases the Medicaid funding cap for Puerto Rico, the U.S. Virgin Islands, and the other territories. AARP believes that quality, affordable health coverage should be available to all Americans wherever they reside.

*Underwriting and Age Rating:* AARP believes no one should be denied coverage based on health status or charged higher rates based on age or health status. We strongly commend the Chairmen for including a ban on denying people coverage and on varying rates by health status, and for strictly limiting age rating in the Draft. AARP believes that if age rating is not seriously constrained with national health reform, insurers will likely charge higher rates to older people to substitute for rating based on health.

If any age differential is allowed, AARP believes it should be narrow – no greater than 2-to-1, as in the Tri-Committee’s Draft. In addition, Individuals living in states where no or narrow age rating is allowed today should not be disadvantaged as a result of national health reform. We strongly commend the Committee’s leadership in striving to limit age rating bands to a ratio of 2 to 1. Without such limits, those older Americans who find it most difficult or impossible to obtain coverage today may still be priced out of the market after health reform.

We have serious concerns about the adverse impact on AARP members of alternative proposals to allow insurers to charge older Americans up to five times more than younger people. We question why age rating, especially as high as 5 to 1, is necessary when virtually all health reform proposals under consideration include risk adjustment to compensate for higher costs of enrollees who are sicker or older. Independent actuaries confirm that appropriate risk adjustment should mitigate the need for age rating. We would encourage broadening the risk pooling to minimize adverse selection beyond Exchange plans.

Experience in Massachusetts indicates that without strict age rating limits and adequate subsidies, coverage would still be unaffordable for millions of older Americans. Although Massachusetts capped rate variation for age at 2-to-1, affordability remains a significant issue for some AARP members. Even at a 2-to-1 age rating, the lowest priced “bronze” benefit package costs 60-year-olds between \$420 and \$575 per month; allowing even higher age-related rates would be an insurmountable barrier to coverage for the uninsured in this age bracket, whose median annual income is just \$30,000. Age is a poor proxy for income; older uninsured Americans do not have substantially higher incomes than younger uninsured individuals, whose median income is \$28,461.<sup>3</sup> Continuing to allow health care coverage to remain unaffordable to those who need it most is a serious societal problem.

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<sup>3</sup> Ibid.

Uninsured adults in their late fifties and early sixties experience worse health outcomes and use more services when they enter the Medicare program, and in the years before Medicare their uncompensated health care costs will continue to be shifted to those who have insurance.

Hardship exemptions for those who cannot afford coverage are cold comfort for those in an age bracket where quality coverage is essential for maintaining health and avoiding preventable conditions that will only increase spending once these individuals become eligible for Medicare. Hardship exemptions mean people are still without coverage, and health reform must provide affordable coverage to those who have the most difficulty obtaining it in today's market-and that includes older adults.

Subsidies: Shared responsibility is an important attribute of the proposed legislation. As the Draft proposes an individual requirement for obtaining health insurance and an employer requirement for providing health insurance, assuring affordability of plan premiums *is essential* if AARP is to support this legislation. Adequate subsidies for low- and moderate income individuals must be guaranteed. Subsidies must be adequate, available, secure and administratively feasible, and take into account any higher cost related to any level of age rating that is allowed.

For those who have the lowest incomes, we agree with the Tri-Committee approach that expansion of Medicaid eligibility is an efficient and effective way to assure quality coverage and access to care. AARP also applauds the Committees for establishing ways to give Medicaid beneficiaries the ability to receive coverage through private plans participating in the Exchange without losing the important beneficiary protections they receive under Medicaid. We believe it is essential that states should be required, as in the Draft, to provide wrap-around coverage in the Exchange. We also believe Medicaid should be the default option for Medicaid-eligible individuals who because of literacy, cognitive, or other issues do not make timely choices on their own.

Subsidies should be set on a sliding scale so individuals and families pay no more than a certain percentage of income on premiums as well as other out-of-pocket health care costs. Thus, subsidy calculations should include both family income and actual premium costs that may vary by region or age. In our view, no one should spend more than 10% of their income for health care, including premiums and all other out-of-pocket costs. Those with more limited incomes should pay even less, with exemptions from cost sharing for the poorest for whom any cost sharing can create insurmountable barriers to care. In addition, in order for subsidies to remain affordable and sustainable over time, we must also enact measures to manage skyrocketing costs.

Premium credits and subsidies should be generous enough to effectively help those with modest incomes meet the responsibility to have qualifying coverage. They should be provided on a sliding scale reaching high enough that vulnerable families and older adults can afford both premiums and cost sharing. Otherwise, Americans will continue to face the prospect of being uninsured or underinsured and will be forced to seek a hardship exemption. Further clarification is needed on how the subsidy would work.

*Benefit Packages:* We strongly support requiring insurers to cover a broad range of essential benefits, as suggested in the Draft. AARP strongly agrees with the Tri-Committee that preventive services – including services necessary to manage chronic conditions that otherwise result in serious, expensive complications – should be provided with no or minimal cost sharing. We urge the Committee to also include care coordination, disease management and other approaches to improve quality of care in the list of minimum services to be covered in order to help reduce spending for avoidable and costly institutional admissions, preventable complications, and errors – strategies that are particularly beneficial for people with multiple chronic conditions.

*Individual and Employer Responsibility:* The Tri-Committee Draft would require individuals to have health coverage that meets minimum standards and to report such coverage annually. Employers who do not provide qualifying coverage will be required to contribute to the cost of their coverage for their employees, including those who access forms of public coverage. Combining an individual mandate with an employer mandate takes advantage of risk pooling and reduces the overall cost of coverage.

Also, requiring everyone to participate greatly reduces insurers' interest in underwriting based on age or health status and ensures that healthier individuals are included in the risk pool. As with other elements of health care reform, however, AARP can support these requirements only with the assurance of adequate subsidies. We cannot support mandated coverage that people or businesses cannot afford – subsidies must be adequate, available, secure and administratively feasible.

*Public Health Insurance Option:* AARP has repeatedly stated its commitment to finding quality, affordable health care options for our members. At its most recent meeting, the AARP Board of Directors approved principles to help determine whether or not a public plan option can help meet that commitment.

Based on the Draft, the Tri-Committee's public health insurance option appears to satisfy the following principles of bringing down health care costs and improving value of U.S. health care spending by:

- Providing access to quality care for all;
- Contributing to lowering all costs;
- Preserving choices of providers with adequate network to support access to care;
- Ensuring accountability and transparency in its operations; and
- Operating through a public-private partnership.

We understand the Tri-Committee's desire to encourage providers to participate in the Exchange by temporarily paying them rates based on but higher than current Medicare rates. However, we support the temporary nature of this requirement. AARP believes it is critically important that the public health insurance option should in no way negatively affect Medicare beneficiaries' access to providers.

We also agree with the Draft that the public option should play by the same rules as private insurers, and that the entity running the Health Insurance Exchange should not operate the public option.

## **Strengthening and Improving Medicare**

Approximately twenty million AARP members rely on Medicare for their health coverage.<sup>4</sup> They spend on average about 30% of their out-of-pocket spending on health care – six times more than people with job-based coverage,<sup>5</sup> and those who cannot afford supplemental coverage face bankruptcy from high medical bills because Medicare has no upper limit on cost sharing. More than half of all Medicare beneficiaries have annual incomes below \$20,000,<sup>6</sup> and the economic security of older Americans has only worsened in the economic downturn.

Medicare is a vital program that health reform must strengthen and make more affordable, both to ensure that current beneficiaries can get the high quality care they need and to sustain the program for future generations. AARP commends the Tri-Committee's recognition that strengthening and improving Medicare is essential to effective health care reform, and is pleased that many of AARP's key Medicare goals for health care reform are included in the Draft.

Congress also needs to wring waste and inefficiencies out of Medicare – while improving quality and protecting beneficiaries – to keep it affordable for both beneficiaries and taxpayers. The following are important Medicare changes that AARP believes should be included in comprehensive health care reform:

Lowering Rx Costs: AARP applauds the Tri-Committee's leadership for recognizing the importance of closing the Medicare doughnut hole. Medicare beneficiaries face disproportionately high out-of-pocket costs and closing the doughnut hole will go a long way to remedying this problem. The Draft proposes to reduce and, over time, actually eliminate the doughnut hole in Part D. This will be an important change for beneficiaries as it will save them thousands of dollars in drug costs and keep them healthier by ensuring they can afford their medications.

Of course other steps are also necessary to lower drugs costs, and each of these steps will make closing the doughnut hole easier and improve access to pharmaceuticals generally. These include:

- Expanding access to generics, including creation of a pathway for generic biologics;
- Requiring drug companies to provide Medicaid rebates for dual eligibles in Part D;
- Secretarial Negotiation of Drug Prices;
- Discounting the cost of brand name drugs for beneficiaries in the doughnut hole as announced by the White House along with Senators Baucus and Dodd; and
- Safe Importation of Drugs.

Making Medicare More Affordable: In addition to lowering the out-of-pocket costs for all beneficiaries, it is essential to use health care reform to improve the patchwork of

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<sup>4</sup> This number represents nearly half of the program's total beneficiaries.

<sup>5</sup> Health Affairs, Setting a Standard of Affordability for Health Insurance Coverage, June 4, 2007

<sup>6</sup> U.S. Census Bureau 2008 Current Population Survey, Annual Social and Economic Supplement, Table PINC-01.

programs that help low-income Medicare beneficiaries pay for prescriptions, premiums, deductibles, and other health costs.

The Draft proposes to do this in a number of key ways:

- First, it raises the income threshold for assistance to 150% of poverty, helpfully making the standard the same across programs.
- Second, it eliminates the stringent asset tests that prevent people who did the right thing and saved a small nest egg for retirement from receiving vital assistance.
- Third, it makes sure beneficiaries know that these low-income assistance programs exist and simplifies the application process to ensure that our most vulnerable beneficiaries get the help they need.

*Keeping Medicare Sustainable:* Skyrocketing health care costs, not the aging population, are the main driver of Medicare spending increases.<sup>7</sup> These spiraling costs must be reined in soon in order for the program to serve future generations. Without reform, Part B premiums – which have more than doubled since 2000 – will continue to absorb a growing share of the incomes of beneficiaries. Also, the current economic crisis is deteriorating Part A Trust Fund solvency even further.

Medicare Advantage was created to provide more choices, greater care management and savings for Medicare beneficiaries. There is much about Medicare Advantage that is commendable and should be preserved, but the program has become too costly, even wasteful, at a time when the Medicare program cannot afford any waste. AARP applauds the Tri-Committee's proposal to end the overpayments to Medicare Advantage plans. We also want to commend the Tri-Committee for recognizing that these overpayments must be eliminated with minimal disturbance to beneficiaries.

Fortunately, there are many proposals to improve the quality of the care in Medicare and also save money for both beneficiaries and taxpayers. With this in mind, Congress must pursue these solutions now, as an integral part of health care reform. AARP commends the Tri-Committee for including so many of these solutions in the Draft:

- Revising the way Medicare pays doctors and hospitals to reward high quality care rather than how much care is provided, including through a “medical home” pilot and an “accountable care organization” pilot as well as bonus payments for quality, quality reporting requirements and higher payments for efficient geographic areas;
- Working to reduce unnecessary re-hospitalizations through payment changes;
- Improving care coordination for dual eligibles;
- Reducing waste, fraud and abuse and creating effective systems for doing so into the future; and
- Reforming physician payment rates by permanently addressing the SGR.

Strengthening the primary care workforce is an essential part of ensuring the provision of quality affordable health care for all. The Draft recognizes this by increasing rates for

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<sup>7</sup> Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November 2007.

certain primary care services and creating initiatives that will shape the health care workforce for years to come. Going forward, effective practice models in Medicare that emphasize, encourage, and improve primary care should be expanded and incentives should be created to encourage individuals to practice in primary care. Interdisciplinary care teams also should be encouraged, as they can provide quality care for individuals and recognize the valuable role and contributions of a variety of care providers.

We applaud the Tri-Committee's recognition of the importance of strengthening the nursing workforce and are pleased that the Draft provides up to \$220 million a year within the Public Health Investment Fund for this goal. We also urge Congress to modernize Medicare's support for nursing education to produce more highly skilled advance practice nurses, including those who deliver primary care, preventive and care coordination services to address the needs of an aging and diverse population.

*Reducing Costly Hospital Re-Admissions through a Medicare Transitional Care Benefit:*

More than 20% of older Americans suffer from five or more chronic conditions that account for 75% of total Medicare spending, mainly due to high rates of hospital admission and readmission. One-fifth of Medicare beneficiaries were re-hospitalized within 30 days of discharge; one-third were readmitted within 90 days, according to a recent *New England Journal of Medicine* study (April 2009). Half of those re-hospitalized within 30 days had not seen a doctor since discharge. The study estimated that Medicare spent \$17.4 billion on largely preventable re-hospitalizations in 2004.

Transitions, such as those from hospital to home, are risky. Patients discharged without transitional or follow-up services frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. Without assistance, most family caregivers lack the knowledge, skills and resources to effectively address the complex needs of older adults coping with multiple coexisting conditions. Preventable hospital admissions often result from poor communication among older adults, family caregivers and health care providers. Patients often report getting conflicting instructions from different providers.

The Draft contains a medical home pilot that will help enhance continuity of care and also uses payment policy changes to help put systems in place to address unnecessary hospital readmissions. Ultimately, AARP believes that a more comprehensive approach to resolving transitional care issues would ensure that the highest-risk Medicare beneficiaries receive transitional care services they need to help keep them out of the hospital and improve their quality of care. We therefore urge that the AARP-endorsed Medicare Transitional Care Act (H.R. 2773) be included in the final Tri-Committee health reform bill. H.R. 2773 specifically targets beneficiaries at highest risk for hospital readmissions or poor transitions, such as individuals with multiple chronic conditions, cognitive impairment, depression, or a history of multiple re-hospitalizations. The Medicare Transitional Care Act would fit well with re-admissions policies proposed by the Tri-Committee. AARP believes that, together, these initiatives will save—not cost—federal health care dollars, and we look forward to working with the Tri-Committee to achieve these savings.

Multiple, rigorous trials show transitional care services for older adults with chronic conditions can significantly improve outcomes, prevent hospital readmissions, reduce costs and increase patient satisfaction. For example, a randomized controlled clinical trial of the “Transitional Care Model” demonstrated significantly lower re-hospitalization rates from all causes sustained through 12 months and a 39% reduction in total health care costs for net savings of \$4,845 per patient after one year. Patients age 65+ with heart failure received transitional care services (e.g., face-to-face visits and telephone follow-up) coordinated and delivered by an Advanced Practice Nurse (APN) for 60 days following initial hospitalization.<sup>8</sup>

Under the Medicare Transitional Care Act, a nurse or other health professional would lead an interdisciplinary care team in:

- assessing the needs of the high-risk individual and their primary caregiver and developing a comprehensive care plan,
- providing home visits and coordinating care with providers across settings,
- teaching self-management skills and assisting with medication management,
- arranging and coordinating community resources and support services, and
- accompanying the individual to follow-up physician visits as needed.

These services would be available to high-risk individuals during their hospital stay and up to 90 days after discharge. Performance measures would be established with public reporting and payment established based on these measures.

*Reducing Racial and Ethnic Disparities:* Reducing racial and ethnic disparities is essential to ensuring that all Americans receive the high quality care they deserve. The Draft takes important steps to address disparities, including issuing requirements for the collection of racial and ethnic data and providing temporary grants for reimbursement of translation services in Medicare. Ultimately, the capacity of the Office of Civil Rights must be strengthened in order to enforce both new and existing federal language access requirements. It is also essential to increase cultural diversity and competencies in our nation’s health workforce.

### **Long-Term Care**

Strengthening long-term care (LTC) or long-term services and supports (LTSS) also must be part of health reform. AARP believes all Americans should have the choice to get needed care and services at home because 89% of Americans age 50+ want to live at home as long as possible. This is also critical for cost containment as, on average, Medicaid can support nearly three older people and adults with physical disabilities in home and community-based services (HCBS) for the cost of one person in a nursing home. In addition, states that invest in HCBS can, over time, slow their rate of Medicaid LTC spending. Incentives to encourage states to invest in HCBS and balance their LTC

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<sup>8</sup> Mary Naylor, et al. “Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized Controlled Trial.” *Journal of American Geriatrics Society*, May 2004; 52:675-684.

systems, such as an enhanced Medicaid matching rate, are important, as are financial incentives to strengthen state infrastructure and service systems.

Support for family caregivers is critical, as they help individuals live at home and delay or prevent stays in generally more costly institutional settings. At any given point, about 34 million family caregivers provide and coordinate care to loved ones at home – unpaid assistance with an estimated economic value of about \$375 billion in 2007, which reduces spending on inpatient, home health and skilled nursing facility care.

AARP is pleased to see many provisions to improve nursing home quality and accountability, such as:

- improved information on ownership, inspections, and payroll-based staffing data;
- additional information on Nursing Home Compare;
- a standardized complaint form and improved complaint resolution;
- stronger penalties;
- improved notification of facility closure; and
- improved staff training.

We look forward to working with the Committees to further improve these provisions.

HCBS services are cost-effective, what people want, and provide consumers with greater choice and control to help them live independently in their homes and communities. We strongly urge that provisions to expand HCBS and support family caregivers are included in comprehensive health reform. Specifically, provisions such as the following from the Empowered at Home Act (H.R. 2688/S. 434) and the Retooling the Health Care Workforce for an Aging America Act (H.R. 468/S. 245) should be included in health care reform.

It is also vital that the Committee consider other changes that will be made to Medicaid and their impact on optional services, such as HCBS. We caution against changes in Medicaid that could cause states to reduce HCBS, as they are “optional” services that states are not required to cover, but they are critical to older adults and people with disabilities. We also encourage the Committee to consider policy options that give people more choices to help them pay for the services they need to live independently.

## **Conclusion**

The Tri-committee Draft marks substantial progress toward our shared goal of enacting comprehensive health reform legislation. While many challenges remain, we and other stakeholders share a broad and growing consensus that any differences should not stop us from finding common ground and enacting comprehensive reform this year. The status quo is unsustainable and we cannot afford to fail. We again thank you for your leadership and look forward to working with this Subcommittee and all of Congress to enact comprehensive health reform legislation this year.