



The power to make it better.

September 21, 2009

The Honorable Max Baucus
Chairman
Senate Finance Committee
Washington, DC, 20510

Dear Chairman Baucus:

AARP applauds your diligent work in crafting the America's Healthy Future Act. We support many provisions in this vital legislation and look forward to working with you and the Finance Committee to improve it – especially to ensure that coverage is affordable for older Americans. We urge you to strengthen and move this bill forward in order to enact comprehensive health reform this year to control skyrocketing costs, improve quality and give all Americans access to affordable, quality coverage.

This legislation includes essential components of comprehensive health reform on which there is broad agreement, including:

- Prohibiting insurers from discriminating based on health and gender, placing caps on cost sharing, and banning life-time or annual caps on coverage;
- Establishing "Exchanges" where people without access to group coverage and small businesses can choose from a range of plans that must meet basic quality and coverage standards and low and moderate income individuals can receive sliding-scale subsidies to make coverage affordable;
- Strengthening Medicare with delivery system and payment reforms to promote care coordination, fight fraud, waste and abuse, reduce hospital acquired infections and preventable readmissions, and reward quality rather than quantity of care;
- Substantially filling the Part D "doughnut hole" coverage gap by reducing brand-name drug costs;
- Expanding access and eliminating cost barriers to preventive services; and
- Increasing pay for primary care and funding to train primary care physicians.

AARP also supports provisions for:

- Annual Medicare wellness physician visits to focus on prevention;
- Bonuses to high-quality Medicare Advantage (MA) plans while reducing across-the-board excess payments to all MA plans now made regardless of quality;
- A public/private entity to conduct comparative effectiveness research so patients and physicians have the best scientific evidence on the most effective treatments;
- Uniform data on race, ethnicity, gender and disability to address disparities;
- Transparency on nursing homes and drug makers' payments to physicians, and

- A Centers for Medicare & Medicaid Services Innovation Center and Office of Coordination for Dual Eligible Beneficiaries.

We are particularly pleased that evidence-based transitional care services targeted to high-risk Medicare beneficiaries are in the bill. We look forward to continuing to work with you on this important issue to assist high-risk Medicare beneficiaries and their family caregivers, reduce unnecessary re-hospitalizations, and save Medicare money.

While there is much in this legislation that we can support, there are several troubling provisions and omissions that must be addressed as the legislation moves forward. Chief among these is excessive age rating and inadequate subsidies which together could leave millions of older Americans unable to afford coverage. Others include:

- No provision to close the Part D drug benefit "doughnut hole" coverage gap despite charging enrollees higher Part D premiums;
- No provisions to help low-income Medicare enrollees; and
- Insufficient provisions to expand access to and strengthen home and community-based services (HCBS) to help people live independently.

Adoption of amendments to address these issues is essential to address AARP member concerns with this legislation. These amendments include:

- **Amendment 240 - Kerry C15 to place a 2-1 limit on age rating, and Amendment 234 - Kerry/Menendez C9 so premiums do not exceed 10% of income;**
- **Amendment 88 - Nelson/Rockefeller D1 to close the doughnut hole;**
- **Amendment 23 - Bingaman D4 to strengthen Medicare's low-income programs; and**
- **Amendment 282 - Cantwell C1 and Amendment 241 - Kerry C16 to expand HCBS access.**

Age Rating & Subsidies: We are deeply concerned that the bill would let insurers charge older Americans five times more for premiums than younger people, making insurance unaffordable for the over 7 million older Americans age 50-65 who now lack health insurance. Age rating should be unnecessary given that risk adjustment will compensate insurers for higher costs of sicker or older enrollees. Allowing 5-1 age rating is not acceptable to AARP members and stands in stark contrast to House and Senate HELP Committee legislation that includes a 2-1 age rating limit. Strict 2-1 limits are more acceptable and are included in **Amendment 240 - Kerry C15**. If age rating is not seriously constrained, insurers will likely charge older people higher rates as one way to circumvent the prohibition on rating based on health. Health reform should end discrimination based on health or age once and for all.

We also are concerned that the bill allows premiums to cost as much as 13% of income for middle-income Americans, especially when combined with cost sharing of 27% on average and capped at \$5,800 for individuals and \$11,600 for families.

These costs could quickly add up to make health care unaffordable – consuming as much as 25% of pre-tax income for middle-income people with serious health conditions. Such “worst-case” health status scenarios in fact represent a situation that most if not all of us face eventually. AARP believes premiums and cost sharing combined should cost no more than 10% of income, and less for people with more limited incomes.

This is important because the pre-tax median annual income of uninsured 50-64 year olds is just \$30,000 – only slightly higher than the \$28,500 median for younger uninsured individuals. Age is *not* a good proxy for income among the uninsured. The barrier to affordable coverage from a lack of sufficient subsidies, 5-1 age rating and high cost sharing is a serious problem for our 50-64 year old members who generally have one or more chronic conditions that need ongoing attention.

To further improve the affordability of coverage, we support:

Amendment 357 - Snowe C2 to provide access to the Exchange for individuals whose employer sponsored coverage exceeds affordability protections in the Exchange; and **Amendment 513 - Snowe F1** to allow Americans over the age of 55 to have a higher threshold at which the excise tax on high cost insurance would be effective.

Closing the Part D “Doughnut hole” Coverage Gap: We support the provision to cover half the cost of brand name drugs in the Part D “doughnut hole” coverage gap, but we are disappointed that the bill does not include a provision to close the Part D “doughnut hole” coverage gap over time. Covering half the cost of branded drugs in the gap is not a substitute for closing the gap, which is expected to double in size by 2016. The Administration has pledged to close the gap, and the House bill would close the coverage gap entirely over time. Approximately 2.9 million older Americans fall into the doughnut hole each year, and it is essential that **Amendment 88 - Nelson/Rockefeller D1** be adopted to keep the President’s promise to seniors to close the doughnut hole.

We also oppose a provision that would raise prescription drug premiums for middle-income working people in Medicare Part D who already pay more into the system in higher taxes. Instead of asking people to pay more, we should take steps to lower the cost of drugs. The doughnut hole makes this provision particularly troubling, since those required to pay these higher premiums would not be eligible for the 50% discount on branded drug coverage in the gap. Asking higher income people to pay higher premiums and receive no benefits while in the doughnut hole is simply untenable.

In addition, we object to freezing the thresholds for Part B and Part D income-related premiums for 10 years, as this would create an AMT-like bracket creep problem that will subject many more individuals to this income-related tax.

Strengthening Low Income Medicare Assistance: The legislation lacks any provisions making long over-due improvements to programs that help Medicare's low-income enrollees afford the care they need. This patchwork of programs fails to assist millions of people who need help because of needless red tape, inconsistent rules in different programs, and asset tests that penalize people who - despite limited incomes - did the right thing in saving a small nest egg for retirement. Various Medicare Savings Programs that pay Part B premiums and, for those below poverty, all Medicare cost sharing, now enroll less than one third of people eligible for this assistance. An estimated 3 million eligible people have not enrolled in the Part D Low Income Subsidy that pays premiums and most cost sharing. Many more who need help from these programs are not eligible because of unreasonable asset limits on program eligibility. Health care reform legislation should set uniform rules for all these programs, increase and ultimately eliminate asset tests, and raise income eligibility levels. We urge that **Amendment 23 - Bingaman D4** be adopted to increase asset limits for the Part D low-income subsidy and Medicare Savings Programs, extend the Qualified Individual program, and makes other improvements to programs serving low-income seniors and other Medicare beneficiaries, as the House has done in H.R. 3200.

Home & Community-based Services: We are disappointed that there are not more robust provisions to expand access to home and community-based services (HCBS) to help people live independently. We appreciate provisions supporting Aging and Disability Resource Centers and the Money Follows the Person Rebalancing Demonstration, but these are small steps. We urge you to include more robust provisions to expand access to these cost-effective services that the vast majority of people greatly prefer to institutional care, as well as financial incentives to states to help them do so. We urge that **Amendment 282 - Cantwell C1** be adopted to increase access to HCBS, in part by providing a temporary, targeted increase in the federal match for Medicaid spending on HCBS for states who agree to make certain structural reforms in their state long-term care systems, as well as **Amendment 241 - Kerry C16** to expand access to HCBS with some provisions of the bipartisan Empowered at Home Act (S. 434).

There are several additional areas where AARP has concerns, some of which could be addressed by proposed amendments.

Generic Biologics: AARP supports **Amendment 61 - Schumer D1** which would change the Medicare Part B billing codes for biosimilar drugs. AARP has been an ardent supporter of the creation of a biogenerics pathway and we believe that this provision will seek to encourage the use of biosimilar drugs and save consumers and Medicare money.

Nursing Education: We support provisions in the bill to open up more Medicare Graduate Medical Education slots to primary care, but believe it should also increase Medicare funding for Graduate Nursing Education to address the severe shortage of nurses and nurse educators in our country. We therefore support **Amendment 69 - Stabenow D4** to provide training for advance practice nurses as in the Medicare Graduate Nursing Education Act (S. 1569). This would increase advanced practice registered nurses by 25%, which is equal to over 19,000 professionals who could provide primary care, chronic care management, transitional care, and other types of care supported by Medicare.

Elder Justice Act and Long-Term Care Background Checks: We have long supported the Elder Justice Act (S. 795) to create a comprehensive approach to ensuring an adequate public-private infrastructure and resolving to prevent, detect, treat, understand, intervene in, and where appropriate, aid in the prosecution of, elder abuse, neglect, and exploitation. We therefore support **Amendment 37 - Lincoln/Hatch D5** which would add this legislation to the America's Healthy Future Act. We also support **Amendment 84 - Stabenow D19** that would provide for national and state background checks on direct patient access employees of certain long-term care providers and provide federal resources to states for these activities to help prevent elder abuse.

Workplace Wellness: We support positive incentives to promote healthy behaviors and workplace wellness programs, and therefore support **Amendment 317 - Carper C1** to provide tax credits for employers who offer these programs. However, we do not support several proposed amendments that would increase the amount that employers can vary premiums based on participation in such programs. Such proposals can have harmful consequences, especially in minority and low-income communities with few resources to help change behavior. Discounted premiums for healthy behaviors will require higher premiums for people who are unable to change unhealthy behaviors, leaving people who greatly need coverage without insurance. The goal of health reform should be to ensure that everyone – regardless of health status – has affordable health care coverage options. Discounts for healthy behavior should not become a back door way to “cherry pick” and deny coverage to the sick, a practice health reform must end.

Medicaid counter-cyclical matching: Given the expansion of Medicaid included in this legislation, it is important that Congress also ensure adequate federal funding to states for this vital safety net program. We therefore support **Amendment 197 - Rockefeller C17** to provide an automatic increase in the federal matching rate for the Medicaid program during periods of national economic downturn.

Medical Malpractice Reform: AARP agrees that our system for handling medical malpractice needs reform. The tort system does a poor job of compensating most people injured by medical errors – especially older Americans who can recoup little in economic damages. It is slow, expensive, and most injured people get nothing at all. The tort system also encourages providers to hide mistakes to avoid lawsuits, rather than report errors and learn how to prevent them. We therefore support **Amendment 158 - Enzi D1** to authorize grants to states under the Social Security Act for the development, implementation, and evaluation of alternatives to resolve medical disputes. These alternatives would have to make the medical liability system more reliable and accessible, promote a reduction in health care errors and encourage early disclosure of errors, allow for collection and analysis of patient safety data related to disputes, and provide for an appeals process and access to civil litigation. We oppose proposed amendments that would simply cap non-economic damages because such caps do little to ensure fair compensation or reduce errors.

Care Coordination: We support **Amendment 45 - Wyden D2**, cosponsored by Sen. Carper, which would provide high cost Medicare beneficiaries suffering from multiple chronic conditions with coordinated, primary care services in their homes or residences from a team of qualified health care professionals, as in the Independence at Home Act (S.1131).

Medicare Advantage and Original Medicare: We agree that Medicare Advantage plans should not continue to receive excess payments across the board and that plans should only receive bonuses if they provide high quality care and service. We also support **Amendment 36 - Lincoln D4** which would allow Medicare beneficiaries enrolled in MA or MA-PD plans to return to original Medicare in the first 45 days of the Calendar Year, which will help protect beneficiaries from abusive marketing and enrollment practices. This amendment should be improved, however, to ensure that individuals using this option will be able to regain supplemental Medigap coverage.

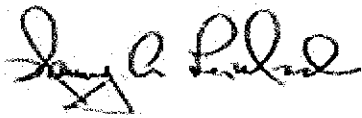
Equity for Puerto Rico and the Territories: We greatly appreciate that the legislation would raise the cap on Medicaid funding in the territories, and urge Committee members to consider several proposed amendments that would further increase health care equity for Americans in these jurisdictions.

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Medigap cost sharing: We are concerned that the bill would impose new cost sharing on people in Medicare who purchase "C" and "F" supplemental Medigap policies. People choose these policies specifically because they do not require cost sharing. Medigap plans gives people on fixed incomes financial security and health security -- the peace of mind that even if they have a health crisis or frequent, ongoing health care needs that they will be able to manage.

Thank you again for your hard work in advancing comprehensive health reform legislation. We look forward to working with you, Ranking Member Grassley and your colleagues on both sides of the aisle in the coming weeks to pass a health care reform package that works for every American.

Sincerely,

A handwritten signature in black ink, appearing to read "Nancy LeaMond". The signature is written in a cursive style with a large initial "N" and "L".

Nancy LeaMond
Executive Vice President