

**TESTIMONY SUBMITTED TO THE**  
**SENATE FINANCE COMMITTEE ROUNDTABLE**  
**ON**  
**EXPANDING COVERAGE IN HEALTH CARE REFORM**

**May 5, 2009**

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

For further information, contact:

Paul Cotton

(202) 434-3770

Government Relations & Advocacy

Chairman Baucus, Ranking Member Grassley, distinguished Committee members, thank you for inviting AARP and our Divided We Fail allies to this timely discussion on expanding health care coverage. I am AARP President Jennie Chin Hansen. On behalf of AARP's more than 40 million members, we commend you for your bipartisan leadership and commitment to enacting comprehensive health care reform this year.

Comprehensive reform to provide affordable coverage to all Americans could not be more urgent, as coverage losses are snowballing in our current economy. In just the first quarter of this year, two insurers alone – UnitedHealth Group and Wellpoint – reported that 900,000 and 500,000 of their enrollees, respectively lost coverage. One recent report estimated that 4 million Americans have lost coverage since the recession began, and as many as 14,000 may be losing coverage every day.<sup>1</sup> This is on top of 46 million who lacked coverage in 2007.<sup>2</sup> Others suggest that nearly 87 million were uninsured for some part of 2007-2008.<sup>3</sup>

We simply cannot fix our broken economy without fixing our broken health care system.

Just 63% of employers now offer coverage, leaving over 55 million workers unable to get coverage at work.<sup>4</sup> This is especially hard on AARP members aged 50-64 who often cannot find affordable coverage on their own because insurers charge exorbitant rates based on age and/or deny coverage altogether to those with pre-existing health conditions. The AARP Public Policy Institute found that over 7 million Americans aged 50-64 were uninsured in 2007 – a 36 percent increase from 2000 – and more have undoubtedly lost coverage since.<sup>5</sup>

Job-based coverage itself is increasingly unaffordable.

---

<sup>1</sup> Center for American Progress, Health Care in Crisis: 14,000 Losing Coverage Each Day, February 19, 2009.

<sup>2</sup> U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2007.

<sup>3</sup> Families USA, Americans at Risk: One in Three Uninsured, March, 2009.

<sup>4</sup> HRET/Kaiser Family Foundation, 2008 Employer Health Benefits Survey.

<sup>5</sup> AARP Public Policy Institute, Health Care Reform: What's at Stake for 50-to-64Year-Olds? March 2009.

In the past eight years, premiums for a family of four have grown faster than both earnings and inflation.<sup>6</sup> Average annual premiums for job-based family coverage were \$12,680 in 2008, almost double the 2000 figure,<sup>7</sup> and the more employees must pay, the less likely they are to enroll.<sup>8</sup>

People with private non-group insurance are worse off, often spending over 10% of their income on health care.<sup>9</sup> For those aged 50-64 more than two thirds spend that much or more out of pocket.<sup>10</sup> And Institute of Medicine research shows that large numbers of uninsured threaten even those who have coverage, as privately insured adults in areas with high uninsurance rates have lower rates of access to and satisfaction with care.<sup>11</sup>

Despite declining coverage rates, total health care spending is skyrocketing. Without reform, the Centers for Medicare and Medicaid Services (CMS) estimates that national health expenditures will nearly double over ten years, rising to \$4.3 trillion by 2017.<sup>12</sup> Medical price inflation is by far the largest driver of this increase, and accounts for 51% of this health care spending growth; population increase accounts for only 15%.<sup>13</sup>

This unsustainable cost growth places a huge burden on governments, families, and business, threatens our global competitiveness and makes coverage increasingly unaffordable. Some may advocate delaying health reform given the economy and the fundamental challenges it presents. However, we believe we cannot afford to delay and applaud you for making enactment of health reform this year a top priority this year.

For AARP, key priorities that we must address in health reform include:

- Providing affordable coverage options to all Americans, especially those aged 50-64;

---

<sup>6</sup> HRET/Kaiser Family Foundation, 2008 Employer Health Benefits Survey

<sup>7</sup> Ibid.

<sup>8</sup> Kaiser Family Foundation. February 2007, Snapshots: Health Care Costs, Insurance Premium Cost-Sharing and Coverage Take-up.

<sup>9</sup> Jessica Banthin, Agency for Healthcare Research & Quality, "Out-of-Pocket Burdens for Health Care: Insured, Uninsured, and Underinsured" presentation. September 23, 2008.

<sup>10</sup> AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds?, March 2009.

<sup>11</sup> IOM: America's Uninsured Crisis: Consequences for Health and Health Care, Feb. 24, 2009.

<sup>12</sup> Centers for Medicare and Medicaid Services, National Health Expenditure Projections 2007–2017.

<sup>13</sup> California HealthCare Foundation. Snapshot, Health Care Costs 101, 2008.

- Strengthening Medicare by lowering health costs and improving benefits;
- Helping people stay in their homes and out of costly institutions; and
- Ensuring that both the benefits and costs of reform are shared by all generations.

We believe that the best way to meet these goals is through comprehensive reform to ensure that all Americans have access to high quality, affordable coverage.

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

Health reform must make affordable coverage choices available to all Americans, especially those aged 50-64 who are not yet eligible for Medicare. The AARP Public Policy Institute estimates that 13% or 7.1 million adults aged 50-64 were uninsured in 2007 – 1.9 million more than in 2000.<sup>14</sup> People in this age range who lose job-based coverage often find it impossible to get affordable individual coverage because insurers consider age and pre-existing conditions when setting rates and most Americans in this age range have one if not several such conditions. Industry data show that insurers reject between 17% and 28% of applicants aged 50-64.<sup>15</sup> Those who can find individual coverage tend to receive less generous benefits than those with employer coverage, yet on average pay premiums that are three times higher and total out-of-pocket spending that is over twice that of those with employer coverage.<sup>16</sup>

The best way to help 50-64-year-olds is to make coverage affordable for everyone by:

- Guaranteeing that all individuals and groups wishing to purchase or renew coverage can do so regardless of age or pre-existing conditions;
- Prohibit charging higher premiums because of health status or claims experience;
- Providing a choice of qualified plans through an Exchange or Connector;
- Providing subsidies based on income so coverage is affordable for everyone;

---

<sup>14</sup> AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds?, March 2009.

<sup>15</sup> AHIP, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.

<sup>16</sup> AARP Public Policy Institute, Health Care Reform: What's at Stake for 50- to 64-Year-Olds?, March 2009.

- Addressing costs system-wide through prevention and wellness, care coordination, fighting fraud, waste, and abuse, and revising incentives to reward quality rather than quantity of care; and
- Ensuring that any cost-sharing obligations do not create barriers to needed care.

As Congress considers health care reform, several interrelated and complex issues will need to be decided to ensure that consumers receive quality, affordable health care coverage. For example:

***Subsidies:*** The administration and amount of subsidies is critical. People need subsidies up front, rather than as after-the-fact tax credits that would leave many individuals unable to afford premiums while they wait for reimbursement. Subsidies should be set on a sliding scale so individuals and families pay no more than a certain percentage of incomes on out-of-pocket costs – including premiums. Those with more limited incomes should pay even less, with hardship exemptions for the poorest for whom any cost sharing can create insurmountable barriers to care.

***Underwriting and Age rating:*** In general, AARP supports community rating, where insurers do not charge higher rates or deny coverage based on age or pre-existing conditions. However, we understand that banning age rating altogether would raise premiums for the young who now generally pay several times less than older people. We appreciate that some in the insurance industry are offering to no longer disqualify or increase premiums based on pre-existing conditions. If age rating is not also seriously constrained, insurers will likely charge higher rates to older people to substitute for rating based on medical condition – in which case older Americans will bear the brunt of the cost shift. Therefore, if any age differential is allowed it should be narrow – ideally no greater than 2-to-1. In addition, adequate subsidies will be necessary to ensure that age rating does not make coverage unaffordable for older Americans.

***Mandates:*** Some are proposing that individuals be required to purchase insurance, and/or that employers be required to offer it. Mandates are appealing to many because they greatly reduce insurers' interest in underwriting based on age or health status and because they ensure that healthier individuals are included in the risk pool.

However, AARP can support mandates, but only with the assurance of adequate subsidies. We cannot support mandated coverage that people cannot afford – subsidies must be adequate, available, secure and administratively feasible. In order to ensure that subsidies remain affordable and sustainable, we must also enact measures to manage skyrocketing costs while improving quality.

**Exchange:** There are important questions about how an Exchange would operate and the Federal Employees Health Benefit Program and the Massachusetts health reform model show this to be a viable option. An Exchange could function effectively at either a federal, regional, or state level, but there should be a clear standard federal benefit package that defines the benefits to be included (e.g. physician care; chronic care coordination; hospitalization, mental health, and drugs).

## **Protecting and Improving Medicare**

Because health reform affects Americans of all ages, including those over 65 and those with insurance, coverage proposals must also improve quality and efficiency in Medicare. Medicare helps millions of older and disabled Americans, but many parts of this vital program need improvements. More than half of all beneficiaries have annual incomes below \$20,000.<sup>17</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>18</sup> and those who lack supplemental coverage face bankruptcy from high medical bills because Medicare has no upper limit on cost sharing.

To ensure that Medicare is affordable and effective for beneficiaries, Congress should:

- Begin closing the Part D drug benefit's coverage gap (doughnut hole) in which beneficiaries must pay the full cost of drugs and act to lower drug costs through drug price negotiation, safe importation, creating a pathway for generic biologics and requiring drug companies to provide Medicaid rebates for dual eligibles in Part D;

---

<sup>17</sup> U.S. Census Bureau 2008 Current Population Survey, Annual Social and Economic Supplement, Table PINC-01.

<sup>18</sup> Health Affairs, Setting a Standard of Affordability for Health Insurance Coverage, June 4, 2007

- Establish a Medicare transitional care benefit to help patients transition from the hospital to their homes, which can prevent re-hospitalizations and reduce overall costs.
- Strengthen the patchwork of programs that help low-income beneficiaries afford prescriptions, premiums, and deductibles by raising the low-income threshold, eliminating asset tests that penalize people who did right thing and saved a small nest egg for retirement, making sure beneficiaries know these low-income programs exist, and simplifying the application process;
- Take steps to address racial and ethnic disparities in care by issuing comprehensive requirements for collecting racial and ethnic data, strengthening the Office of Civil Rights and providing resources to enforce language access requirements, ensuring adequate reimbursement for language services, and increasing cultural diversity and competencies in the health workforce; and
- Helping all beneficiaries with rising Medicare out-of-pocket costs by imposing a cap on catastrophic costs which would help people who have high hospitalization costs or who depend on costly medications such as cancer drugs.

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 Congressional Budget Office (CBO) has found that skyrocketing costs throughout our health system far outweigh growing enrollment from an aging population in driving unsustainable Medicare spending increases.<sup>19</sup> Without reform, Part B premiums – which have more than doubled since 2000 – will continue to far outpace Social Security cost of living increases.<sup>20</sup> The Medicare Trustees last year estimated that total expenditures will increase from \$432 billion in 2007 to \$882 billion in 2017, and that the Medicare hospital trust fund would be exhausted by 2019.<sup>21</sup>

---

<sup>19</sup> Congressional Budget Office, *The Long-Term Outlook for Health Care Spending*, November 2007.

<sup>20</sup> Centers for Medicare and Medicaid Services, 2008 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Fund, Table V.C1 and V.C2.

<sup>21</sup> Centers for Medicare and Medicaid Services. 2008 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. Table III.A1.

The current economic crisis is deteriorating Part A Trust Fund solvency even further.

Fortunately, many proposals to improve quality in Medicare save money for both beneficiaries and taxpayers in the long run. These include:

- Revising payment incentives to rewarding quality rather than quantity of care;
- Bundling payments to increase efficiency and encourage coordinated care; and
- Implementing health information technology.

Proposals to reign in excessive payments to plans and providers also help to keep the program affordable.

A key step to wring out waste and inefficiency while improving quality would be to establish a transitional care benefit. A recent study found that one in five beneficiaries discharged from a hospital were back in the hospital within 30 days and about one-third were re-hospitalized within 90 days.<sup>22</sup> Half of those re-hospitalized within 30 days had not seen a physician since discharge, and Medicare spent \$17.4 billion in 2004 on these largely preventable re-hospitalizations.

Under a transitional care benefit, for example, nurse-led interdisciplinary teams could reduce unnecessary hospital readmissions by ensuring that beneficiaries receive necessary follow-up services, supports, and education, coordinating communication among all members of the care team and management of medications, and supporting beneficiaries' family caregivers who coordinate their care.<sup>23</sup>

### **Addressing Chronic and Long-Term Care**

A cornerstone of comprehensive reform is improving care coordination across all settings and ensuring access to home-and-community-based services (HCBS) so people can stay in their homes and out of costly institutions. This is essential for improving quality and achieving savings.

---

<sup>22</sup> Jencks et al, *New England Journal of Medicine*, 360:1418-28, April 2, 2009.

<sup>23</sup> *American Journal of Nursing*: September 2008 - Volume 108 - Issue 9 p. 58-63.



More than 70 million Americans ages 50 and older – four out of five older adults – have at least one chronic condition.<sup>24</sup> People with chronic diseases often have difficulty with basic life activities such as bathing, dressing, or eating, and have significantly higher hospitalization rates and emergency room visits. Their health care spending (shared among patients and payers) is higher than that for people without a chronic disease.<sup>25</sup> CBO reports that about 75% of Medicare spending is for beneficiaries with five or more chronic conditions who see an average of 14 physicians each year.<sup>26</sup>

Uncoordinated care for people with chronic conditions results in poor quality, including costly medical errors and unnecessary tests and hospital and nursing home stays. This increases costs to individuals, family and other informal caregivers, as well as public and private payers. Additionally, Medicaid is the largest payer of long-term care (LTC) in this country, but it requires coverage of generally more costly institutional care and only covers HCBS at the states' option. Yet states that invest in HCBS can, over time, slow their rate of Medicaid spending on LTC.

Support for family caregivers, who often serve as “de-facto” care coordinators and are the backbone of the LTC system, is essential. Family members help loved ones get needed care while risking their own health and financial security to provide unpaid care – with an estimated economic value of about \$375 billion in 2007.<sup>27</sup> Family caregivers can reduce Medicare inpatient expenditures, as well as expenditures for home health and skilled nursing facility care.

To improve care for those with multiple chronic conditions and/or LTC needs, health reform should:

- Encourage and support better care coordination across all settings;
- Work to keep individuals out of hospitals, emergency rooms, and nursing homes;
- Provide individuals with supports to live independently in their homes and communities;

---

<sup>24</sup> AARP Public Policy Institute, *Beyond 50.09*, Chronic Care, A Call to Action for Health Reform.

<sup>25</sup> Ibid.

<sup>26</sup> Congressional Budget Office, *Budget Options Volume I: Health Care*, December 2008.

<sup>27</sup> AARP Public Policy Institute, *Valuing the Invaluable: The Economic Value of Family Caregiving*, 2008 Update, November 2008.

- Support family caregivers so they can help keep loved ones healthy at home;
- Improve Medicaid long term care coverage by making improvements in the Medicaid HCBS state plan option, raising income eligibility levels, providing an enhanced match and requiring spousal impoverishment protections for Medicaid HCBS;
- Better coordinate care and reduce costs for individuals eligible for Medicare and Medicaid; and
- Modernize Medicare funding for nursing education to ensure there are enough properly skilled nurses to coordinate the care of Medicare beneficiaries.

## **Conclusion**

Various stakeholders continue to disagree on the specific provisions of comprehensive health care reform. More important, however, is the broad and growing consensus that we cannot allow these differences to stop us from finding common ground and enacting reform legislation this year. AARP and our Divided We Fail allies are working diligently to find workable solutions to bridge these differences, and we will continue to do so because we all understand that we cannot afford to fail. We cannot fix our broken economy if we do not fix our broken health care system, and we will all need to work together in order to succeed. We again commend this Committee's leadership and look forward to working with both sides of the aisle to make enactment of meaningful, comprehensive health reform a reality this year.