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October 19, 2011

The Honorable Patty Murray
Chairwoman
Joint Select Committee for Deficit Reduction
448 Russell Senate Office Building
Washington, DC 20510

The Honorable Jeb Hensarling
Chairman
Joint Select Committee for Deficit Reduction
129 Cannon House Office Building
Washington, DC 20515

Dear Senator Murray and Representative Hensarling:

On behalf of millions of members nationwide and all Americans age 50 and older, AARP writes to express opposition to cuts in Social Security, Medicare, or Medicaid benefits – including increased cost-sharing – currently under discussion. Older Americans recognize the urgent need to address the nation's fiscal deficit and acknowledge the daunting task you face to help put our nation's finances on a more secure path. But older Americans, across party and regional lines, strongly oppose fast-track cuts to the health care and retirement benefits they have paid into and depend upon.

Like many Americans, older Americans struggle with lost pensions and savings, lower home values, higher health care costs, and long periods of unemployment for those who need to continue working. Older Americans, with average incomes of roughly $20,000, count on every dollar of their Social Security and health care benefits. Their health and economic security should be front and center as you work to enact a meaningful, bipartisan solution to address our nation's fiscal challenges.

Social Security

Social Security is currently the principal source of income for nearly two-thirds of older American households receiving benefits, and roughly one third of those households depend on Social Security for nearly all of their income. Today, every dollar of the average benefit of about $14,000 is absolutely critical to the typical beneficiary. Moreover, the Social Security Trust Funds have run a surplus for decades, and as such, Social Security has reduced the past need for additional government borrowing from the public and resulted in a public debt that is less today than what it otherwise would have been. In short, Social Security has not contributed to the deficit, and Social Security benefits should not be reduced for the purpose of reducing the deficit. In particular, while some have discussed reducing Social Security benefits by moving to a chained consumer price index (CCPI), AARP is opposed to adopting the CCPI to reduce the deficit. This is not a small change. The CCPI – which will take over $100 billion dollars out of the pockets of older Americans in the next 10 years alone – will compound dramatically over time, resulting in an annual benefit that is nearly $1,000 lower by the time a beneficiary reaches age 85. As a result, the older and poorer a beneficiary becomes, the larger the benefit cut. In addition, the current index that is used

to calculate the cost of living increase already likely under-reports the increased costs experienced by seniors – particularly health care cost increases.

Medicare

Over 47 million older Americans and Americans with disabilities depend on Medicare today. Medicare is the bedrock of health security for these individuals and their families. As legislation is developed to address our nation's deficit, AARP strongly urges Congress to reject any proposals that would impose arbitrary, harmful cuts to the Medicare program or shift additional costs onto Medicare beneficiaries. The typical beneficiary today, living on an income of roughly $20,000, already struggles to pay for their ever-rising health and prescription drug costs – and nearly 20 percent of their income currently goes to health care costs.

We are concerned about proposals put forth by some policymakers that would shift additional costs onto Medicare beneficiaries. Such cost shifting undermines current and future beneficiaries' access to quality care; it does not rein in overall health care costs; and it fails to improve health care quality in the Medicare program for current and future beneficiaries. For example, the addition of a home health copay or a copay in the first 20 days of skilled nursing facility (SNF) coverage simply shifts costs onto Medicare beneficiaries and Medicaid, which pays cost-sharing in many cases for dual eligibles. Medicare beneficiaries who may be subject to these copays are likely to be older, have more chronic conditions, be in poorer health, have lower incomes, and need help with daily activities – thus they already face higher costs than other Medicare beneficiaries. Forgoing necessary home health or SNF care if there is a copay could lead to higher Medicare costs in the form of increased inpatient costs, such as unnecessary hospitalizations, or the use of higher cost care. Likewise, adding a clinical lab copayment would impose unnecessary additional cost-sharing onto beneficiaries who lack the clinical judgment to determine whether lab services are necessary.

Similarly, AARP strongly opposes proposals that would increase the age of eligibility for Medicare from 65 to 67. Enacting this policy will increase cost-sharing by individuals who are not yet eligible for Medicare by an estimated over $2,000 per year (many of whom currently lack access to affordable, comprehensive health insurance coverage); will increase Medicare premiums for everyone enrolled in the program; and will increase costs for employers who offer health insurance coverage. In short, coverage will likely decrease, and overall health care costs will likely increase.

Other proposals to simply shift costs onto beneficiaries and other payers fail to address the root problems of rising health care costs throughout the health care system. For example, proposals to shift additional costs onto higher income Medicare beneficiaries by increasing the premium surtax on those with incomes of $85,000 or more fail to recognize that these individuals have already paid more into the Medicare program through higher payroll and income taxes, and are already subject to higher-income Part B and Part D premiums. If we choose to enact a surtax on those with higher incomes, we should not simply target Medicare beneficiaries.

Others have proposed the imposition of additional premiums or taxes for beneficiaries who choose a low-cost sharing Medigap policy. These proposals fail to take into account that people choose these policies because they provide certainty 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 financially. While studies suggest that those with coverage tend to get more care, that care must be medically necessary – we do not want to discourage needed care. Proposals that would apply changes to current policyholders would unfairly impact existing contracts – contracts whose premium payments have already built in the cost of guaranteed renewability under state law.

Finally, we remain concerned that unless Congress acts by the end of the year, physicians and other clinicians (such as nurse practitioners) who treat Medicare beneficiaries will see their payment rates reduced by nearly 30 percent. Facing this constant uncertainty and dramatic cuts to their payments, there is growing concern that more and more physicians will choose to no longer take Medicare patients, which impacts beneficiaries' access to care. AARP believes the currently flawed payment system must be reformed, and we urge Congress to enact the longest possible resolution to the SGR problem.

Medicaid/Long-Term Services and Supports

Beneficiaries who qualify for both Medicaid and Medicare, commonly known as "duals," are among the neediest, most complicated, and most expensive populations that either program serves. There is a clear need to provide duals with integrated and coordinated care, and doing so could result in both savings to taxpayers and better care for beneficiaries. Information needed to properly integrate Medicare and Medicaid is now being developed through state demonstrations. Changes to care delivery for this population should be based on the lessons learned and best practices from these demonstrations and other experiences in order to prevent harm to this vulnerable population.

AARP also urges you to avoid arbitrary caps or limits or other harmful cuts to Medicaid that could reduce vital access to care, including essential home and community-based services (HCBS) and nursing home care. Such cuts could put the health and safety of seniors and people with disabilities at great risk, and ultimately cost federal and state governments more. For example, Medicaid cuts could reduce access to much needed, preferred, and cost effective HCBS. Cutting HCBS could result in more people having to go to nursing homes – with average costs of $75,000 per year – leading to a quicker spend down of assets and thus dependence on Medicaid for their long-term care needs.

Arbitrary limits or cuts to federal matching Medicaid spending don't make costs disappear; they simply shift costs to individuals, providers, and state governments. Significant cuts to Medicaid will harm individuals and families who rely on Medicaid for health or long-term services and supports (LTSS), including formerly middle income people whose life savings have been wiped out by the high costs of LTSS. Nearly a third of those turning age 65 will have LTSS costs that exceed their ability to pay and will need Medicaid assistance to help with LTSS. In addition, Medicaid cuts often translate into job losses in the health and LTSS workforce – including for medical and health centers and nursing homes – which can reduce access to care for many older persons, even those whose care is not paid for by Medicaid.

Cuts to Medicare and Medicaid could also shift additional costs to family caregivers. A recent AARP report found that the estimated value of family caregivers' unpaid contributions was approximately $450 billion. It is unfair and ineffective to shift even more costs on to these family caregivers, many of whom help to keep their loved ones where they prefer – at home – and out of more expensive nursing home care.

Cost Savings – Not Cost Shifting – to Protect Beneficiaries

In your efforts to save health care dollars, we urge you to focus on the root problem of high health care costs, and not simply seek to shift costs to states, employers and individuals. Cost-shifting does nothing to address the economic toll of high health care costs on the nation, nor does it improve the delivery of health care generally. Rather, it causes greater harm, and less health security, for older Americans and others who rely on those programs. AARP believes the committee can find savings in health care without harming beneficiaries. Before we ask older Americans to contribute more out of their pockets for health care, we must first tackle the waste, high cost and inefficiency in our health care system.

Several proposals would do just that. Efforts to root out and eliminate fraud can simultaneously improve the Medicare and Medicaid programs while saving taxpayer dollars. The bipartisan "Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayers' Dollars Act" ("FAST Act" – S.1251)) and the "Medicare Common Access Card" (S. 1551/H.R. 2925) are two such proposals. These bills build upon and expand anti-fraud efforts in a comprehensive way to ensure that program dollars are spent on legitimate beneficiary needs rather than on phony bills or criminally priced products.

In addition, there are a number of ways to save money by reducing the high cost of pharmaceuticals – one of the fastest growing components of health care. Such changes will save money for beneficiaries and other payers as well as reduce the burden on taxpayers. AARP has long supported a wide range of pharmaceutical savings proposals and believes the committee should take steps to reduce drug costs before it considers any cuts that could harm Medicare or Medicaid beneficiaries. These steps include:

- *Prescription Drug Rebates for Part D*: Even when only applied to the *low income subsidy* population of Part D, the extension of Medicaid rebates would save the Medicare program over $100 billion over the next ten years without harming beneficiaries.

- *Biologic Exclusivity:* Reducing the exclusivity period for biologic drugs, which will speed lower cost generics to market.

- *Prohibit Pay-For-Delay Agreements:* Preventing abuses in patent settlements between generic and brand prescription drug companies will help to bring lower cost generic drugs to market sooner.

- *Medicare Secretarial Negotiating Authority:* Medicare should be able to use the bargaining power of its 47 million beneficiaries to negotiate for lower prescription drug prices.

- *Prescription Drug Reimportation:* The Pharmaceutical Market Access and Drug Safety Act would establish a framework for the safe, legal importation of lower-priced prescription drugs from abroad.

- *Encouraging Generic Utilization in the Medicaid Program*: The Affordable Medicines Utilization Act of 2011 would encourage states to improve the use of generics in their Medicaid programs instead of more costly brand equivalents.

Significant savings related to the Medicare program, as well as reforms to the health care delivery system, have recently been enacted into law. Such reforms, implemented in a manner that achieves higher quality and better delivery of care and services, should achieve savings in Medicare, Medicaid, and the entire health care system. In 2010, the Institute of Medicine estimated excess system-wide health spending yielding little or no value at $765 billion, including unnecessary services, inefficient delivery, and missed prevention opportunities. It is imperative that we address these delivery system challenges. Changes include:

- *Accountable Care Organizations (ACOs)*: ACOs that are able to improve quality and reduce health care costs will be eligible to share some of the savings accrued to the Medicare program. In the ACO model, entities will be jointly accountable for care coordination and the care they provide, thus reducing the incentive to provide unnecessary testing and procedures. HHS estimates that ACOs could save Medicare nearly $1 billion in the first three years.

- *Home- and Community-Based Services (HCBS)*: On average, Medicaid can provide HCBS to three people for the cost of serving one person in a nursing home. We should encourage HCBS, rather than cuts to Medicaid that may reduce HCBS and result in more people having to go to nursing homes. Research shows that states that invest in HCBS, over time, slow their rate of Medicaid spending growth, compared to states that remain reliant on nursing homes.

- *Reduce Adverse Events*: The HHS Inspector General reported that hospital care associated with adverse and temporary harm events cost Medicare an estimated $4.4 billion annually. OIG recommended broadened patient safety efforts and further incentives to hospitals to reduce adverse events through payment and oversight functions.

- *Medicare Transitional Care Benefit:* Helping people transition to home or other settings safely after a hospital stay will help prevent costly, unnecessary hospital readmissions. Such a benefit can help save some of the over $17 billion Medicare spends annually on largely preventable hospital readmissions and significantly reduce the 20 percent of people in Medicare who are readmitted to the hospital within 30 days of their discharge.

We know you face a difficult task and a compressed time period. As you tackle this difficult challenge, we strongly urge you to oppose cuts in Social Security, Medicare, and Medicaid – including increased cost-sharing – that will further burden older Americans already struggling in this difficult economy. If you have any questions, please feel free to contact me or have your staff contact Joyce Rogers of our Government Affairs office at 202-434-3750.

Sincerely,

A. Barry Rand

cc: The Honorable Max Baucus
The Honorable Xavier Becerra
The Honorable Dave Camp
The Honorable James Clyburn
The Honorable John Kerry
The Honorable Jon Kyl
The Honorable Rob Portman
The Honorable Pat Toomey
The Honorable Fred Upton
The Honorable Chris Van Hollen