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October 30, 2012

The Honorable Jim DeMint
167 Russell Senate Office Building
Washington, DC 20510

Dear Senator DeMint:

I am writing in response to your letter and report of September 20, 2012. I have served for six years as a member of the all-volunteer AARP Board of Directors, including during AARP's decision to support comprehensive health care reform legislation. I have also served as the chair of AARP's National Policy Council. In 2012, I became the volunteer president of AARP.

As I read your letter and report, I believe that they reflect a fundamental misunderstanding about why AARP supported health care reform. As someone who has dedicated countless hours to helping AARP carry out its vital mission, I am disappointed in your suggestions of AARP's motivations during the health care reform debate and can assure you that we acted singularly in pursuit of the decades-long Association priority of improving the quality and accessibility of health care for older Americans. This letter provides a detailed discussion about our long path to supporting the ACA, including:

1. How AARP sets its policy positions;
2. AARP's long history of studying health care issues and the need for comprehensive reform;
3. Why, specifically, AARP supported the final health care reform legislation, including our support for key provisions such as closing the "doughnut hole" in Medicare Part D, increasing coverage of preventive care, ensuring that more Americans can age in their homes, and increasing access to health insurance coverage for those ages 50-64;
4. That AARP did not support health care reform for financial reasons; and
5. That AARP considered the views of our members and older Americans in deciding to support health care reform, and received support and assistance from 1.3 million of our members and volunteers in advocating for reform.

I hope that this letter demonstrates that, even though we may disagree on certain policies, AARP arrives at its policies through a deliberative process, and bases its policies on input from many different people and a significant amount of research in an effort to forge policy solutions that AARP believes will benefit all older Americans.

1. AARP'S POLICY DEVELOPMENT PROCESS

AARP is a nonprofit, nonpartisan organization committed to helping people 50+ have independence, choice and control in ways that are affordable and beneficial to them and society as a whole. We carry out this commitment in many different ways – including through our public policy and advocacy work, through our outreach and volunteer programs, in our publications and educational materials, and by providing access to member benefits that offer value and socially responsible features.

AARP has a standard process by which it determines which policies or legislative provisions we will support. AARP's National Policy Council is tasked with studying issues and developing policy recommendations to be presented to the AARP Board of Directors. The Council is comprised of twenty-five volunteer leaders from around the country who have a record of public policy experience and interest on issues such as health care, economic security, and consumer protection. Members are selected by a special committee of current Council members and Board members.

The Council carefully studies issues and often invites outside experts from a variety of backgrounds and perspectives to present their positions. With regard to health care, for example, the Council heard from Senators Bob Bennett (R-UT), Orrin Hatch (R-UT), and Gordon Smith (R-OR) and the Heritage Foundation, among others. For many issues, the process may also include surveying AARP members and other older Americans to help determine which issues are important to them.

The positions developed by the National Policy Council are then sent to AARP's Board of Directors for consideration and approval and, if approved, ultimately codified in the AARP Policy Book. At least every two years, the National Policy Council reviews all policies in the Policy Book and brings any recommended changes to the Board of Directors.

2. AARP'S LONG FOCUS ON HEALTH CARE REFORM

Since its inception, AARP has advocated for improvements to health care for older Americans. In 1958 – even before Medicare existed – we worked to persuade private health insurers to provide coverage options for older persons. With Medicare's enactment in 1965, AARP became its champion and we have been working to protect and strengthen Medicare ever since.

In the early 1990s, at the direction of the AARP Board, we developed our own health reform proposal called "Health Care America." We promoted that proposal and participated in the many White House health reform task forces to help build a plan that could gain majority support. In the wake of the unsuccessful effort to enact comprehensive health care reform legislation in 1993-94, AARP turned our attention to the states and achieved many successes with improvements at the state level, including expansion of home and community based services for people with long term care needs.

Over the years, AARP has been at the center of key legislative initiatives to strengthen and improve Medicare and other federal health programs, including major initiatives such as the Balanced Budget Act of 1997 and the Medicare Prescription Drug, Improvement and Modernization Act. In 2003, we worked closely with the Bush Administration and Congress to enact Medicare Part D. Along the way, we engaged in health reform campaigns to bring health coverage to the broader population – including people who were not yet eligible for Medicare.

In 2006, after the first successful roll out and implementation of Medicare Part D, we began to revisit the potential for broader health care reform. Health care cost increases were gaining greater public attention and the impact of health costs on individuals and the economy was a topic of concern for large and small businesses as well as consumers and workers. We realized that any solution to the problem would need to be embraced by key stakeholders from divergent perspectives, and we began to look for like-minded collaborators.

Divided We Fail

Our search for collaborators led us to the Business Roundtable, a group of the most powerful Fortune 500 corporations, and the National Federation of Independent Business, the largest representative of American small business. We also sought out the Service Employees International Union, the country's fastest growing union, which represents a range of workers, including health care workers. The four groups came together to lead an effort called "Divided We Fail" (DWF).

DWF negotiated a set of principles that each of the groups subscribed to, and we worked together to demonstrate that divergent groups had much in common when it came to the need to establish lifetime health and financial security for all Americans. DWF enlisted more than 160 supporting organizations, covering a broad range of stakeholders. DWF convened events, sent joint letters to Congress and the President, testified before Congress, and actively promoted the need for change – particularly reform of health care. The collaboration was highly visible and successful in establishing that these diverse and important interests agreed on the need for change, and as we headed into the 2008 election, all emphasized the importance of reforming the health care system.

Health Action Now

The stage was set for a robust discussion of the need for health care reform following the 2008 Presidential campaign. Consistent with our advocacy history and Board-approved policies, AARP kicked off our organization-wide *Health Action Now* campaign in the spring of 2009 to enact comprehensive health care reform.

Throughout the Health Action Now campaign, the all-volunteer AARP Board was very involved in, and ultimately responsible for, setting AARP's priorities for the initiative. At the outset of the campaign, the Board and staff reviewed key elements necessary for effective reform. The Board evaluated each of these elements, using criteria such as its impact on health care, the benefits to individuals age 50+ and the value of AARP's advocacy in these areas.

Based on the extensive amount of information the Board considered, we initially set the following six areas as AARP priorities for reform:

1) Guaranteeing affordable coverage for Americans age 50-64;
2) Closing the Medicare Part D coverage gap or "doughnut hole";
3) Creating a Medicare transition benefit to help people return safely to their homes after a hospital stay and prevent costly hospital readmissions;
4) Increasing federal funding and eligibility for home and community based services through Medicaid so older Americans can remain in their homes as they age and avoid more costly institutional care;
5) Creating a pathway for the approval of generic versions of biologic drugs to reduce the price of these costly treatments; and
6) Improving the Medicare Savings Programs and the Part D Low Income Subsidy (LIS) so more Americans can afford the health care and prescription drugs they need.

As we will discuss in detail below, AARP had long-standing policy around each of these six priorities. Such policy pre-dated the 2009-10 health care reform effort and represented AARP's best thinking on how to most effectively and responsibly serve the health care needs of those fifty and older. Our assessment of those needs reflected close attention to problems with access and affordability that our members had related to us in a variety of forums over a period of many years.

A dominant theme of AARP's health care reform work, dating back to Divided We Fail, was the unacceptable "cost of doing nothing" – the conviction that failure to act would simply guarantee continuation of the escalating cost of care. There was universal consensus across the ideological spectrum that anything as big and important as health care reform would require difficult decisions among every constituency. AARP was prepared to make these decisions, driven by facts and data, with a particular focus on the impact of any proposal on the lives of Americans 50+.

The Medicare Advantage program was a prime example. For nearly a decade, AARP had raised concerns with the excess payments to what eventually became the Medicare Advantage program. AARP firmly believed that private options within Medicare were an important component, but that Medicare Advantage plans – which are offered by private insurance companies that originally claimed they could provide better care at a lower cost – must compete on the basis of quality and efficiency, not excess taxpayer-funded subsidies. AARP's support for saving Medicare money by reducing Medicare Advantage costs was fueled by reports that insurance companies that offered Medicare Advantage received an average of 14 percent more per person than traditional Medicare. These subsidies were paid both by higher premiums for those in traditional Medicare, and by taxpayers. By reducing the excess subsidies to Medicare Advantage, we believed Medicare could save over $100 billion that could be used to strengthen Medicare for everyone.

The Board, with input from staff and previously-set AARP policies, actively guided AARP advocacy throughout the campaign. In addition to assessing how various forms of health care legislation matched up against our criteria, the Board also considered the implications of again supporting a bill that might lack broad bipartisan support. Having been through such a scenario in 2003 with Medicare Part D legislation, this was not something AARP took lightly, recognizing it would once again open us up to the inaccurate criticism of partisanship – in that case coming from the political left for our work with a Republican Administration and Congressional majorities. While AARP continued to call for bipartisan support throughout the health reform debate, we once again chose to act in response to the identified health care needs of people age 50 and over, despite the unfortunate lack of bipartisanship, in order to successfully advance key priorities for older Americans.

It is important to keep in mind that had AARP made broad bipartisan backing a prerequisite for our support of important health care advancements, we would have not supported either Part D or the Affordable Care Act. While members of Congress and others may disagree with either or both of these decisions, our support of these two pieces of legislation represents a reliance on health care principles and the best interests of Americans 50+.

3. THE AFFORDABLE CARE ACT: AN OPPORTUNITY TO MAKE PROGRESS TOWARD AARP'S KEY POLICY OBJECTIVES

Contrary to the implication of your letter, AARP's position on the ACA and the overall health reform

package was driven exclusively by the wants and needs of older Americans. While there were certainly those age 50 and above, both members and non-members, who disagreed with our support of the overall legislative package, AARP had years of research indicating that the wants and needs of the 50+ population would best be served by the component parts of the ACA. As a social welfare organization, we serve the needs of all Americans 50+, not just members. In the years leading up to the 2009 health care reform effort, AARP's Public Policy Institute performed numerous studies around what older Americans, including AARP members, needed from health care reform, resulting in the six policy goals set as priorities by the Board, identified above and discussed in detail below.

A. Guaranteeing affordable coverage for Americans age 50-64

AARP has long been concerned about uninsured 50-64 year-olds. AARP's Public Policy Institute described the problem in regularly updated reports issued in 1998, 2002, 2005 and 2007. The most recent report, issued in May 2007, found that 7 million Americans age 50-64 lacked health insurance (attached as Exhibit 1). Contrary to popular belief, many uninsured people were employed, but they could not obtain coverage from their employer. Purchasing insurance on the individual market was simply too expensive due to excessive age rating or altogether unavailable due to preexisting condition exclusions.

This research helped AARP identify the problem as well as some potential solutions. Ensuring access to affordable coverage for 50-64 year-olds required lowering costs by limiting age rating and prohibiting insurers from denying coverage due to preexisting conditions. In AARP's 2007 Policy Book, the National Policy Council, with Board approval, called for regulation requiring insurers to use community rating instead of age rating and to limit coverage exclusions for preexisting health conditions. As the health care reform debate heated up, AARP surveyed its members to determine where they stood on key aspects of reform. In April 2009, 61 percent of AARP members told us that they "strongly favor" and another 23 percent said they "somewhat favor" "making insurance available to everyone regardless of their health history," confirming our belief that our members and the 50+ both needed and wanted limits on these insurance practices.

AARP continued to look at the insurance needs of 50-64 year-old Americans over the next few years. Their access to coverage was not improving. A 2009 update of the regular AARP report on the subject showed that the number of 50-64 year-old Americans without coverage had increased slightly to 7.1 percent (attached as Exhibit 2). In addition, the update noted that up to 28% of applications from 50-64 year-olds to purchase coverage on the individual market were being rejected by the insurer, further confirming the need for reforms.

AARP also believed that removing barriers to obtaining Medicaid coverage would increase the availability of coverage for 50-64 year-old Americans. In a September 2008 study, *Millions of Americans Can't Get Medicaid: What Can Be Done?,* AARP determined that, second only to those in their 20's, Americans in their 50's and 60's represented the largest segment of uninsured low-income adults (attached as Exhibit 3).

AARP did not ask members specifically about expanding Medicaid coverage, but 55% of members stated in the 2007 survey that "Government should see that everyone has minimum health benefits" when asked what the government's role should be and given four options. Likewise, 70% of members said "government's role in health care" should be either "expanded greatly" or "expanded somewhat." In

2009, 75% of members told AARP that they would either "strongly favor" or "somewhat favor" "helping low income people purchase their health insurance with government assistance."

Limits on age rating, prohibitions on coverage exclusions for preexisting conditions, assistance in purchasing coverage, and expanding Medicaid were the keys to ensuring affordable coverage for 50-64 Americans. But the Affordable Care Act included other provisions designed to increase access to health insurance, including the "individual mandate," which many believe is integral to the effort to greatly increase affordable access to coverage for 50-64 Americans.

AARP had been studying the issue of an "individual mandate" for several years. Recognizing that such a mandate could become part of any reform legislation at either the national or state level, the National Policy Council set out to define the parameters in which a mandate would be acceptable. The 2007 National Policy Book spelled out the conditions that must be met before AARP could support any legislation that included a provision requiring individuals to purchase insurance (relevant section attached as Exhibit 4). Principal among them was that any requirement for individuals to purchase insurance be coupled with appropriate subsidies for low and middle income consumers – an outcome similar to the "individual mandate" in the ACA.

AARP also confirmed that a policy requiring individuals to obtain insurance did not conflict with our members' views. In December 2007, the National Policy Council conducted a broad survey of AARP members and non-members on a variety of issues including health care. The survey results would help guide the Council's work in establishing AARP's policy positions. The survey included an explicit question about requiring individuals to buy insurance and providing public subsidies to do so. In response, 67% of members and 61% of non-members stated that they either "strongly agree" or "somewhat agree" with the following statement:

> It should be made mandatory that every person buys health insurance. People with higher incomes who do not have coverage should be required to buy coverage or accept it from their employer, and the government would help to pay for coverage for those moderate and low-income families so long as it is affordable to them.

AARP also surveyed its members again and found broad support for an "individual mandate" and the related subsidies. In an April 2009 survey, 63% of members stated that they either "strongly favor" or "somewhat favor" requiring individuals to obtain health insurance and providing subsidies for those who could not afford insurance.

By mid-2009, AARP had empirical evidence that millions of 50-64 year-olds needed access to affordable health insurance coverage and that solutions such as limiting age rating, prohibiting preexisting condition exclusions, providing subsidies to those needing help purchasing coverage, and expanding Medicaid would dramatically improve access. We ultimately believed provisions in the ACA intended to accomplish these goals were a significant improvement over current law and warranted our support.

B. Closing the Medicare Part D coverage gap or "doughnut hole"

Likewise, AARP based its support for closing the "doughnut hole" on both policy research and member feedback. A 2009 AARP report found that millions of Americans would be responsible for up to $3,000

in prescription drug costs before additional coverage kicked in (attached as Exhibit 5). By 2016, that hole was expected to reach $6,000. AARP had found compelling evidence that the lack of coverage in the doughnut hole caused seniors to forego medication, resulting in adverse health effects and expensive hospital stays.

When AARP asked its members if they were worried about the high cost of prescription drugs, the answer was a resounding yes. The December 2007 survey revealed that 82 percent of members were "very much worried" or "somewhat worried" about the price of prescription drugs. An April 2009 survey similarly showed concern by more than two-thirds of the respondents. Once again, AARP had clear evidence that closing the doughnut hole would greatly benefit the health and economic well-being of millions of members and older Americans.

C. Creating a Medicare transition benefit to help people return safely to their homes after a hospital stay and prevent costly hospital readmissions

Perhaps no issue had been more carefully studied at AARP in the years preceding the 2009-10 health care reform debate than creating a Medicare transition benefit. In March 2009, AARP released *Beyond 50: Chronic Care; A Call to Action for Health Reform* (attached as Exhibit 6). This comprehensive research report included original data analysis, six focus groups, and two national opinion surveys of people with chronic conditions and their caregivers. The report focused on ways to improve care coordination for people with chronic conditions. One of the strongest conclusions was the need for, and the effectiveness of, transitional care coordination after hospital discharge. The report authors specifically recommended the creation of a new Medicare benefit that would provide transitional care for beneficiaries at high risk of rough transitions and costly re-hospitalization.

D. Increasing federal funding and eligibility for home and community based services through Medicaid so older Americans can remain in their homes as they age and avoid more costly institutional care

Almost all health care experts agree that serving aging Americans in their homes instead of more expensive institutions is the wave of the future. Research of older Americans also has consistently shown that the overwhelming majority of people would prefer to age in their homes and avoid nursing homes (see March 2008 *Healthy at Home* report attached as Exhibit 7). Moreover, the cost savings are real. In 2008, AARP released a state-by-state review of efforts to transition long term care beneficiaries away from institutions (attached as Exhibit 8). Sadly, despite grants and other efforts by Centers for Medicare & Medicaid Services beginning as early as 2001 to encourage states to save money and provide services in the home, many states were not making progress. A follow-up report in March 2009 from AARP, *Taking the Long View: Investing in Medicaid HCBS is Cost-Effective*, looked at several case studies in states already implementing a shift from institutional care and found that both their residents and the state budgets were being rewarded (attached as Exhibit 9). But more help from the federal government was needed. And relevant provisions of the ACA provided some of that help.

E. Creating a pathway for the approval of generic versions of biologic drugs to reduce the price of these costly treatments

In 2008, AARP released *Strategies to Increase Generic Utilization and Associated Savings*, a

comprehensive report on ways to lower drug costs through the increased use of generics (attached as Exhibit 10). The report found that use of biologic drugs was on the rise but that the FDA lacked the ability to approve generic versions of these often very high cost biologics. AARP highlighted this problem in a May 2009 fact sheet that concisely laid out the high costs of biologic drugs (attached as Exhibit 11).

AARP's April 2009 member survey asked specifically about legislation to allow generic versions of biologic drugs on the market. Not surprisingly, 62% strongly favored and another 23% somewhat favored "the government devoting resources toward approving generic versions" of biologics. While there is a small upfront cost to establish a pathway for approval of generic biologics, the long-term savings for individuals, as well as Medicare, Medicaid and throughout the health care system, would be substantial. The ACA included a pathway for the approval of generic biologics.

F. Improving the Medicare Savings Programs and the Part D Low Income Subsidy (LIS) so more Americans can afford the health care and prescription drugs they need

By the spring of 2009, AARP had consistently heard from members and other Americans 50+ that they were concerned about the high price of prescription drugs – including responses to both the 2007 and 2009 surveys described above. In the 2007 survey, 75% of members reported that they were either "very worried" or "somewhat worried" about "not being able to afford the health care services" they need. In 2009, 65% of members reported the same concern.

Programs such as the Medicare Savings Program and LIS help low income seniors pay for needed health care and prescription drugs. But poor coordination between the two programs along with burdensome application processes meant many eligible seniors were not receiving the help they need.

Most importantly, both programs imposed low asset tests. In May 2007, AARP Board Member Joyce Payne testified before both the House Ways & Means Committee and the Energy & Commerce Committee (attached as Exhibits 12 & 13). She noted that an estimated 2.3 million low income seniors were denied help because they had retirement assets slightly above the eligibility limit. Raising or removing the asset limit was a simple and cost effective means to ensure millions of low income seniors could afford needed health care without punishing those who attempted to save for retirement.

Key elements of the Association's six priority areas, as well as other improvements in the delivery of health care, were included in the legislative vehicles entering the final stages of the ACA debate. For that reason, the AARP Board of Directors voted unanimously on October 21, 2009, to put AARP's advocacy muscle behind comprehensive health care reform. Recognizing the fluid legislative situation in Congress, the Board empowered AARP to support legislation containing provisions the Board deemed necessary for true reform. Ultimately, the final version of the Affordable Care Act and the companion Health Care and Education Affordability Reconciliation Act met the Board's high standard for support.

4. AARP DID NOT SUPPORT HEALTH CARE REFORM FOR FINANCIAL GAIN

Your materials repeat the false assertion from a 2011 report, *Behind the Veil,* by Rep. Wally Herger (R-CA) and Rep. Dave Reichert (R-WA) that AARP "could receive a windfall exceeding $1 billion over the

next ten years" from the enactment of the ACA. Unfortunately, the *Behind the Veil* report is based on numerous erroneous assumptions.

To reach the $1 billion figure, the report relies on a number of assumptions related to mass migration of enrollees from Medicare Advantage (MA) to Medigap plans. The report assumes: 1) that United Healthcare will maintain a Medigap market share of 34% for the next 10 years; 2) that at least 50% of seniors leaving MA will enroll in Medigap; 3) that seniors leaving MA will enroll in more expensive Medigap plans instead of plans that provide less coverage and charge lower premiums; and 4) that Medigap premiums will increase at nearly 5% annually. All of these assumptions are impossible to predict with any reliability.

Most importantly, the report assumes that 4.9 million seniors will leave MA in 2014 as a result of the ACA. The report cites only a July 26, 2010, email from Richard Coyle, Deputy Director of CMS's Office of the Actuary, to support this figure. AARP has not seen this email. But it should be noted the actuarial analysis submitted to Congress by the Medicare Trustees on August 5, 2010 – just 10 days later – estimates that only 1.9 million MA enrollees would leave in 2014. And that number has since been revised downwards, both consistently and dramatically, as ACA provisions have been implemented. In the 2012 Trustees' report, only 226,000 MA enrollees are expected to leave MA in 2014 – a huge difference from the 4.9 million relied on in *Behind the Veil*. In fact, the actuarial analysis submitted to Congress in 2012 estimates that nearly 2.5 million *more* MA enrollees will continue to enroll in MA in 2020 than the Trustees originally estimated in their 2010 report. In September, the Centers for Medicare and Medicaid Services announced that 2013 MA enrollment is projected to increase by 11% with no increase in premiums, meaning that between 2010, when the ACA was enacted, and 2013, MA enrollment will have increased by 28% while premiums will have declined by 10%.

To be clear, AARP did not attempt to analyze the impact of any health care reform legislation on our royalty income for the simple reason that the answer would not have influenced our advocacy priorities or decisions. In any event, these dramatic shifts in the Trustees' reports, as well as the actual data to date, show how difficult it would have been to predict consumer behavior in the face of major changes to the health care market with any reliability, especially ten years in the future.

It's also worth noting that many organizations dedicated to improving health care for older Americans supported the Affordable Care Act, including the National Association of Area Agencies on Aging, the National Committee to Preserve Social Security and Medicare, the National Council on Aging, the National Senior Citizens Law Center, and the American Association of Homes and Services for the Aging. As far as we can discern, none of these organizations receive royalty income or stood to gain financially in any way from the enactment of health care reform. Yet their analysis of what legislation would help protect seniors led them to the same conclusion that AARP's National Policy Council and Board reached – to support health care reform.

5. RESEARCH SHOWED THAT AARP MEMBERS SUPPORTED THESE POLICIES

Your report indicates that AARP membership demonstrated "overwhelming opposition" to the ACA. That is simply not the case. While we did receive a number of negative calls, notably, more than 1.3 million AARP members and activists registered their support for health care reform by engaging in grassroots advocacy activities such as signing petitions or contacting their members of Congress –far

exceeding the number of members who called, wrote, or emailed AARP to express their opposition to health care reform.

Further, as discussed above, AARP surveyed its members to determine their support for health care reform and the component policies such as closing the "doughnut hole" in Medicare Part D, increasing coverage of preventive care, ensuring that more Americans can age in their homes, and increasing access to health insurance coverage for those ages 50-64. Those surveys revealed broad support for many key parts of comprehensive reform. And finally, years of AARP research showed the deep need among American seniors for key provisions of the ACA, also as described above.

In November 2009, after the House of Representatives passed its health care bill, AARP commissioned a poll to test our members' views of the law and its key components. Despite months of intense public debate, the survey found strong support for key elements of the law, including:

- Requiring insurance companies to cover routine checkups and preventive care with no extra charge (77% support)
- Preventing insurance companies from denying coverage based on preexisting conditions (75% support)
- Stopping insurance companies from charging much higher premiums because of age (68% support)
- Closing the "doughnut hole" (69% support)
- Providing a voluntary long term care program (66% support)
- Requiring individuals to buy insurance and providing subsidies (68% support)

Throughout the course of the debate, we continued to monitor public polling on health care reform. External polling of voters 50+ supported many of our internal findings. For example, a Kaiser Family Foundation poll conducted in 2010 showed strong support among people 50-64 and 65+ for key components of health reform, including:

- Creating a health insurance exchange or marketplace where small businesses and people who don't get coverage through their jobs can compare prices and benefits.
  - age 50-64: 78% extremely/very important
  - age 65+: 66% extremely/very important
- Reforming the way health care works, for example, so that insurance companies can't deny coverage for preexisting conditions, and can't cap the benefits people get over a lifetime.
  - age 50-64: 76% extremely/very important
  - age 65+: 73% extremely/very important
- Helping to close the Medicare "doughnut hole" so seniors would no longer have a period where they are responsible for paying the full cost of their medications.
  - age 50-64: 72% extremely/very important
  - age 65+: 62% extremely/very important]

AARP respects and appreciates the differing views expressed by any member, but we balance that feedback – as we have done consistently throughout our history – with our longstanding support for issues based on years of policy research, opinion polling of AARP members and other Americans, and our

policy development process. While we deeply value every member, we recognize that it is impossible to totally satisfy more than thirty-seven million people on every policy position we take.

CONCLUSION: AARP SUPPORTED PASSAGE OF THE ACA TO IMPROVE THE QUALITY AND ACCESSIBILITY OF HEALTH CARE FOR 50+ AMERICANS

AARP's decision to support comprehensive health care reform, including the ACA, was driven by our sincere belief that it would improve the lives of 50+ Americans. We based that decision on extensive research around what older Americans, including AARP members, needed and wanted from health care reform. All of this research work, going back well before the most recent health care legislative debate, resulted in principles and goals established by our all-volunteer National Policy Council and Board of Directors. The inclusion of legislative provisions addressing these principles and goals guided AARP's position on health care reform.

Further, these policies were reviewed over many years by dozens of volunteers serving on our 25-member National Policy Council and 22-member Board of Directors. These individuals represent almost every walk of life imaginable – academics, advocates, businesspeople, medical professionals, Democrats, Republicans and independents. They stand to gain nothing from AARP's financial success or failure.

Over the course of the last decade, these volunteers dedicated countless hours to help AARP craft an effective, balanced and pragmatic approach to obtain real health care reform. They were motivated by nothing more than a heartfelt desire to ensure that every American could age with dignity – never having to forego medical care or cut pills in half. Like me, my colleagues on the Board of Directors determined that once the Affordable Care Act included a number of AARP's priorities, it represented an opportunity for significant and responsible improvement of the nation's health care system, benefiting not only our members and other 50+ Americans, but all Americans.

Sincerely,

Robert G. Romasco
President

Enclosures

cc: A. Barry Rand

List of Exhibits

Exhibit 1 – *Data Digest: Health Coverage among 50- to 64-Year-Olds*, AARP Public Policy Institute, May 2007

Exhibit 2 – *Health Care Reform: What's at Stake for 50- to 64-Year-Olds*, AARP Public Policy Institute, March 2009

Exhibit 3 – *Millions of Americans Can't Get Medicaid: What Can Be Done?*, AARP Public Policy Institute, September 2008

Exhibit 4 – 2007 AARP National Policy Book9 (excerpt)

Exhibit 5 – *Closing the "Doughnut Hole" Will Help Protect Over One-Third of Medicare Beneficiaries from High Drug Costs*, AARP Public Policy Institute, 2009

Exhibit 6 – *Beyond 50: Chronic Care; A Call to Action for Health Reform*, AARP Public Policy Institute, March 2009

Exhibit 7 –*Healthy at Home*, AARP Foundation, March 2008

Exhibit 8 – *A Balancing Act: State Long-Term Care Reform*, AARP Public Policy Institute, July 2008

Exhibit 9 –*Taking the Long View: Investing in Medicaid HCBS is Cost-Effective*, AARP Public Policy Institute, March 2009

Exhibit 10 – *Strategies to Increase Generic Utilization and Associated Savings*, AARP Public Policy Institute, December 2008

Exhibit 11 – *Biologics in Perspective: The Case For Generic Biologic Drugs*, AARP Public Policy Institute, May 2009

Exhibit 12 – Testimony of AARP Board Member Joyce Payne, Ed.D. before the House Ways & Means Committee, May 2007

Exhibit 13 – Testimony of AARP Board Member Joyce Payne, Ed.D. before the House Energy & Commerce Committee, May 2007