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October 5, 2012

The Honorable Thomas Coburn
SR-172 Russell Senate Office Building
Washington, DC 20510-3604

The Honorable John Barrasso
SD-307 Dirksen Senate Office Building
Washington, DC 20510-5003

The Honorable Phillip Gingrey
442 Cannon House Office Building
Washington, DC 20515-1011

The Honorable Charles Boustany, Jr.
1431 Longworth House Office Building
Washington, DC 20515-5724

Dear Senator Coburn, Senator Barrasso, Representative Gingrey, and Representative Boustany:

I write in response to the follow-up questions your staff posed by email regarding our letter to you of July 13. (A copy of the July 13 letter is included as Exhibit 1 for your convenience, as today's responses should be read in the context of that letter.) The email requests more information about AARP's efforts in support of health care reform legislation, specifically the Affordable Care Act ("ACA").

1. **Did employees or those who claim to represent the interests of the White House request that Barry Rand meet with Senator Nelson – or any other member of Congress – for the purpose of influencing his vote on the President's health care bill? If yes, please list all White House employees or representatives that made such a request, when those requests were made, and the members of Congress who were the targets of those requests.**

As we have previously explained, on December 15, 2009, Jim Messina, White House Deputy Chief of Staff for Operations, suggested that Barry Rand contact Senator Ben Nelson. Also, as we previously explained, it was well known that Senator Nelson was a key vote, we had already been in contact with Senator Nelson's office, and we did not need guidance on legislative activity.

We have conducted a search of email and other records and interviewed key AARP staff to ascertain whether there were any similar requests. Our inquiry located an indication that Jim Messina also asked that Barry Rand speak with Senator Byron Dorgan about the health care

reform legislation during a meeting with Senator Dorgan on October 14, 2009 to discuss the Dorgan-Snowe Amendment to the legislation (which would have allowed importation of FDA-approved prescription drugs). As with Senator Nelson, AARP was already in touch with Senator Dorgan independent of any request by the Administration. Indeed, AARP had been a longtime supporter of the bipartisan drug importation bill authored by Senators Dorgan and Snowe.

2. **Did employees or those claiming to represent the interests of the White House request that AARP orchestrate "robo calls" to influence Senator Nelson's vote – or the vote of any other sitting or former member of Congress on the President's health care bill? If yes, please list all White House employees or representatives that made such a request, when those requests were made, and the members of Congress who were the targets of those requests.**

As previously discussed, Jim Messina suggested to AARP on December 15, 2009 that AARP encourage members to call Senator Nelson. As we also previously noted, AARP initiated messages, at our own determination, to the states of a number of key Senators, including Senator Nelson. We have conducted a search of email and other records and interviewed key AARP staff to ascertain whether there were any similar requests and we found none.

3. **Did Democratic operatives solicit money from AARP to fund the White House 501(c)(4) Healthy Economy Now "Super Pac"? If yes, please list the names of all operatives who made such solicitations and when those solicitations were made.**

Having determined that our goals aligned with Healthy Economy Now, AARP contributed to that organization to help advance our policy objectives. We have conducted a search of email and other records and interviewed key AARP staff to ascertain whether there was a solicitation for funds by any administration officials and found no indication of such a solicitation. Nicholas Baldick, director of Healthy Economy Now, solicited support for Healthy Economy Now on or about April 15, 2009.

4. **You mentioned in your July 13, 2012 letter that "AARP contributed money to several organizations as part of our advocacy efforts around passage of the ACA, during the 111th Congress." Please list the organizations AARP made contributions to as part of its efforts to pass the President's health care law in the 111th Congress – both those made during the 111th Congress and those made before the start of the 111th Congress.**

AARP discloses all the organizations to which it contributes funding for advocacy efforts as well as for other purposes in its annual Form 990 informational return filed with the Internal Revenue Services. Please see attached the relevant schedules for calendar years 2008, 2009, and 2010 (Exhibit 2).

5. **How many of the White House "top 25 targets from house leadership…to (be) thanked with ads" for voting in favor of the President's health care law did AARP thank with advertisements for their vote? Please list all members thanked, when**

those advertisements were run, and the type of advertisement used to thank each target.

The complete list of Members to whom AARP offered its public appreciation for their support of the ACA through "thank you" advertisements was attached to our previous response. All of the advertisements were newspaper advertisements for which the insertion orders were placed on November 13, 2009, except for two that were placed on November 18, 2009. Those two were the advertisement for Representative Pomeroy in the *Forum* (Fargo, North Dakota) and for Representative Connolly in the *News & Messenger* (Manassas, Virginia).

As previously noted, AARP often offers thanks to Members who support its positions after legislation is enacted. While the White House had its own view of whom should be thanked and that list certainly included some of the Members of Congress that AARP chose to acknowledge for their support, AARP determined whom it would thank through advertising.

6. **Please provide the specific questions and methodology AARP used to conclude that seniors supported the President's health care law? In addition, please include the numbers of respondents for each effort and what percentage of the total AARP membership they represented at the time.**

As explained in our previous response, AARP conducted significant qualitative and quantitative analysis of the views of AARP members and other Americans on key components of health care reform, including feedback through a variety of mechanisms, such as events at the state and local levels, polling and surveys, phone calls, and emails. This effort included the poll referenced in our July 13 letter: a nationwide survey of 1,003 members, which, according to the report, allows for generalization to AARP members age 50 and greater, with a margin of sampling error of ±3.1%.

Further, AARP's Public Policy Institute performed extensive research around what older Americans, including AARP members, needed from health care reform. All of this 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 and broadly supported both by research on the needs of older Americans and by input from older Americans themselves. The inclusion of legislative provisions addressing these principles and goals guided AARP's position on health care reform. In sum, AARP's support of health care reform cannot be explained solely by examining public opinion polls. Instead, this letter will provide a detailed discussion about our long path to supporting the health care reform including: (1) How AARP sets policy generally; (2) AARP's long history of studying health care issues and the need for comprehensive reform; and (3) Why, specifically, AARP endorsed the Affordable Care Act.

1. **AARP'S POLICY DEVELOPMENT PROCESS**

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. 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, are 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 what eventually became known as Medicare Part D – a program that includes prescription drug coverage in Medicare. 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.

Throughout the DWF campaign, it was always acknowledged that the individual groups might eventually part ways on the specifics of solutions. The hope was that agreement on the need for solutions would propel the conversation on health care reform to a critical point where action would be taken. DWF proved successful in making the case for the need for health care reform and moving the process forward.

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, they 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. While AARP continued to call for bipartisan support throughout the health care reform debate, we once

again chose to act in response to the identified health care needs of people age 50 and over, despite the 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+ —and a rejection of partisanship.

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

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 those in the 50+ population, 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. The ACA included the key policies that AARP determined would help 50+ Americans.

1. 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 (Exhibit 3). Contrary to popular belief, many uninsured 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 (Exhibit 4). 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 20s, Americans in their 50s and 60s represented the largest segment of uninsured low-income adults (Exhibit 5).

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 year-old Americans. But the Affordable Care Act included other provisions designed to increase access to health insurance, including the "individual mandate", which has the potential to greatly increase affordable access to coverage for 50-64 year-old 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 6). 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" the following health insurance reform proposal:

> "If you currently have health insurance, you could choose to keep it. If you do not have health insurance through your employer, you would be required to buy a health insurance policy from an insurance company or from a public program similar to Medicare. For those who could not afford to buy insurance, the government would help you pay some of the cost through a special fund set up for that purpose. Some of the money in this fund would be provided by a tax on employers who do not provide health insurance for their employees. Insurance companies would no longer be able to exclude people who have a history of illness."

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.

2. 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 (Exhibit 7). 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.

3. ***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* (Exhibit 8). 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 cost over $400,000 to prepare and took over 18 months to complete. 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-hospitalizations.

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***

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 9). 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 (Exhibit 10). Sadly, despite grants and other efforts by Center 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 (Exhibit 11). But more help from the federal government was needed. And relevant provisions of the ACA provided some of that help.

5. ***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 (Exhibit 12). The report found that use of biologic drugs is 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 (Exhibit 13).

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 other health insurers, would be substantial. The ACA included a pathway for the approval of generic biologics.

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

By the summer 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 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 (Exhibits 14 and 15). 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.

B. Research showed that members and others supported these policies.

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

We certainly do not suggest that all seniors supported the ACA. In the course of the health care reform debate, AARP received calls from both members and non-members expressing opposition to the ACA. Although the level of calls was significant, it was consistent with other instances in which AARP took leadership positions in high profile, contentious and partisan debates, including those that led to the creation of Medicare Part D in 2003 and our successful efforts in 2005 to prevent the diversion of Social Security funds to private accounts. 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 long-standing support for issues based on years of policy research and 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 over thirty-seven million people on every policy position we take. Notably, over 1.3 million AARP activists took actions in support of health care reform over the course of the 2009-10 legislative debate, including telephone calls, petitions, emails, text messages, faxes and letters to congressional offices – strong evidence of a broad base of support for the bill.

7. **To what extent did you educate seniors on concerns raised by the Medicare Actuary related to access problems caused by Medicare cuts in the law? Please provide**

specific examples of any AARP communications with its members that share or evaluate these repeated warnings.

AARP has consistently championed accessibility to health care providers for Medicare beneficiaries. We have long recognized that dramatic cuts in payments to health care providers could result in many providers choosing to no longer treat Medicare patients. At the same time, we acknowledged the need to find savings in our health care system, including Medicare, in order to improve Medicare's long term financial stability.

In this light, AARP reviewed the concerns raised by the Chief Actuary Richard S. Foster regarding health care reform, as we did when he raised concerns about President George W. Bush's proposal to create Medicare Part D. While Mr. Foster warned that reduced payments to health care providers could result in reduced access, he also indicated that this problem could be avoided with careful monitoring. And while he noted that such monitoring could result in lower savings than estimated in his memo, he also acknowledged that the complexity of health care reform meant that those estimates were "subject to a substantially greater degree of uncertainty than is usually the case with more routine health care proposals." See November 13, 2009 Memo from Chief Actuary Richard S. Foster.

Importantly, the associations representing the health care providers themselves, particularly the American Medical Association and the Federation of American Hospitals, continued to support reform despite Mr. Foster's concerns about payment reductions for exactly such providers. In direct response to Mr. Foster's November 13, 2009 memo, Charles "Chip" Kahn, president of the Federation of American Hospitals, issued the following statement:

> "Hospitals' commitment to our mission of serving the health care needs of seniors in communities across America is steadfast. A memorandum recently issued by the CMS Actuary analyzing the effects of "America's Affordable Health Choices Act of 2009" (H.R. 3962) concludes that some providers may end their participation in the Medicare program. Hospitals always will stand by senior citizens. This summer, hospitals agreed to contribute substantial Medicare savings as part of our shared sacrifice to reform health care and achieve near universal coverage for all Americans. We are pleased with the legislative progress as well as the movement towards market-based solutions. And we look forward to working with Congress and the Administration to enact legislation that will enable hospitals to continue to provide our patients, including seniors, with ready access to the highest quality health care possible."

During the health care debate, we issued numerous public statements and repeatedly urged Congress to prevent arbitrary cuts to physicians (Exhibit 16). Since the enactment of health care reform, AARP has continued to advocate actively on access issues, including issuing statements (Exhibit 17), and we will persist in our efforts to ensure that those in Medicare continue to have access to high quality health care providers.

8. Please provide specific examples of AARP communications with its members and Congressional Democrats (before enactment of the 2010 health law) expressing AARP's concern that the Independent Payment Advisory Board could have "a negative impact on access to care." Before endorsing the provision, did AARP offer any legislative solutions to eliminate this existing concern?

AARP publicly expressed concerns about the Independent Payment Advisory Board (IPAB) before enactment of the Affordable Care Act. On December 8, 2009, AARP issued a press release (attached as Exhibit 18) supporting a proposal to ensure that all health care costs would be addressed by any new board instead of focusing solely on Medicare:

> "It is critical that any legislation strengthens Medicare and does not weaken it. These amendments help make sure that as we fix our troubled health care system that Medicare remains a vibrant option for the millions who rely on it. Therefore, the Board's scope must be expanded to look at total health spending so we can make health care affordable for all Americans."
> AARP Executive Vice President Nancy LeaMond, "AARP Supports Freshman Senators' Amendments to Lower Health Care Costs."

On January 6, 2010, AARP CEO Barry Rand sent a letter to Senator Reid and Speaker Pelosi expressing support and concern regarding various aspects of health care reform including AARP's opposition to the Senate bill's provision on IPAB (Exhibit 19):

> "[W]e do not support approaches, such as those suggested in the Senate's proposed Independent Payment Advisory Board, that rely too heavily on the Medicare program to achieve cost-containment objectives. Specifically, we are opposed to the Medicare savings targets for 2020 and beyond, which would need to be met every other year even if Medicare growth does not exceed inflation growth. AARP believes the health care system, including Medicare, is inextricably linked, and if we are to truly solve the health care cost crisis for our children and grandchildren, we must consider public and private sector costs simultaneously."

AARP also issued an accompanying press release on the same date highlighting AARP's opposition to the Senate's IPAB provision (Exhibit 20). All of our statements and press releases were made publicly available on our website.

In addition to access concerns, during consideration of the legislation, AARP advocated to protect beneficiaries from higher costs. AARP urged Congress to include consumer protections that would prohibit benefit reductions or increases in seniors' already high out of pocket costs, eventually enacted as part of IPAB.

9. Does AARP believe the law's prohibition against "rationing" care would fully protect seniors from dangerous cuts under IPAB's mandatory spending targets? If not, please provide a list of instances when AARP expressed this concern to the White House and House and Senate leaders.

After enactment of the ACA, which included the establishment of IPAB, AARP continued to examine IPAB provisions and publicly express concerns about their implementation.

In order to consider the potential impacts of IPAB further, on December 17, 2010, AARP's Public Policy Institute held a roundtable on issues related to IPAB, focusing on three main areas: (1) the implications of the savings targets for growth in the Medicare program; (2) the IPAB process for developing recommendations and implementing mandated spending cuts to the program; and (3) the potential for using IPAB to transform delivery and payment in the Medicare program.

As proposals to implement and even expand IPAB's role were discussed in the spring of 2011, AARP consistently expressed our concerns to Congress. On April 27, 2011, AARP submitted testimony before the Senate Special Committee on Aging hearing on "Protecting the Promise to Our Seniors: Social Security, Medicare, and the Older Americans Act," criticizing the Obama Administration for proposing an expansion of IPAB's authority:

> "President Obama recently suggested that the Independent Payment Advisory Board (IPAB), established under the new law, be expanded. AARP agrees with many of the Independent Payment Advisory Board's original goals -- extending Medicare solvency, slowing cost-growth and improving quality without reducing benefits or increasing cost-sharing for people in Medicare. However, we remain concerned about the spending targets the IPAB must meet in its second ten years and the unintended impact these savings targets might have on beneficiaries' access to or quality of care. We would have strong concerns with expanding the role of this unelected, unaccountable board. We will carefully monitor how these proposals move forward to ensure that Medicare is protected and strengthened for the millions of people who depend upon it."

On May 4, 2011, AARP submitted a Statement for the Record to a Senate Finance Committee hearing on Budget Enforcement Mechanisms drawing attention to IPAB's potential impact on access to care:

> "The new law already includes an Independent Payment Advisory Board (IPAB) which, although it contains some important consumer protections, could potentially trigger cuts that may impact seniors' access to care. During the health care debate, AARP raised concerns about the arbitrary IPAB targets, and the role of an unelected and unaccountable board. We have also continued to point out the shortcoming of any strategy that singles out Medicare instead of targeting waste, inefficiency and delivery system reform throughout the health care system.
>
> While IPAB is charged with looking at access and provider payment policies in the broader context of health system trends, we remain extremely concerned expanding IPAB could have a negative impact on Medicare beneficiaries' access to care. We do, however, strongly urge Congress to maintain the consumer protections supported by AARP – including prohibitions on cutting benefits, raising seniors' already high out of pocket costs, and rationing care -- enacted as part of IPAB."

AARP also issued a press release on same date highlighting concerns about IPAB (Exhibit 21).

On June 23, 2011, AARP submitted a Statement for the Record to the Senate Finance Committee hearing "Health Care Entitlements: The Road Forward":

> "The new law also includes an Independent Payment Advisory Board (IPAB) which, although it contains some important consumer protections, could potentially trigger cuts that may impact seniors' access to care. During the health care debate, AARP raised concerns about the arbitrary IPAB targets, and the role of an unelected and unaccountable board. We have also continued to point out the shortcoming of any strategy that singles out Medicare instead of targeting waste, inefficiency and delivery system reform throughout the health care system.
>
> While IPAB is charged with looking at access and provider payment policies in the broader context of health system trends, we remain extremely concerned expanding IPAB could have a negative impact on Medicare beneficiaries' access to care. We do, however, strongly urge Congress to maintain the consumer protections supported by AARP – including prohibitions on cutting benefits, raising seniors' already high out of pocket costs, and rationing care – enacted as part of IPAB."

On July 1, 2011, AARP submitted and the *Boston Globe* published a letter to the editor expressing concerns about IPAB:

> "While we remain concerned that over the longer term the board could have a negative impact on access to care, we do strongly urge Congress to maintain the consumer protections supported by AARP, including prohibitions on cutting benefits, raising seniors' out-of-pocket costs, and rationing care. The protections we fought for would help safeguard the critical benefits that seniors have earned through a lifetime of hard work. However, we will remain vigilant to protect against any proposal, including proposals to cap or arbitrarily cut Medicare, that would harm access or roll back these important consumer protections. "
> David Certner, AARP Legislative Policy Director, "AARP has serious concerns about advisory board."

AARP's persistent drumbeat on IPAB received significant media attention as well, including in the *New York Times*, Associated Press, and Fox News.

We hope this information is helpful and answers your questions.

Sincerely,

Robert G. Romasco

Robert G. Romasco
President

Attachments

cc: A. Barry Rand

List of Exhibits

Exhibit 1 – July 13, 2012 letter from AARP to Senators Barrasso and Coburn and Representatives Boustany and Gingrey
Exhibit 2 – AARP Forms 990, Schedule I, for 2008, 2009, 2010
Exhibit 3 – *Data Digest: Health Coverage among 50- to 64-Year-Olds*, AARP Public Policy Institute, May 2007
Exhibit 4 – *Health Care Reform: What's at Stake for 50- to 64-Year-Olds*, AARP Public Policy Institute, March 2009
Exhibit 5 – *Millions of Americans Can't Get Medicaid: What Can Be Done?*, AARP Public Policy Institute, September 2008
Exhibit 6 – 2007 AARP National Policy Book (excerpt)
Exhibit 7 – *Closing the "Doughnut Hole" Will Help Protect Over One-Third of Medicare Beneficiaries from High Drug Costs*, AARP Public Policy Institute, 2009
Exhibit 8 – *Beyond 50: Chronic Care; A Call to Action for Health Reform*, AARP Public Policy Institute, March 2009
Exhibit 9 –*Healthy at Home*, AARP Foundation, March 2008
Exhibit 10 – *A Balancing Act: State Long-Term Care Reform*, AARP Public Policy Institute, July 2008
Exhibit 11 –*Taking the Long View: Investing in Medicaid HCBS is Cost-Effective*, AARP Public Policy Institute, March 2009
Exhibit 12 – *Strategies to Increase Generic Utilization and Associated Savings*, AARP Public Policy Institute, December 2008
Exhibit 13 – *Biologics in Perspective: The Case For Generic Biologic Drugs*, AARP Public Policy Institute, May 2009
Exhibit 14 – Testimony of AARP Board Member Joyce Payne, Ed.D. before the House Ways & Means Committee, May 2007
Exhibit 15 – Testimony of AARP Board Member Joyce Payne, Ed.D. before the House Energy & Commerce Committee, May 2007
Exhibit 16 – Examples of AARP's public statements urging Congress to prevent arbitrary cuts to physicians
Exhibit 17 – Examples of AARP's public statements on ensuring access to health care providers for Medicare beneficiaries
Exhibit 18 – *AARP Supports Freshman Senators' Amendments to Lower Health Care Costs*, December 8, 2009
Exhibit 19 – Letter to Leader Reid and Speaker Pelosi, January 6, 2010
Exhibit 20 – *AARP Letter to Congress Outlines Critical Health Care Reform Priorities*, January 6, 2010
Exhibit 21 – *AARP Urges Finance Committee to Consider Impact on Seniors During Deficit Debate*, May 4, 2011