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October 11, 2012

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Cliff Stearns
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Joseph Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Michael C. Burgess
Vice Chairman
Subcommittee on Health
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Upton, Chairman Stearns, Chairman Pitts, and Vice Chairman Burgess:

I am writing in response to your letter of September 20, 2012. I 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 and in 2012, I became the volunteer president of AARP.

As someone who has dedicated countless hours to helping AARP carry out its vital mission, I believe that your suggestion that AARP supported health care reform for partisan purposes is completely unfounded. AARP worked closely with the Administration – as we did with Members of Congress and the dozens of like-minded advocacy organizations and associations who also supported reform – to ensure that any legislation would benefit our members and all 50+ Americans.

AARP never makes decisions based on the political needs of any candidate or party. In fact, we worked just as closely with the Bush Administration to enact what eventually became known as Medicare Part D – a program that includes prescription drug coverage in Medicare.

As this letter will make clear, AARP's motivation has always been a desire to improve the quality and accessibility of health care for older Americans. This letter will provide a detailed discussion about our long path to supporting the ACA, including explanations of:

1. AARP's procedure for establishing Association policies;
2. AARP's track record of advocating for health care reform;
3. AARP's decision to endorse the ACA; and
4. How AARP and 1.3 million of our members and volunteers advocated for key provisions of the ACA that substantially benefit Americans 50+, including 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,

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. 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.

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 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

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 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 (attached as Exhibit 1). 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 (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 has the potential 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" 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 (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.

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* (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 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-hospitalization.

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 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 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 (attached as Exhibit 9). 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 (attached as Exhibit 10). 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 (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 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 (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.

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

4. AARP FOUGHT FOR COMPREHENSIVE HEALTH CARE REFORM

When health care reform moved forward in 2009, AARP knew that it had to be actively engaged in the debate to ensure that policies to benefit those age 50 and over were part of the final legislation. As a result, AARP aggressively engaged in advocacy activities with both the

legislative and the executive branches, and worked closely with other like-minded groups and associations. As we have on other issues throughout our history, AARP utilized an internally-developed, comprehensive strategy, with frequently updated day-to-day tactics, to work toward passage of health care reform that addressed the key priorities of AARP members and all older Americans.

Of course, AARP's greatest strength as an advocacy organization is our millions of grassroots activists who dedicate their time and energy to vital causes affecting 50+ Americans. Over the course of the 2009-2010 legislative debate on health care reform, over 1.3 million AARP grassroots activists took a total of nearly three million actions in support of reform, including telephone calls, petitions, emails, text messages, faxes and letters to congressional offices.

In addition, AARP's staff participated in many meetings with Members of Congress of both parties, congressional staff, and administration staff. Our employees explained AARP's policies and views on multifaceted and complex legislation and made certain that AARP's six core policy goals were included in the final health care reform legislation.

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.

Contrary to the implications in your letter, the volunteers serving on our 25-member National Policy Council and our 22-member Board of Directors were intimately involved in AARP's long road to supporting the ACA. I know because I served on our Board of Directors at that time. My board colleagues who represent almost every walk of life imaginable – academics, advocates, businesspeople, medical professionals, Democrats, Republicans and independents – were well informed and deeply involved in this decision. We determined that once the Affordable Care Act included AARP's priorities, it represented an historic opportunity for true health care reform that would benefit our members and other 50+ Americans.

Sincerely,

Robert G. Romasco

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