



January 23, 2018

The Honorable Mick Mulvaney
Director
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

RE: FY 2018 Budget Priorities

Dear Director Mulvaney:

As the largest nonprofit, nonpartisan organization representing the interests of Americans age 50 and older and their families, AARP respectfully urges the Administration to support and strengthen policies and programs important to older Americans. While the following addresses AARP's priorities and most immediate concerns, we have additional discretionary and mandatory spending concerns that will be more fully addressed as the FY 2018 and 2019 budget processes unfold over the next few days and months.

MEDICARE

Our members and other older Americans believe that Medicare must be protected and strengthened for today's seniors and future generations. The typical senior, with an annual income of under \$26,200, already spends one out of every six dollars on health care and counts on Medicare for access to affordable health coverage.

Medicare remains financially sound, and dire predictions about its insolvency are unfounded. The 2017 Medicare Trustees report extended its projection of the Part A Hospital Insurance Trust Fund's ability to pay full benefits to 2029, and Medicare spending continues to grow more slowly than private insurance spending. Our health care system can of course continue to improve the quality and value of care delivered. We are committed to finding ways to responsibly reduce spending without harming beneficiaries or radically overhauling the Medicare program that millions of Americans depend upon and expect to be there when they need it.

We will continue to oppose changes to current law that cut benefits, increase costs, or reduce coverage for older Americans, including efforts to undermine the guaranteed benefit structure of Medicare or turn it into a voucher-type program. Proposals to turn Medicare into a defined contribution system –often called premium support –may claim to reduce federal spending, but they do so by dramatically shifting costs to beneficiaries, not by reducing the cost of health care. Any additional cost-shift or reduction in coverage will negatively affect many beneficiaries' pocketbooks and ability to get care. Based on previous iterations of the

proposal, the value of the proposed voucher would be tied to a general economic index, instead of actual health costs that tend to rise faster than other costs. The price of plans, therefore, would likely increase faster than the value of the voucher, pricing seniors out of the plan they chose (that may include their doctor), or forcing them to pay the premium or cost-sharing difference out of their own pockets. Furthermore, the premium support system would inevitably raise premiums and co-pays for people who stay in the traditional Medicare program. Over time, private plans would likely attract healthier and wealthier beneficiaries, weakening the traditional Medicare risk pool.

We urge the Administration to focus instead on responsible solutions that will actually reduce health care costs. These include: better care coordination for high-cost beneficiaries with chronic conditions; investing in home and community-based services to help keep people out of costly institutional settings; lowering brand name prescription drug costs; and using technology to make it easier for consumers and family caregivers to access care and adhere to care plans. Furthermore, we support efforts to reduce health care costs through payment and delivery system reforms designed to improve quality and make Medicare more efficient. We also strongly support maintaining Medicare improvements such as cost-free access to preventive benefits and additional steps to crack down on fraud, waste, and abuse.

We also urge improvements in Medicare's low-income programs, such as raising asset limits that penalize people who did the right thing by saving a small nest egg for retirement, as well as ensuring assignment to prescription drug plans that meet their needs. In addition, we continue to oppose freezing Part B and Part D income-related premium thresholds, which penalize both work and savings, and we urge that the thresholds be indexed.

MEDICAID AND LONG-TERM SERVICES AND SUPPORTS

Medicaid is a vital safety net and intergenerational lifeline for millions of individuals, including more than 17 million seniors and children and adults with disabilities who rely on the program for critical health care and long-term services and supports (LTSS) (e.g., assistance with daily activities such as eating, bathing, dressing, managing medications, and transportation). Today, older adults and people with disabilities account for approximately 60% of Medicaid spending. Funding cuts will result in loss of coverage, benefits, and services for this vulnerable population.

AARP continues to oppose Medicaid per capita cap and block grant funding proposals because such changes would endanger the health, safety, and care of millions of people who depend on the essential services provided through Medicaid. A fixed federal funding structure, either by person or for a category of people, would likely result in significant and overwhelming shifts in costs to states, state taxpayers, and families unable to shoulder the costs of care without sufficient federal support. Most states are ill equipped to respond to this shortfall of funds. These changes would result in cuts to program eligibility, services, or both, ultimately harming some of our nation's most vulnerable citizens, including those receiving assistance to live in their homes and communities, nursing home residents, and those who rely on Medicaid for other essential benefits.

We have serious concerns about setting caps when per-beneficiary spending for low-income seniors will likely increase in future years. For example, by 2026, the Boomer generation will be in their 80's, and they will likely need higher levels of service including home and community-based services (HCBS) and/or nursing home care. This will move them into the highest cost group of all seniors. In addition, caps would not accurately reflect the cost of care in each state, particularly for seniors and people with disabilities. This problem would compound over time, putting more pressure on states to make harmful cuts.

Instead, AARP encourages the Administration and Congress to address Medicaid's longstanding bias toward institutional care. It is time to update the law to better reflect where and how people want to receive services. We recommend that states be given the ability to use Medicaid dollars for HCBS without having to request permission from the federal government through a waiver. HCBS are far more cost effective compared to institutional care. For every person in a nursing home, states could serve three people in their homes and communities, where they want to be.

In addition, the ACA provided states with new options and enhancements to provide HCBS. We urge that any changes to current law retain and enhance provisions that enable more individuals to receive services in their homes and communities rather than costly institutional care. Finally, AARP continues to oppose Medicaid policies that would limit access to critical health services and supports, including lifetime limits on coverage, enrollment caps, burdensome work and cost-sharing requirements, and the elimination of presumptive and retroactive eligibility.

PRESCRIPTION DRUGS

Older Americans use prescription drugs more than any other segment of the U.S. population, typically on a chronic basis. Affordable medications are critical to manage their chronic conditions, cure diseases, keep them healthy and improve their quality of life.

In 2015, retail prices for brand name prescription drugs widely used by older Americans increased by an average of 15.5% compared to the general inflation rate of 0.1%. The average cost of a single specialty drug is \$52,486 –more than twice the median income of Medicare beneficiaries and more than three times the average Social Security retirement benefit.

We urge the Administration to take action to help Medicare enrollees with high drug costs. For example, we support allowing the Secretary of Health and Human Services to negotiate drug prices on behalf of millions of Medicare beneficiaries. We support the safe importation of prescription drugs and believe the Administration should use its existing authority to allow importation, similar to actions taken in the past during shortages of critical prescription drugs. In those cases, the FDA identified the product, evaluated it and its manufacturing chain for quality and safety, and ensured that the manufacturer is willing and able to import the drug. Furthermore, drug manufacturers should be required to provide Medicare Part D Low-Income Subsidy beneficiaries with the same rebates and discounts that Medicaid receives for prescription drugs.

Congress and the Administration should also work to lower prescription drug costs by implementing policies that will foster competition and allow less expensive alternatives to come to market as soon as possible. Accordingly, we support reducing the period of exclusivity afforded to biologics from twelve years to seven years. Longer waits for less expensive versions of biologics, known as biosimilars, cost both taxpayers and consumers billions of dollars and may force consumers to forgo needed drugs due to high costs. AARP also supports efforts to end pay-for-delay agreements and end abuses of Risk Evaluation and Mitigation Strategies (REMS) that stifle the production of generic drugs. We are also concerned with practices such as “evergreening” which enables brand-name drug manufacturers to extend patent protection or market exclusivity with only marginal improvements to an existing drug. We urge the Administration to restrict such practices, granting additional market exclusivity in extremely limited circumstances for innovations that fill an unmet medical need and substantially improve existing therapies.

Moreover, we support efforts to increase transparency in the pharmaceutical market. Doing so will enable us to better understand why drugs are priced so high when they come to market and why those prices increase over time. We encourage the Administration to collect and make public information related to what drug companies spend on “true” drug development, not including activities conducted by public entities such as the National Institute of Health or by other companies later acquired.

PRIVATE INSURANCE MARKET

Critical protections, including the prohibition on insurances overcharging older Americans because of their age, help keep coverage affordable for Americans aged 50-64+. The existing 3:1 age rating, already a compromise that requires older Americans to pay three times more than younger individuals for the same coverage, must be retained and protected. Prior to enactment of the ACA, many insurers were permitted to charge older Americans five times or more than what others paid for the same insurance. We strongly oppose any efforts to impose what amounts to an age tax on older Americans, including any changes to the current 3:1 age rating or change in available tax credits based on income.

In addition to limits on age rating, a strong combination of insurance market reforms, broad risk-pooling, restrictions on gender discrimination, and cost-sharing limits are needed to ensure that coverage is affordable and accessible. We strongly support maintaining existing insurance market rules relating to guaranteed issue and prohibitions on pre-existing condition exclusions. We also believe that the ban on annual and lifetime limits and allowing children to stay on their families’ policy until age 26 are essential.

We are very concerned about recent Administration and legislative actions that could increase costs and reduce coverage for millions of Americans, including older Americans who purchase coverage on the individual market. According to the Congressional Budget Office (CBO), the recent repeal of the ACA’s individual mandate will lead to millions more uninsured and premium increases of at least 10%. According to an AARP analysis, that means annual premiums for 64-year-olds in the individual market could increase by an average of \$1,490.

We strongly urge the Administration and Congress to work together on bipartisan policies that can help stabilize the individual insurance market.

MEDICAL EXPENSE DEDUCTION

We applaud recent Congressional action that returns the medical expense itemized deduction threshold from 10% to 7.5% of adjusted gross income. The tax increase caused by the higher threshold fell disproportionately on the old and the sick -- even those at moderate-income levels -- especially since the deduction provides help to those with large medical costs that often include expensive long-term care costs. Since the lower 7.5% threshold is only in place through 2018, we strongly support legislation to make the 7.5% threshold permanent.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Millions of older Americans, as well as low-income families, people with disabilities, and active duty military and veterans participate in SNAP -- a vital nutrition safety net that maintains their health and well-being. Older Americans who rely on SNAP have low, fixed incomes and often have high medical costs. SNAP can mean the difference between aging at home or going into a nursing home, something that would shift more costs onto the health care system and taxpayers. Recent proposals to cut billions of dollars from SNAP, reduce access to benefits and shift costs onto states would be detrimental to millions of hungry Americans, including more than 4 million older Americans who rely on the program. We urge the Administration and Congress to work together on a bipartisan basis to protect and strengthen SNAP in the Farm Bill reauthorization.

DISCRETIONARY PRIORITIES

AARP remains deeply concerned about the FY 2018 Administration request that proposes elimination or deep reductions in safety net programs important to older Americans. We are grateful that the Appropriations Committees have thus far rejected these proposals, but we urge additional funding to account for rapid growth in the number of seniors requiring assistance.

Low Income Home Energy Assistance (LIHEAP)

Low Income Home Energy Assistance (LIHEAP) effectively and efficiently provides much-needed energy assistance for 6.1 million American households suffering short-term financial difficulties due to illness, job loss or other unanticipated expenses. 70% of these households include at least one member who is elderly, disabled, or a child under the age of six. AARP urges full funding for LIHEAP.

Legal Services Corporation (LSC)

The Legal Services Corporation (LSC) helps provide the elderly and people with disabilities with legal representation, information, counseling, and education in civil legal matters. In

2014, 16% of the clients served by LSC grantees were age 60 and older. And, nearly one in five (18%) of those eligible for LSC-funded services are persons with disabilities. LSC grantees assisted an estimated 190,000 seniors and their family members with legal issues related to predatory lending and consumer fraud, access to affordable housing, and necessary medical care. The current funding is inadequate to meet the legal needs of the poor. A recent study has shown that 80% of the civil legal needs of the eligible population are still not being met. AARP urges no less than \$400 million for the LSC.

Title III Core Services (Older Americans Act)

More people are living to be 85+ than ever before. Many of these older adults face economic and health challenges that make them more likely to need long-term services and supports (LTSS) to live independently. Four out of every five older adults have multiple chronic conditions. Nearly four million adults over the age of 65 live in poverty and at least one in seven seniors, or more than 8.3 million, struggle with hunger.

AARP supports the Older Americans Act (OAA) Title III programs that help older adults maintain their health and live independently. Title III provides services such as: home care, congregate and home-delivered meals, case management, family caregiver support, transportation, adult day care, legal services, elder abuse prevention, and job training and employment opportunities for low-income older adults.

Supportive Services

The supportive services of the OAA, Title III, Part B, provide the bedrock of long-term services and supports that help older adults maintain their independence and dignity in the less costly environments of their homes and communities where they want to live. OAA supportive services can also help delay or prevent the need for individuals to receive Medicaid LTSS. Investing more in home-based supports will prevent unnecessary nursing home placement and poor management of nutritional and chronic health conditions. AARP urges no less than current funding levels for Title III supportive services.

Nutrition Programs

People receiving OAA services are at higher risk of nursing home placement than others in their age group. Without cost-effective intervention, institutional care costs will increase. A 2012 Brown University statistical analysis of 16,000 nursing homes concluded that states spending an additional \$25 per year per adult aged 65 and older on home-delivered meals could reduce their percentage of low-care nursing home residents by one percentage point, compared to the national average. And, cost data from home-delivered meal providers shows that they can feed a senior for an entire year for what the same cost as a single day in the hospital. AARP urges no less than \$900 million for Title III nutrition programs.

Family Caregiver Programs

About 40 million family caregivers provide about \$470 billion annually in unpaid care to their loved ones. Family caregivers assist with tasks, such as eating, bathing, dressing, transportation, medical/nursing tasks, managing finances, and care coordination. Our country relies on the contributions family caregivers make and should recognize and support them. Family caregivers often need information about the best ways to help their loved one live at home or in the community. Aging and Disability Resource Centers (ADRCs) provide streamlined access for consumers and family caregivers seeking one-on-one person-centered counseling as well as information and referral assistance about public and private options for LTSS. We request that you include sufficient funds for ADRCs to address their needs.

The National Family Caregiver Support Program and Lifespan Respite Care Program provide vital support to family caregivers. By 2020, it is projected that there will be 17.8 million non-institutionalized seniors age 65 and over with one or more limitations in daily activities. This represents an increase of 3.2 million seniors (or 22% between 2014 and 2020) needing caregiver assistance. AARP recommends no less than \$154 million for FY 2018 for the program.

Senior Community Service Employment Program (SCSEP)

SCSEP is unique in that it has a dual purpose: it is the only program to focus on building skills and employment opportunities for low-income older workers while also enhancing important community services. Through SCSEP, the dignity of older Americans is enhanced, poverty is alleviated, and the program shows that low-income older workers can meet employer needs for in-demand jobs. The most recent data shows that in FY2015 SCSEP, provided jobs and training for 65,170 economically disadvantaged older adults who in turn provided over 35 million hours of community service to private nonprofit agencies across the country. Of these participants, 10,456 were placed in unsubsidized employment and their community service was valued at more than \$300 million. AARP urges restoration of SCSEP funding to the pre-2008 level of \$600 million.

Social Security Administration (SSA) Operating Minimum Requirements

The Social Security Administration cannot maintain customer service levels with existing funding. Beneficiaries currently report significant dissatisfaction with reduced field office hours and inexcusable phone waiting times if they are able to get through at all. In FY2015, more than 3.5 million callers reported being unable to get through to a customer service representative. In addition, the average processing time for cases involving hearing requests exceeds 540 days, which is more than twice SSA's own target goal of 270 days. At a minimum, SSA requires an additional \$320 million annually to cover increases in fixed costs. AARP estimates that \$13.4 billion is required for FY 2018 to enable SSA to restore customer service levels to acceptable standards.

Over the next decade, nearly 18 million Boomers will reach traditional retirement age, and the number of beneficiaries of SSA's three federal programs is expected to increase from 64.8 million in FY 2015 to 66.5 million in FY 2016 and 68.4 million in FY 2017. AARP respectfully submits that the Administration's FY 2018 budget blueprint for SSA is inadequate to correct long-standing deficiencies and alarming trends in customer service and other areas. Without a higher level of funding, SSA will be unable to fulfill its core mission of delivering Social Security services in a way that meets changing needs.

Conclusion

In conclusion, AARP greatly appreciates the opportunity to comment on these programs of great importance to older Americans. Should you have any questions regarding these priorities, please do not hesitate to contact me or Joyce Rogers, Senior Vice President for AARP Government Affairs at (202) 434-3750.

Sincerely,

A handwritten signature in black ink that reads "Jo Ann C. Jenkins". The signature is written in a cursive style with a large, looped initial "J".

Jo Ann C. Jenkins
Chief Executive Officer