March 1, 2019

The Honorable Lamar Alexander  
Chairman  
Committee on Health, Education, Labor, and Pensions  
United States Senate  
Washington, DC 20510

The Honorable Patty Murray  
Ranking Member  
Committee on Health, Education, Labor, and Pensions  
United States Senate  
Washington, DC 20510

Dear Chairman Alexander and Ranking Member Murray:

On behalf of AARP’s nearly 38 million members, thank you for the opportunity to offer recommendations to help address America’s rising health care costs. With members in all 50 States, the District of Columbia, and the U.S. territories, AARP is a nonpartisan, nonprofit, nationwide organization that helps empower people to choose how they live as they age, strengthens communities, and fights for the issues that matter most to families, such as health care, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP shares your desire to reduce overall health care spending, particularly by addressing the costs of health care goods and services. Reducing overall health spending should not come from shifting costs onto consumers, diminishing quality, or restricting access to needed care. Instead, Congress must focus on the prices charged to consumers and the inefficiencies in delivering care. Below, we offer several suggestions for reducing spending without jeopardizing the health and well-being of individuals and their families.

**Reducing Prescription Drug Prices**

The rising cost of prescription drugs is a key priority for most Americans, particularly those age 65 and older. Older Americans use prescription drugs more than any other segment of the U.S. population. In fact, Medicare Part D enrollees take an average of 4.5 prescriptions per month, and over two-thirds have two or more concurrent chronic illnesses. However, older Americans continue to struggle to afford the drugs they need. Most Medicare beneficiaries live on modest incomes, with an annual median of just over $26,000. One-quarter have incomes of just over $15,000. One-quarter have less than
$15,000 in savings. Unfortunately, older Americans and many others simply do not have the resources to absorb rapidly escalating prescription drug prices, and are often unable to afford the medications they need.

AARP has been tracking the prices of widely-used prescription drugs since 2004. Our most recent Rx Price Watch Report focused on brand-name drugs and found that their retail prices increased by an average of 8.4 percent in 2017 – four times the rate of inflation. AARP’s report also examined how drug companies’ relentless price increases add up over time and found that the average annual cost of one brand-name drug – now around $6,800 – would have been just under $2,200 in 2017 if retail price changes had been limited to general inflation between 2006 and 2017. The average annual price increases for brand name drugs have exceeded the corresponding rate of inflation every year since at least 2006. More importantly, this problem goes beyond a few bad actors: virtually all of the manufacturers we track raise their prices every single year.

AARP supports a number of reforms aimed at lowering prescription drug prices and costs. We strongly believe that it is critical that any proposals to lower prescription drug costs do not simply shift the costs around in the health care system without addressing the root problem: the prices set by pharmaceutical companies. To that end, AARP supports efforts to encourage generic competition, such as the bipartisan Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act (S.340/ H.R.965), which would combat certain anticompetitive practices used by some brand-name pharmaceutical companies to block market entry of lower-cost generic drugs. We also support bipartisan measures that would ban pay-for-delay deals. Finally, AARP supports efforts to reduce the exclusivity periods awarded to biologics, which often have some of the highest prices of any drugs on the market.

In addition, AARP has long supported providing the Secretary of Health and Human Services (HHS) with the authority to negotiate lower prescription drug prices. With more than 40 million beneficiaries in Medicare Part D, there is no reason for the federal government not to use purchasing power to negotiate for lower prescription drug prices.

We also support reforming the problematic Part B payment methodology for prescription drugs to incentivize the use of lower-cost drugs and reduce out-of-pocket costs for consumers. The current Part B payment methodology does not provide Medicare with adequate leverage to address escalating prescription drug prices and protect consumers. While more definitive study is needed, the likelihood that the current methodology is influencing providers to use more expensive drugs over less expensive alternatives is reason enough to warrant change.

Above all, we support efforts to lower out-of-pocket costs, but believe reforms in this area need to be coupled with other efforts targeted at lowering the list price set by drug manufacturers. We need to remove costs from the system rather than simply shift costs around. Simply put, current prescription drug price trends are not sustainable. High and

growing drug prices are affecting all Americans in some way. Their cost is passed along to everyone with health coverage through increased health care premiums, deductibles, and other forms of cost-sharing. They are also driving larger spending increases for a variety of taxpayer-funded programs. Meanwhile, drug companies are working very hard to try to shift the blame to others in the health care system, leaving them free to set incredibly high prices and increase them with little restraint.

It is long past time for Congress to take action to rein in high drug prices. Thoughtful bipartisan efforts to help reduce prescription drug prices could save tens of billions of dollars for patients, taxpayers, and the U.S. health care system. More importantly, it will help ensure that all Americans have affordable access to the drugs that they need to get and stay healthy.

**Aging in the Community**

The American health care system often emphasizes acute care or institutional care settings when prevention and management, or community-based care, would provide more value to the consumer. Receiving care in the setting that best suits their needs and wishes can not only improve the individual’s care experience, but can lower their costs as well. Because Medicare is the largest health care payer, its policy changes drive changes throughout the health care system. We recommend Congress make improvements to Medicare to spur change among other payers and sectors of the health care system.

For instance, we urge Congress and the Administration to expand the Independence at Home Demonstration to be a permanent program in Medicare, such as in the *Independence at Home Act of 2017* (S. 464 in the 115th Congress). AARP has long been a supporter of the Independence at Home (IAH) program. This interdisciplinary approach to care leverages the expertise of an array of health care and social service providers to better deliver and coordinate care to Medicare beneficiaries with multiple chronic conditions who need help with daily activities and have high costs. These home-based primary care teams provide access to care 24 hours a day, 7 days a week. They provide care at home, where people want to be, saving the time, difficulties, and stress that getting to multiple doctors’ appointments can entail for those on Medicare and their family caregivers. Importantly, this model of care also recognizes and supports family caregivers and the vital role they play in providing and coordinating care for their loved ones.

We are pleased that IAH has shown not only improved quality of care, but has also produced cost savings in each of the first three performance years. Whether avoiding unnecessary hospital stays, ensuring appropriate use of medications, or better coordinating care, IAH benefits Medicare beneficiaries, their families, and providers, as well as Medicare. Expanding IAH would improve the quality of care and provide person- and family-centered care to more Medicare beneficiaries. Congress and the Administration could expand IAH and make it a permanent part of Medicare by amending the law as in S. 464, or possibly do so administratively.
Furthermore, AARP recommends Congress pass the *Home Health Care Planning Improvement Act* (S. 296) which would authorize nurse practitioners, clinical nurse specialists, certified nurse-midwives and physician assistants as eligible health care professionals who can certify patient eligibility for home health care services under Medicare. This bill would allow advanced practice registered nurses (APRNs), the group which currently manages the significant majority of skilled care,\(^2\) to certify Medicare patients for home health benefits. This critical change would improve access to important home health care services, including in rural and frontier areas, and potentially prevent additional hospital, sub-acute care facility and nursing home admissions – all of which are costly to the consumer, the taxpayer, and Medicare.

Health care costs can also be reduced by maintaining health and preventing illness. Key to this is ensuring all Americans have access to proper nutrition. Protecting older Americans from food insecurity is a priority for AARP, and keeping people healthier is one of the most effective ways to reduce health care costs. The Older Americans Act (OAA) Title III-C nutrition services program plays an important role in reducing hunger and food insecurity, and promoting socialization, health and well-being, by providing nutritious meals. A 2018 report contracted by the Administration for Community Living (ACL) found that congregate meal program participants had lower health care expenditures and were more able to remain living in their home compared with non-participants. Cost data from home-delivered meal providers shows that they can feed a senior for an entire year for the same cost as one day in a hospital or 10 days in a nursing home. Many program recipients receive one or more OAA services and collectively these services help to keep older adults in their homes—90 percent receiving home-delivered meals and 61 percent participating in group meals reported that these services helped them continue living at home, which is generally a less costly environment.

Yet, many low-income older adults who likely need meals do not receive them, according to a U.S. Government Accountability Office (GAO) report.\(^3\) Due to economic constraints, 6.7 million Americans ages 60 and older are food insecure or very low food secure. Seniors that do not have access to enough food have lower nutrient intakes and worse health outcomes. Providing a greater investment in the nutrition programs can enable more seniors to remain at home and in better health, avoiding costlier services.

Similarly, the Supplemental Nutrition Assistance Program (SNAP) – the nation’s largest federal nutrition program – is an important safety net for all Americans, particularly adults ages 50 and older. According to AARP’s Public Policy Institute, 8.7 million SNAP households (over 40 percent) had at least one adult aged 50 or older in 2016. SNAP is especially important for older Americans because many face challenges to employment or live on fixed incomes and, therefore, have limited financial resources to spend on


necessities like food, housing and essential medicine. SNAP participation is associated with reduced hospital and nursing home admissions among older adults, as well as overall reduced health care costs. Reducing enrollment barriers and administrative burdens is particularly important for older Americans considering that nearly 60 percent of older adults who are eligible for SNAP are not enrolled in the program. Conversely, AARP is opposed to changes that would create roadblocks to SNAP participation for older Americans.

Supporting Family Caregivers

There are about 40 million family caregivers providing an estimated $470 billion annually in unpaid care to their loved ones.\(^4\) Family caregivers provide a broad range of assistance to any relative, partner, friend, or neighbor with whom they have a significant relationship and who has chronic or disabling conditions. Family caregivers assist with daily tasks such as dressing, eating, transportation, and managing finances; provide emotional support; coordinate care and communicate and advocate with health care and other providers; and perform medical/nursing tasks, such as wound care and managing multiple medications. Family caregivers are often the default care coordinators and can be a consistent presence with the individual they are assisting across different providers and settings. According to a national survey, about 32% of family caregivers provide at least 21 hours of care a week, on average doing 62.2 hours of care weekly.\(^5\)

As the baby boomers age, it will be essential to recognize and support family caregivers in their caregiving roles. Family caregivers will only face greater strains in the coming years as the "caregiver support ratio" – the number of potential family caregivers aged 45-64 for each person aged 80-plus – shrinks. In 2010, the ratio was more than seven potential caregivers for every person in the high-risk years of 80-plus. By 2030, this ratio is projected to decline sharply to 4 to 1 and to less than 3 to 1 in 2050.\(^6\) People age 80 and over are the most likely to need long-term services and supports (LTSS) and the 80-plus population is projected to increase by 79 percent from 2010-2030, while the population aged 45-64 is projected to increase by only 1 percent during this same time period. If family caregivers were no longer available, the economic cost to the American health and LTSS systems would increase astronomically. Family caregivers can help reduce unnecessary hospitalizations and delay or prevent more costly nursing home care.

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AARP commends the Committee’s leadership in enacting the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act (P.L. 115-119) in 2018. The development of a strategy to better recognize and support family caregivers will help provide additional insights and recommendations to further support family caregivers through private and public sector actions. Effective and swift implementation of the law is important.

We also urge the Committee to look for additional opportunities to support family caregivers in the Committee’s jurisdiction, including as part of the Older Americans Act (OAA) reauthorization. For example, AARP urges the Committee to increase the authorized funding level for the OAA’s National Family Caregiver Support Program (NFCSP) to provide family caregivers with critical support and allow grantees the ability to fully respond to local needs without having to redirect resources from one population to another. Additionally, AARP supports mandating the use of comprehensive, standardized family caregiver assessment tools to ensure that family caregivers receive the support and services they need.

Understanding the family caregiving situation is a critical step in the process for linking the family caregiver to the most appropriate supports and services (e.g., counseling, respite care etc.). The circumstances of each caregiver are varied. Questions regarding the skills, abilities and knowledge of family caregivers can help to identify the tasks that are most problematic and stressful for the caregiver. This information, in turn, can lead to targeting supportive services more effectively and efficiently. Better targeting of supports and services can also protect family caregivers from negative aspects of caregiving and may improve care outcomes for the care recipient, including reduced usage of emergency services and delayed placement in nursing homes. The majority of Area Agencies on Aging (AAAs) – 69 percent – already use a standardized assessment tool. The most effective interventions begin with an assessment, and we believe that using a standardized assessment tool should now be standard practice. The NFCSP led the way on family caregiver support and should lead the way on assessing the needs of family caregivers. We also note that supportive services (Title III-B) help older adults remain in their homes and communities, where they want to be and which are generally less costly environments. OAA supportive services can also help delay or prevent the need for individuals to receive Medicaid LTSS. Investing more in home- and community-based supports will help prevent or delay unnecessary nursing home placement.

**Meaningful Data and Information**

Congress should require all providers (e.g. hospitals, physicians, etc.) or all payers (e.g. public programs and private insurers) to publish the actual price paid – not the price charged. They should also report the out-of-pocket costs faced directly by consumers. This information should be presented for both inpatient and outpatient episodes of care, and not broken down in line-items, as done in a hospital master charge sheet. Ideally, price disclosure information would be available for all services. At the very least total cost of care information should be made available for the most common episodes of
care and procedures, such as hip/knee replacements and coronary artery bypass grafting.

If the goal is to encourage consumers to take price information into consideration when choosing care, then that information needs to be understandable and easily applicable. We know that the price charged by a provider is seldom the price actually paid, and that insurers and payers negotiate different payments. Therefore, making only the charge master or listed price available is of limited value because it does not actually show the true cost burden.

It would be unacceptable, however, for individuals and their family caregivers to shoulder the responsibility for lowering health care costs. Even with access to greater information, they have no control over pricing, and often have little choice in where or from whom they seek care. We are concerned that greater transparency could become a pretext used to justify steering people into lower-cost care, regardless of the quality or the individual’s wants and needs.

Thank you, again, for seeking to address high health care costs. We appreciate the opportunity to provide feedback, and look forward to working with you to improve care and lower costs for all Americans. If you have any questions, please contact me, or have your staff contact Andrew Scholnick of our Government Affairs team at ascholnick@aarp.org or 202-434-3770.

Sincerely,

Joyce A. Rogers
Senior Vice President
Government Affairs