



**TESTIMONY SUBMITTED TO THE
SENATE HEALTH EDUCATION LABOR AND PENSIONS
COMMITTEE**

ON

HEALTH CARE REFORM LEGISLATIVE OPTIONS

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**AARP
601 E Street, NW
WASHINGTON, DC 20049**

**WITNESS: JOHN ROTHER
AARP EXECUTIVE VICE PRESIDENT
POLICY AND STRATEGY**

**For further information, contact:
Nora Super
Government Relations & Advocacy
(202) 434-3770**

Chairman Kennedy, Ranking Member Enzi, distinguished Committee members, thank you for inviting AARP to this timely discussion on health care reform options. I am John Rother, executive vice president and director of policy and strategy for AARP. AARP appreciates your leadership and the opportunity to participate in this roundtable.

Today, I am proud to represent nearly 40 million members of AARP – half of whom are over age 65 and therefore participate in the Medicare program, and half who are under age 65. As many as 7 million of all persons age 50-64 are uninsured today, both age groups face serious problems in access to appropriate care, even if they are insured. I am happy to be here today to discuss some of the options you are considering to address these problems.

Insurance Market Reforms

There are few issues of greater concern to AARP's membership than improving health insurance markets across the United States to assure that all Americans have available to them affordable high quality coverage choices. Many older Americans, especially those age 50-64 who are not yet eligible for Medicare or those with pre-existing chronic conditions, often cannot secure health coverage at any price. Industry data show that insurers reject between 17% and 28% of applicants aged 50-64.¹ Those who can find individual coverage tend to receive less generous benefits than those with employer coverage, yet on average pay premiums that are three times higher and have total out-of-pocket spending that is over twice that of those with employer coverage.² The AARP Public Policy Institute estimates that 13% or 7.1 million adults aged 50-64 were uninsured in 2007 – 1.9 million more than in 2000 – and this figure is growing rapidly in our current difficult economy.³

AARP believes that the best way to make coverage affordable for everyone is by:

- Guaranteeing that all individuals and groups wishing to purchase or renew coverage can do so regardless of age or pre-existing conditions;
- Prohibiting insurers from charging higher premiums because of age, health status or claims experience;
- Providing a choice of qualified plans through a "Gateway" or Exchange with subsidies based on income and the actual premiums each age group faces in the market so coverage is affordable for everyone;
- Addressing costs system-wide through prevention and wellness, care coordination, fighting fraud, waste, and abuse, and revising incentives to reward quality rather than quantity of care; and

¹ AHIP, "Individual Health Insurance 2006-2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007.

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

³ Ibid.

- Ensuring that any cost-sharing obligations do not create barriers to needed care.

We are pleased that many of these issues have been addressed in the Committee's proposed legislation released this week.

Connector/Gateway: The intent of the Gateways is to facilitate the purchase of coverage and products at an affordable price by qualified individuals and employer groups. AARP embraces the establishment of an Affordable Health Benefit Gateway in each state. As described, the Gateway construct would provide balance and flexibility -- clear federal guidelines and standards to assure quality coverage while maintaining the traditional state role in the oversight of insurance.

Planning grants would be provided to states to create state or regional Gateways. Further encouragement for the state to proactively launch or participate in a Gateway lies in the stipulation that residents of the state would not be eligible for premium credits or an expanded Medicaid match until they adopted specified standards. If a state takes no action, the federal government would step in and operate that state's program. Gateways would become financially self-sustaining through a surcharge on participating health plans. As envisioned, consumers would be able to purchase insurance either inside or outside of the Gateway and private or public entities would offer navigation assistance to help individuals and employers obtain affordable coverage. Quality standards for health plans offering essential health care benefits through the Gateway would be specified.

Policymakers have learned much by observing and studying the laboratory of Massachusetts and its successful health coverage experiment. Over the years, other states have adopted alternative health reform models. We are pleased that the Committee bill treats Puerto Rico and the other territories equally with the states with respect to the programs in its jurisdiction. We commend the Committee, especially the leadership of Senators Kennedy and Dodd, for recognizing that quality, affordable coverage should be available to all Americans wherever they reside. It is important to make certain that the insurance market rules are the same inside and outside of the Gateway.

In short, the proposal appears to embrace a reasonable and practical balance between federal policy direction and the reality of diverse insurance markets and state regulatory capabilities across the U.S.

Underwriting and Age Rating: In general, AARP supports community rating, where insurers do not charge higher rates or deny coverage based on age or pre-existing conditions. If age rating is not seriously constrained within national health reform, insurers will likely charge higher rates to older people to substitute for rating based on medical condition.

If any age differential is allowed, AARP believes it should be narrow – no greater than 2-to-1, as in the committee’s proposed legislation. Individuals living in states where no or narrow age rating is allowed today should not be disadvantaged as a result of national health reform. We strongly commend the Committee’s leadership in striving to limit age rating bands to a ratio of 2 to 1. We believe it is essential that health care reform result in providing affordable coverage to those who have the most difficulty obtaining it in today’s market and that is particularly true for older adults.

We have serious concerns about the adverse impact on AARP members of alternative proposals that allow insurers to charge older Americans up to five times or more premium rates. We question why age rating, especially as high as 5 to 1, is necessary when virtually all health reform proposals under consideration include risk adjustment to compensate for higher costs of enrollees who are sicker or older. Independent actuaries confirm that appropriate risk adjustment should mitigate the need for age rating.

Experience in Massachusetts indicates that without strict age rating limits and adequate subsidies, coverage would still be unaffordable for millions of older Americans. Although Massachusetts capped rate variation for factors including age at 2-to-1, affordability remains a significant issue for some AARP members. Even at a 2-to-1 age rating, the lowest priced “bronze” benefit package costs 60-year-olds between \$420 and \$575 per month. If the rate band were set at 5-to-1, the “bronze” package would cost \$1,050 to \$1,335 per month, or up to \$16,020 a year--over half the median annual income of \$30,000 for uninsured Americans aged 50-64 today.⁴ AARP’s concern about age rating and subsidies only increases as we consider most other states where rates of the uninsured are higher and family income levels are much lower than in Massachusetts.

Age is a poor proxy for income; older uninsured Americans do not have substantially higher incomes than younger uninsured individuals, whose median income is \$28,461, only slightly lower than uninsured 50-64 year olds.⁵ Continuing to allow health care coverage to remain unaffordable to those who need it most is a serious societal problem. Uninsured adults in their late 50s and early 60s experience worse health outcomes and use more services when they enter the Medicare program, and in the years before Medicare their uncompensated health care costs will continue to be shifted to those who have insurance.

Hardship exemptions are not an answer, and are cold comfort for those who cannot afford coverage due to high premiums and are in an age bracket where high quality coverage is essential for maintaining health and avoiding preventable

⁴ AARP Public Policy Institute analysis of U.S. Census March 2008 Current Population Survey.

⁵ Ibid.

conditions that will only increase expenditures once these individuals become eligible for Medicare.

Subsidies: Shared responsibility is an important attribute of the proposed legislation. As the legislation proposes an individual requirement for obtaining health insurance and an employer requirement for providing health insurance, assuring affordability of plan premiums *is essential* if AARP is to support this legislation. Adequate subsidies for low- and moderate income individuals must be guaranteed. Subsidies must be adequate, available, secure and administratively feasible, and take into account any higher cost related to any level of age rating that is allowed.

For those who are low-income, expansion of Medicaid eligibility across the United States is an efficient and effective way to assure quality coverage and access to care. AARP believes that offering Medicaid as a wrap around benefit or offering subsidies and/or tax credits to help low-income individuals purchase private coverage could mean that the most vulnerable Americans will not benefit from health reform; such a design will lead to unnecessary expenditures as the construct is administratively unfeasible.

Subsidies should be set on a sliding scale so individuals and families pay no more than a certain percentage of income on premiums as well as other out-of-pocket health care costs. Thus, subsidy calculations should include both family income and actual premium costs that may vary by region or age. AARP asserts that no one should spend more than 10% of their income for health care, including premiums and all other out-of-pocket costs. Those with more limited incomes should pay even less, with exemptions from cost sharing for the poorest for whom any cost sharing can create insurmountable barriers to care. In addition, in order for subsidies to remain affordable and sustainable over time, we must also enact measures to manage skyrocketing costs.

Premium credits and subsidies should be generous enough to effectively help those with modest incomes comply with their new responsibility -- to secure qualifying coverage. Premium credits and subsidies should be provided on a sliding scale; the scale should reach high enough that vulnerable families and older adults will be able to afford both their premiums and health costs. Otherwise, Americans will continue to face the prospect of being uninsured or underinsured and will be forced to seek an exemption from their shared responsibility. Further clarification is needed on how the subsidy would work.

Benefit Packages: We strongly support requiring insurers to cover a broad range of essential benefits, as suggested in draft legislation on this Committee's website. Preventive services – including services necessary to manage chronic conditions that otherwise result in serious, expensive complications – should be provided with no or minimal cost sharing. We are pleased that the Committee is considering including provisions to provide incentives for providers to encourage

care coordination, disease management and similar efforts to improve quality of care and help reduce spending for avoidable and costly institutional admissions, preventable complications, and errors for people with multiple chronic conditions.

Individual and Employer Responsibility: The HELP proposal would require individuals to have health coverage that meets minimum standards and to report such coverage annually. Employers who do not provide qualifying coverage will be required to contribute to the cost of their coverage for their employees, including those who access forms of public coverage.

Requiring everyone to participate is necessary because it greatly reduces insurers' interest in underwriting based on age or health status and because it ensures that healthier individuals are included in the risk pool. However, AARP can support these requirements only with the assurance of adequate subsidies. We cannot support mandated coverage that people or businesses cannot afford – subsidies must be adequate, available, secure and administratively feasible. In order to ensure that subsidies remain affordable and sustainable, we must also enact measures to manage skyrocketing costs while improving quality.

Community Living Assistance Services and Supports

AARP appreciates Chairman Kennedy's leadership and commitment to including long-term services and supports in comprehensive health care reform legislation. AARP strongly agrees that long-term services and supports must be included in any health reform package. People with disabilities and older adults need better options to help keep them independent and functioning at their highest level. Our members want to live in their homes and remain independent in their communities as long as possible. That is why expanding access to home and community-based services is one of AARP's key health care reform priorities.

Our current welfare based Medicaid policies vary tremendously from state to state, include an institutional bias, and only assist people after they have exhausted their assets. Medicaid provides critical services for millions of people and must be improved, such as by expanding access to Medicaid home- and community-based services. At the same time, individuals also need more choices to help them pay for the services they need to live independently. Home and community-based services are also often more cost effective than institutional care, and an aim of health care reform is to assure affordable insurance coverage for everyone.

The HELP Committee's bill includes a modified version of the Community Living Assistance Services and Supports Act (CLASS Act, S. 697/H.R. 1721), which would create a voluntary public insurance program that individuals could purchase and if they become eligible, receive a cash benefit to pay for the long-term services and supports they need to remain independent. The CLASS Act

provisions would offer a generally broad-based opportunity for individuals to receive a minimum level of coverage for long-term care services and supports without having to deplete their assets or be denied coverage due to a pre-existing condition. These are important features, as is the cash benefit that would give enrollees choice and control over the services and supports they need. We applaud Senator Kennedy's efforts in taking this positive step toward providing important insurance protection for individuals long-term care services and supports. We also appreciate that the program is designed to be budget-neutral. We look forward to working with Senator Kennedy, Senator Enzi, Senator Harkin and other leaders on the Committee who are committed to finding solutions that meet the needs of families and their caregivers.

The Committee's narrative also notes that it is considering the Long-Term Care and Retirement Security Act that would provide tax incentives for the purchase of private long-term care insurance and address private long-term care insurance consumer protections. AARP believes a sustainable financing system for long-term care services and supports will require a combination of sustainable public and private resources. Tax incentives for private long-term care insurance may lower the cost of this insurance for some individuals and encourage them to purchase it, but these incentives would not benefit individuals who cannot afford such insurance or cannot qualify for it due to pre-existing conditions. Updating and strengthening consumer protections for private long-term care insurance is critical. If a CLASS Act approach is enacted, individuals could choose to purchase private long-term care insurance coverage to supplement their CLASS Act benefit and could be helped by the consumer protections and tax incentives.

We also note that this legislation includes a family caregiver tax credit to help family caregivers who are providing assistance to their loved ones. AARP strongly supports efforts to support family caregivers. In 2007, about 34 million family caregivers provided care at any given point in time, and about 52 million provided care at some time during the year. The estimated economic value of their unpaid contributions was approximately \$375 billion in 2007, up from an estimated \$350 billion in 2006.⁶

Creating a Pathway for Safe and Affordable Generic Biologic Drugs

Spending on biologic drugs is growing nearly twice as quickly as spending on traditionally-developed "small molecule" drugs. Overall biologic drug sales reached \$75 billion in 2007⁷, and it is estimated that spending on biologics will continue to increase substantially through 2012.⁸

⁶ AARP Public Policy Institute, Valuing the Invaluable: The Economic Value of Family Caregiving, 2008 Update. Insight on Issues 13, November, 2008.

⁷ IMS Health, "IMS Health Reports Global Biotech Sales Grew 12.5 Percent in 2007, Exceeding \$75 Billion," June 17, 2008.

⁸ Express Scripts, "2007 Drug Trend Report," April 2008.

Biologics treat serious diseases such as cancer, multiple sclerosis, and rheumatoid arthritis but often cost 10, 15, or even 20 times more than most non-biologic drugs. Users of these often life-saving medications are typically forced to pay exorbitant amounts to treat their conditions.

AARP agrees with the report released just yesterday by the Federal Trade Commission (FTC) that lack of competition in the biotech market has resulted in higher costs and less innovation. Another major contributor to the increase in spending on biologics is the lack of a statutory pathway at the Food and Drug Administration to approve generic, or bio-equivalent, biologic drugs.

AARP has endorsed the “Promoting Innovation and Access to Life-Saving Medicine Act (S.726/H.R. 1427),” which would create such a pathway as well as a process for timely patent dispute resolution and we applaud Senators Brown, Collins, Schumer, and Vitter for their leadership in sponsoring this critical legislation.

While we continue to have concerns--also echoed in the FTC report about the 12-year exclusivity period included in the Senate HELP Committee compromise, we believe that the underlying legislation that includes Chairman Kennedy’s amended language to close the so-called “ever-greening” loophole is a constructive and important contribution that merits inclusion in this package. We therefore believe it should be included in the Committee health reform mark. Conversely, if the ever-greening provision is not addressed, we believe that this legislation would represent an empty promise in that it would set up an environment in which biotech companies could make modest changes to the underlying product and get continual 12-year cycles of effective monopoly protection.

We appreciate the continued leadership of Committee members Senators Kennedy, Brown, Hatch, Enzi, and Bingaman on this issue. We look forward to working with them on the promise that on this – the 25th Anniversary of the Hatch-Waxman law – we provide a workable pathway for generic options in order to provide more choice in a marketplace that works to the advantage of consumers.

Lowering the costs of biologic drugs also presents an opportunity to begin to close the coverage gap – or doughnut hole – in the Medicare Part D benefit. This is an issue of great concern to AARP members. About one in four Part D enrollees, not enrolled in low-income subsidies, who filled one or more prescriptions in 2007 fell into the doughnut hole in 2007, according to a Kaiser Family Foundation report. On average, patients’ out-of-pocket drug spending doubles when they reach the doughnut hole. A pathway to generic biologics can help more people avoid the coverage gap, as well as provide savings to begin to close the doughnut hole.

Health Quality and Delivery System Reform

Care for people with chronic conditions makes up three quarters of total health spending, yet many experts agree that much of the health care system is not well organized to meet the needs of people with chronic conditions. Clinicians tend to focus on the particular problem that a patient presents at each visit. But delivering good care for people with chronic diseases calls for proactive steps by both individuals and providers to care for chronic care between visits. For patients, this could include adhering to advice on exercise and diet, taking medications as prescribed, and monitoring signs and symptoms. For providers, this includes monitoring care over time and settings and having good systems and communication – among providers and with patients and caregivers – that allows tracking and patient-centered care.

Barriers to improvements in care for people with chronic disease include the fragmentation of care delivery, poor transitions between and among settings, and misaligned payment incentives that fail to recognize the value of better integration of services. Poor information systems make these problems worse because providers find tracking patients over time and across settings difficult. Adherence to medications is a key component of effective chronic care management, and patient's failure (or inability) to take prescribed medicines is another major barrier to improvement.

Addressing these barriers requires a multi-pronged strategy that relies on better knowledge, tools, and incentives. For each of these strategies, our recommendations are aimed at providers, family caregivers, and patients—who can play a critical role in managing their own care. Key recommendations for improving coordination of care for people with chronic disease include:

- More testing of care delivery models (for example, medical homes and accountable care organizations) to find out what works.
- Rapid adoption of those models that work. Models that provide care during transitions between hospitals and other settings have proven to improve care, reduce rehospitalizations, and show a positive return on their cost, and should be adopted.
- Incorporating best practices into clinical preparation and training for providers.
- Engaging patients with chronic conditions who are able to participate in their care, providing them with tools to empower their conditions.
- Supporting and engaging family caregivers.
- Encouraging wise use of pharmaceuticals, including making medication more affordable.
- Improving coordination of care through adoption of health information technology and improving incentives through changes in payment policy.

- Ensuring an adequate workforce, including making the most of the workforce we have.

AARP commends the committee for recognizing the necessity of improving quality and efficiency in health care, focusing on outcomes of care, and addressing the challenge of quality improvement by integrating quality improvement and patient safety training into the clinical training of health professionals. Quality and safety problems in the U.S. pervade our health care system. We are gratified to see the growing determination of all sectors to attain greater value from the health system so that organizations deliver high quality, efficient, safe care and engaged patients make informed health decisions that reflect their values and preferences. We are convinced that better quality will lead to a more affordable, sustainable system. To accomplish this, we need better information to support clinical and patient decisions, enabled by the appropriate use of health information technology; and aligned incentives (for providers and patients) to encourage coordinated, patient-centered care that ensures patients the care they need when they need it.

Quality Improvements Infrastructure: AARP is pleased that the committee proposes to support the development of an infrastructure to sustain quality improvements throughout the system by directing the Secretary of DHHS to first identify national priorities for improvement and then to pursue the realization of these priorities through performance measurement and public reporting. AARP already participates in multi-stakeholder activities through consensus organizations (such as the National Quality Forum and the National Priorities Partners) in pursuit of quality improvement, and we agree that the Secretary should help bolster these nascent, but increasingly important, collaborative initiatives through a variety of consultative opportunities identified in the draft legislation. The capacity to evaluate performance throughout the health care system is integral to several features of a reformed health care system, such as improvement in the delivery of chronic care, reduction in disparities among racial and ethnic minorities, and aligning payment with desired outcomes.

It will be important to ensure that priorities are harmonized and made consistent to achieve maximum benefit from resources devoted to quality improvement activities. We note that the draft legislation would require the Secretary to receive recommendations on priorities for performance improvement from a qualified consensus-based entity (section 204(d)(1) while section 399LL (b)(4) identifies 9 specific areas that the Comptroller General would be required to evaluate. Although we believe the identified areas are worthy, there may be some inconsistency in requiring input from the consensus body on the one hand and establishing specific priorities on the other. Similarly, section 213 that provides grants to implement medication management services in the treatment of chronic disease would allow the Secretary to fund (via grants or contracts) the development of performance measures to assess the use and effectiveness of medication management services. Here again, although we think medication

management programs offered by pharmacists have merit to promote safety and encourage greater patient adherence, measures to evaluate performance in this area should be consistent with the requirements applicable to *all* performance measures specified in section 204 (i.e., that they be evidence-based, consistent with national goals and priorities, and endorsed by a national consensus body.)

We are very pleased to see the committee's implicit recognition of the fact that performance measurement in support of quality improvement and decision support should be considered a public good. AARP agrees that providing the federal resources to support measure development, research, dissemination of information on best practices, and the provision of technical assistance is necessary.

Medical Homes and Community Health Teams: We have been a strong supporter of the concept of a patient-centered medical home as a promising approach to promote primary care and encourage not only care coordination throughout the care continuum but patient self-efficacy as well. The committee's idea of establishing "community health teams" to support the medical home model takes in to account the reality that most Americans receive their care from small clinical practices. Therefore, the infrastructure support that is proposed in the draft legislation could help small practices become medical homes that can live up to the promise of the concept. However, we urge that the definition of medical home be expanded to include non-physician clinicians, such as advance practice nurses.

Emergency Care Response and Research: Section 1204 proposes competitive grants for regionalized systems for emergency care response and Section 498D provides support for emergency medicine research. Subsection (d)2(vi) requires applicants for such grants to address pediatric concerns related to the integration, planning, preparedness, and coordination of emergency medical services for infants, children, and adolescents; and section 498D(b) provides for pediatric emergency medical research. We urge the committee to also require that prospective grantees be required to address a similar list for geriatric patients and for the Secretary to conduct research applicable to a geriatric population as well. There is an increasing trend in emergency departments (ED) for visits from older patients: visit rates over the past 11 years have seen substantial increases among patients age 50 and older. In addition, patients over the age of 75 are more likely to arrive at the ER via emergency medical transport (49 percent) than all other patients (4.2 percent) Finally, older adults are especially vulnerable during disasters and face special risks due to the fact that they are more likely to have chronic illnesses, functional limitations, as well as greater sensory, physical, and cognitive disabilities than younger persons.

Reducing and Reporting Hospital Readmissions: Almost one fifth of Medicare patients discharged from a hospital were readmitted within 30 days;

these readmissions cost Medicare \$17.4 billion in 2004. These hospital stays, many of which are preventable, pose a major concern—from both a quality and financial perspective—and must be addressed. AARP concurs with the Committee that information about rates of readmission should be reported to hospitals so that they have the opportunity to act on the information and take steps to eliminate preventable readmissions. We also believe this information should be reported to the public so that patients and clinicians can factor it into their choice of hospitals and also to stimulate improvement (because we know that publishing performance information gets the attention of the provider community and encourages them to pay attention to the data.)

Transitions from hospital to home can be complicated and risky, especially for individuals with multiple chronic illnesses. Patients frequently report difficulty remembering clinical instructions, confusion over correct use of medications, and uncertainty over their prognosis. And in cases where multiple providers are involved, patients often get conflicting instructions from different providers.

A study published in April 2009 in the *New England Journal of Medicine* found that almost one third of Medicare beneficiaries studied who were discharged from a hospital were re-hospitalized within 90 days. Additionally, one-half of the individuals re-hospitalized had not visited a physician since their discharge, indicating a lack of follow-up care

AARP has endorsed The Medicare Transitional Care Act (H.R 2773) which would directly address continuity of care problems by increasing support to patients as they move from the hospital to their new care setting and ensuring that appropriate follow-up care is provided during this vulnerable period. The benefit would be phased-in, initially targeting the most at-risk individuals by providing evidence-based transitional care services tailored to their specific needs. We hope to have a Senate companion bill soon and we urge the Committee to include this transitional benefit in any final health care reform legislation.

Programs to Facilitate Shared Decision Making: The Institute of Medicine identified “patient-centeredness” as one of six attributes of high quality care. In addition, based on its understanding that engaged, activated patients are likely to have better health outcomes, the National Priorities Partners, a broadly representative group of 28 organizations with an interest in improving health care, identified patient and family engagement as one of six national priorities and goals. From a patient’s perspective, the concepts of patient-centered care and patient engagement cannot be fully realized unless patients (or their designated family caregivers) are able to participate as full partners in their health care. This means they must have access to and are able to use information that is relevant, meaningful, applicable, and reliable. Therefore, AARP commends the committee for recognizing the role evidence-based shared decision making tools can play in improving care, and we support opportunities to

expand the availability and implementation of such aids that meet specified criteria and that are suitable across the age span, including vulnerable populations and children. Since use of shared decision making tools is a relatively new idea for patients and providers, the idea of establishing resource centers to provide technical assistance to providers to develop and disseminate best practices could accelerate adoption of these tools.

Increasing the Supply of the Health Care Workforce: We applaud the Committee's leadership in addressing the needs of the health care workforce, including their education and training. Health care services should be provided by a well-trained, fairly compensated workforce who put their patients' needs above all else and who carry out their responsibilities under rules that permit clinicians to maximize the full scope of their training. The nation must have an adequate workforce trained and prepared to take on the needs of an aging population.

AARP supports your proposal for a health workforce commission, which would develop recommendations for workforce needs in the future. Nurses, in particular, are in short supply. Nursing workforce development is appropriately included in the HELP bill. However, we are concerned that the bill does not go far enough in increasing nursing workforce capacity. Because there is no dedicated stream of funding for this purpose, we may be left with an inadequate supply of highly skilled nurses to meet the health care needs of an aging population in the 21st century. We do support provisions to authorize funding for training of primary care "extension" workers, which is inclusive of nursing. AARP also appreciates the Committee's authorization of funding for the development of additional nurse-managed clinics. If we truly are going to reform our delivery system, so that it is person-centered and team-based, we must re-orient and retrain our nation's health care workforce.

We are pleased that provisions from the AARP-endorsed Retooling the Health Care Workforce for an Aging America Act (S. 245/H.R. 468) are included in the HELP Committee's bill. These provisions would help ensure that more individuals are trained in long-term care, chronic care management, and geriatrics and that direct care workers have new training opportunities. In addition, the provisions include voluntary training opportunities for family caregivers.

Conclusion

Thank you again for the opportunity to be with you today. AARP believes our health care system costs too much, wastes too much, makes too many mistakes, and gives back too little value for our money. That is why AARP, on behalf of our 40 million members, believes Congress must pass health care reform that controls costs, improves quality, and provides all Americans with affordable, quality health care choices. We look forward to working with you to enact health care reform this year.

¹ IMS Health, "IMS Health Reports Global Biotech Sales Grew 12.5 Percent in 2007, Exceeding \$75 Billion," Press Release, June 17, 2008.