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PROTECTING THE PROMISE TO OUR SENIORS: PRESERVING SENIOR PROGRAMS

FIELD HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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PROTECTING THE PROMISE TO OUR SENIORS: PRESERVING SENIOR PROGRAMS

WEDNESDAY, APRIL 27, 2011

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Johnston, RI.

The Committee met, pursuant to notice, at 10:00 a.m., at Johnston Senior Center, 1291 Hartford Avenue, Johnston, Rhode Island, Hon. Sheldon Whitehouse, presiding.

Present: Senator Whitehouse [presiding].

OPENING STATEMENT OF SENATOR SHELDON WHITEHOUSE

Senator WHITEHOUSE. Alright. The hearing will come to order.

Before we begin, let me thank everyone who is in attendance here today. I want to extend my particular gratitude to the staff of the Johnston Senior Center, to Tony Zompa and his team for hosting us here today.

And I want to recognize the Mayor of Johnston, who is here today, Mayor Polisena, who has been a friend for many years and takes second place to no one in his support and advocacy for Rhode Island's senior community. So I am very impressed that he is here.

And I would also like to thank Deputy Assistant Secretary Edwin Walker for rearranging his busy schedule and flying up to Rhode Island to be with us here today, as well as Anne Montgomery, who is staff to the Senate Aging Committee from Washington, D.C. We appreciate very much their efforts, and we look forward to Assistant Secretary Walker's testimony, as well as that of all of the witnesses who are going to be testifying today.

It may seem hard to imagine now, but there was a time within the last century when more than half of our Nation's seniors were living below the poverty level. It is really an astounding statistic, and it should be a sobering reminder of the challenges that seniors faced in our country's not-so-distant past.

We should be very proud of how far we have come, and we should defend that progress. The poverty rate among seniors today is lower than any other age group. This is due in no small part to the promises we have kept to make the well-being of our seniors a national priority.

I think I have got too much microphone. I feel where I am getting feedback. Thank you.

That promise began in earnest with the passage of the Social Security Act in 1935, the most successful domestic Government program in our Nation's history and a critical safety net for seniors through good times and bad. Over 200,000 Rhode Islanders rely on

Social Security to help them make ends meet, and I am committed to ensuring that they can count on these benefits.

The enactment of Medicare in 1965 built upon the promise begun by Social Security. At the time, President Johnson said—and I quote—"No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes and their own hopes eaten away simply because they are carrying out their deep moral obligations to their parents."

That is a promise that Medicare has kept and one that we have fought to protect and strengthen. Most recently, under the new healthcare law, seniors can receive lifesaving preventive care services—like screenings for colon cancer, diabetes, and breast cancer—with no copayment.

In addition, the Affordable Care Act fulfills a promise that I made during my campaign in 2006 by moving to close the dreaded Medicare prescription drug donut hole completely by 2020, finally bringing full prescription drug coverage to Medicare recipients. This year, seniors who fall into the coverage gap will receive a 50 percent discount on brand-name drugs.

Since the beginning of the year, this new discount has saved nearly 48,800 Medicare beneficiaries $38 million, an average of $800 per person. For the thousands of Rhode Islanders who hit the donut hole each year, these improvements allow a little more peace of mind.

In July 1965, the same month that Medicare was created, Congress also passed the Older Americans Act. Less well-known than Medicare, the OAA has nonetheless supported a wealth of services that improve quality of life for seniors—health and wellness programs, transportation services, or Meals on Wheels and other nutrition programs like the ones provided right here at the Johnston Senior Center.

In Rhode Island, the Department of Elderly Affairs, directed by Catherine Taylor, has done a great job leveraging Federal funding to provide services that so many of our State's seniors have come to rely on. I want to acknowledge Catherine, who is here with us today, and thank her and her staff for their important work for our Rhode Island community.

For all of the gains that Social Security, Medicare, and the Older Americans Act have made in protecting seniors, each of these critical programs is at a crossroads. The Older Americans Act is set to expire later this year. From my position on the Senate Aging Committee and on the Health, Education, Labor, and Pensions Committee, I pledge to work hard to make sure that the OAA is reauthorized and the services it supports for seniors will continue.

As everyone here knows, Social Security has been a frequent target of attack. In recent weeks, there has been talk about the need to change Social Security, even to cut benefits, in order to reduce our debt. Let me be very clear. Social Security has paid out every dime owed to all eligible Americans without contributing a thing to the Federal deficit or debt. It is fully solvent today and is projected to remain so for another quarter century.

If changes are desired to strengthen Social Security, those changes should be considered independently from work to reduce the deficit. As a founding member of the Defending Social Security Caucus, I intend to work to maintain Social Security as America's cornerstone of retirement security.

Medicare is just as critical. The House of Representatives recently passed a Republican budget which proposes privatizing Medicare and requiring seniors to pay the majority of their health expenses with their own money.

In fact, estimates suggest that this proposal would end up forcing a typical 65-year-old senior to pay on average $12,500 each year in out-of-pocket expenses, starting in 2022, just a decade from now. Here in Rhode Island, where the average senior only gets about $13,600 per year from Social Security, that would be a prescription for poverty creation.

Under the Republican budget, seniors would lose the new benefits provided by the healthcare reform law, those preventive services I mentioned earlier. The Republican budget would also reopen the Medicare prescription drug donut hole, affecting nearly 17,000 Rhode Islanders who, in 2012, would pay an additional $9.5 million for their prescriptions under the House plan.

The attack on Medicare also overlooks the most basic fact of healthcare, which is that all healthcare costs are skyrocketing, irrespective of who the insurer is. There is a problem in healthcare, but attacking Medicare misdiagnoses the problem.

As we get today's hearing underway, I hope that my message is clear. We will protect our promises to our seniors. I look forward to the testimony today and to working with you to protect these important programs.

With that, it is my pleasure to begin the introductions of the first panel of witnesses. Our first witness is Edwin Walker, the Deputy Assistant Secretary for Program Operations at the Department of Health and Human Services Administration on Aging. In this role, he promotes the development of home- and community-based long-term care programs, policies, and services designed to improve the quality of life for older people and improve effectiveness for caregivers.

Edwin is recognized as an expert on the Older Americans Act legislation, and he serves as the primary liaison for the Administration on Aging on legislation related to aging services and programs. He has over 25 years of experience with aging services and programs, previously serving as director of the Missouri Division on Aging.

After Edwin, we will hear from our Lieutenant Governor Elizabeth Roberts. Prior to taking office, Lieutenant Governor Roberts spent over a decade distinguishing herself as an advocate for quality affordable healthcare for every family and built a State-wide reputation as a tireless leader on health and medical issues.

I should add that years ago, when I was the policy chief for Governor Sundlun, my two top staffers were Elizabeth Roberts, who is now our Lieutenant Governor, and Keith Stokes, who is now our director of economic development. So if you wonder why I did a good job in that position, you have to look no further than my staff.

[Laughter.]

Lieutenant Governor Roberts is the chair of the Long-Term Care Coordinating Council, where she is pushing to expand community-based care for seniors and for people with disabilities. In addition, she has shown great leadership in forming and heading the Healthy Rhode Island Implementation Task Force and serving as chair of the Rhode Island Healthcare Reform Commission, where she leads the State's health reform efforts.

Lieutenant Governor Roberts served in the Rhode Island State Senate from 1997 to 2007, is a graduate of Brown University, and earned an MBA in healthcare management from Boston University.

The first panel will conclude with testimony from Chris Koller, Rhode Island's first health insurance commissioner. He took over this role in 2005. The Office of the Health Insurance Commissioner is responsible for health insurance consumer protection, the financial solvency of Rhode Island's health insurers, and directing policies that improve the accessibility, affordability, and quality of Rhode Island's healthcare system.

The office is nationally recognized for its rate review process and its efforts at improving the primary care infrastructure in the State and the readability of health insurance contracts. Prior to taking this position, Mr. Koller was the CEO of Neighborhood Health Plan of Rhode Island, a nationally recognized community health center-based Medicaid health plan. In this role, he was the founding chair of the Association of Community-Affiliated Plans.

Mr. Koller has a bachelor's degree from Dartmouth College and a master's degree in management and religion from Yale University.

So it is a wonderful panel, and I ask Assistant Secretary Walker to lead it off. Please, sir?

[The prepared statement of Senator Sheldon Whitehouse appears in the Appendix on page 30.]

STATEMENT OF EDWIN WALKER, DEPUTY ASSISTANT SECRETARY FOR PROGRAM OPERATIONS, ADMINISTRATION ON AGING, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. WALKER. Thank you so very much, Senator Whitehouse. It is a pleasure to be here.

Over the past year, the Administration on Aging has conducted the most open process for seeking input on the reauthorization of the Older Americans Act in its history. I am pleased to discuss the input we have received and to learn more about the perspectives from Rhode Island.

At the outset, however, I would like to commend you for your leadership as a member of the Senate Special Committee on Aging and other key committees which have jurisdiction over important senior issues, including the Older Americans Act. We are grateful for the support you have provided, as well as your strong leadership in improving the quality of care for families, for protecting against consumer fraud, and supporting elder rights.

I am very impressed by the level of commitment and dedication of Rhode Island's Aging Services Network, and I had the pleasure of meeting your director of the Department of Elderly Affairs,

Catherine Taylor, this morning. And I am impressed by the interest and the enthusiasm of your older citizens and their families.

Rhode Island is one of the highest per capita populations of seniors in the country and plays a large role as a leader in many aspects related to the health and well-being of seniors and the soon-to-be seniors. By winning a number of competitive Federal grant awards, the Department of Elderly Affairs has taken full advantage of opportunities which seek to more efficiently support the needs of frail seniors and their families. We have much to learn from the insights and perspectives of your citizens, and I am quite honored to be here today.

As you indicated, Senator, in 1965, President Johnson signed the Older Americans Act into law, followed by Medicare and Medicaid. These three programs, along with Social Security, have served as the foundation for economic, health, and social support for millions of seniors, individuals with disabilities, and their families.

For more than 45 years, the Older Americans Act has quietly but effectively provided nutrition and community support to millions of people across the Nation and here in Rhode Island. It has also protected the rights of seniors and been a key to their independence.

Annually, nearly 11 million, or 1 in 5, older Americans and their family caregivers are supported through the Older Americans Act network. These services complement medical and healthcare systems, help prevent hospital readmissions, provide transport to doctor's appointments, and support some of life's most basic functions. The assistance is especially critical for the nearly 3 million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission, but who are able to remain in their own homes due to these community supports.

What is more, the need for this support is growing very rapidly. Every day the equivalent of a small town, or more than 9,000 babyboomers, turn 65. Also rapidly increasing is the number of seniors with severe disabilities who are at greatest risk of nursing home admission and Medicaid eligibility.

The reauthorization of the Older Americans Act provides us with the opportunity to strengthen and to build upon a long record of success in serving our families and communities and to help meet that growing need. Over the past year, the Administration on Aging received input and reports from reauthorization listening sessions held throughout the country. This input represented the interests of thousands of consumers.

During the process, we heard a number of themes, and I would like to mention two of them today. First, improve program outcomes and do this by embedding evidence-based interventions in disease prevention programs, by encouraging comprehensive person-centered approaches, by providing flexibility to respond to local nutrition needs, and by increasing efforts to fight fraud and abuse.

Second, we heard remove the barriers and enhance access by extending caregiver supports to parents caring for their adult children with disabilities; by providing ombudsman services to all nursing facility residents, not just older residents; and by utilizing aging and disability resource centers as single access points for long-term care information and to public and private services.

Senator Whitehouse, three brief examples of areas that we would like to discuss with the Congress as you consider legislation include the following. Number one, ensuring that the best evidence-based interventions for helping older individuals manage chronic diseases are utilized. These have been effective in helping people adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits.

Number two, improving the Senior Community Service Employment Program by integrating it with other seniors programs. The President's 2012 budget proposes to move the program from the Department of Labor to the Administration on Aging. We would like to discuss adopting new models of community service, including having seniors assist other seniors so they can remain independent in their homes.

And number three, combating fraud and abuse in Medicare and Medicaid by converting the Senior Medicare Patrol Program to an ongoing consumer-based fraud prevention and detection program and by continuing to use the skills of retired professionals as volunteers to conduct community outreach and education so that seniors and families are better able to recognize and report fraud and abuse.

The Older Americans Act has historically enjoyed widespread bipartisan support. Based in part upon this extensive public input process, we think that reauthorization can strengthen the Older Americans Act and put it on a solid footing to meet the challenges of a growing population, as well as to carry out its important mission of helping elderly individuals maintain their health and independence in their own homes and communities.

Thank you again, Senator, for your leadership in these important issues and for the invitation to be here today. I would be happy to take any questions.

[The prepared statement of Edwin Walker appears in the Appendix on page 34.]

Senator WHITEHOUSE. Thank you, Deputy Assistant Secretary Walker.

I appreciate that you are here, and I look forward to working with you to reauthorize this important legislation. I think what we will do is defer questions until all of the witnesses have testified, and then we can do Q&A as a panel.

So that takes us to our exceptional Lieutenant Governor Elizabeth Roberts.

STATEMENT OF ELIZABETH ROBERTS, LIEUTENANT GOVERNOR, PROVIDENCE, RI

Ms. ROBERTS. Thank you very much, Senator, and good morning.

I am here today in two capacities, as chair of both the Rhode Island Healthcare Reform Commission and as chair of the Rhode Island Long-Term Care Coordinating Council. These are forums for Rhode Islanders to actively participate in health policy and have a real impact on issues that will profoundly affect seniors, those who are nearing retirement and, indeed, all of us.

And I want to thank you for bringing this hearing here today. These issues are very much on the minds of the people in this room

and the minds of the people you and I talk to every day in our work.

I want to thank the Mayor for this exceptional senior center and an exceptional community. I said to the Mayor every time I come to Johnston there are several hundred people here to greet me, and it really says something about this community. And I will commend to you that Rhode Island is one big community, and we look after our seniors and recognize and respect the needs of our seniors and will not leave them behind.

I want to recognize Director Catherine Taylor, and I want to take a moment to recognize Tony Zompa, who is the director of this very good senior center, where it is our privilege to come so often.

And particularly Senator Whitehouse, he commented that I had the privilege to work for him many years ago. He certainly had more dark hair. I had a little more dark hair.

[Laughter.]

But that I think we in Rhode Island are remarkably fortunate at this time in the debate going on in Washington to have someone with the depth of understanding of healthcare, of Medicare, of the needs of seniors, but also the depth of commitment, and we are going to be very well served during what will be a very tough budget fight. And I am glad he has brought this discussion here to Rhode Island to hear directly from the people of this community.

As changes to vital programs like Medicare, Medicaid, and Social Security are being discussed at the national level, it is important that Rhode Islanders are here today to contribute to this dialogue. And I want to thank you again for this opportunity.

Let me first talk about national health reform, the Affordable Care Act, because there has been so much misinformation about this law and its impact on Medicare and seniors. And I want to take a moment to set that record straight.

First of all, health reform, national health reform does not cut benefits for seniors. In fact, it improves those benefits, and I want to reiterate something that Senator Whitehouse said a few minutes ago. The donut hole—and believe me, when I am campaigning, when I am working with seniors, I hear about the donut hole all the time. It will be gradually filled in over time so that we will never again have seniors who cannot afford their medications.

There will now be free annual wellness visits. As somebody who is a—and you will hear more from our health insurance commissioner—but have a deep belief in the importance of maintaining our health and preventing illness and managing chronic illness, having those wellness visits and a strong relationship with a family physician is vital.

And that they will no longer have to pay deductibles and copayments, things that keep people from getting important preventive care. These reforms are part of an effort to focus on keeping people healthy instead of waiting until they get sick. Now, none of us wants to get sick, but it is also more expensive for all of us if we do get ill.

The health reform law also provides incentives for healthcare providers to work together to improve the quality of care and reduce costs. There is no doubt that we need to reduce healthcare costs so that the Government can afford its promises to seniors, as

well as invest in other priorities like education. But we now face a stark choice as to how to do that, and that choice will have a profound effect on seniors today, but also the seniors of tomorrow.

And I looked across the breakfast table at my husband, who I will confess is a little older than I am, and I said, "Well, if the Republicans win, you are going to have a good Medicare program, but not me." And I don't think there is any resident of Rhode Island who wants to have one family member have the protection and good care that Medicare has provided and have another deprived of that.

Instead, do we reform the way we pay for healthcare to encourage better care instead of more care, or do we radically restructure programs to simply make seniors pay more out of their pockets? And do we tie our hands by fragmenting insurance even further by privatizing Medicare, hampering reform, making effective cost containment very difficult, and also making consumer protection very difficult?

As chair of the Rhode Island Healthcare Reform Commission, I can assure you we are working hard to reform the way we pay for and deliver healthcare in this State. We are looking hard at how to be cost effective and cost conscious, but while maintaining quality and access to care. We have been a national leader in improving the care of chronic disease by developing patient-centered medical homes here, primary care providers that know you and help coordinate your care.

And as we move forward in implementing the health reform law, I want to continue to encourage all Rhode Islanders to participate in the dialogue about how do we improve care and do it in a cost-effective way? Real change cannot happen unless everyone in this room, along with physicians, hospitals, nurses, small business owners, and patients are involved, just as we are here today.

My other role that brings me here is as chair of the Long-Term Care Coordinating Council, a group of policymakers and providers of services to the elderly and persons with disabilities and also consumers of those services. Many of the people who participate in that council are here in this room today.

We meet monthly to discuss State policies, as well as the impact of Federal programs and the impact of budget. A small change in how Medicare pays for certain services can have a large impact on all of the people who sit at that table, trying to do the best for Rhode Islanders. And one of the most important reasons for us to all work together to safeguard and strengthen Medicare is that some of the most important reforms will be possible through the significant purchasing power and benefit coverage of Medicare and its ability to work effectively with our Medicaid programs, which provide so much care to seniors in long-term care, both in the community and in nursing homes.

The value of the Long-Term Care Council is that it represents an open forum for some of the most well-informed and knowledgeable participants in the long-term care arena. It is the forum where all facets of the long-term care system are at the same table discussing the common areas of interest and concern.

This coordinated approach allows for thoughtful dialogue and creates an environment that fosters the use of best practices and

information sharing. It makes sure that the services for aging, that the services of Medicaid, that the services of Medicare fit together to serve the people of our State.

So that is a lot about Government policy and how we need to coordinate Government policy, but one of the pleasures of being an elected official is I am also out every day in so many different ways talking to people in the community. And there isn't a person that I talk to who doesn't care deeply about the future of our State and our country, who doesn't want to be responsible with taxes and taxation and with fraud and abuse, but who also wants to make sure that our family members, our parents, our husbands and wives, and our children are going to benefit from the very strong Social Security and Medicare programs that we have in our country today.

You know, it seems a long time ago those days when half of our seniors lived in poverty. You know, it was when my father was born, for example, was that time. But I have no doubt that it would not take us very long to go back there, and I do not see a State or a country that is willing to do that to the people that we share a community with.

So the Republican budget that was put out for discussion a few weeks ago, to me, absolutely breaks that promise for the future, and I, as a public official, will fight as hard as I can and certainly support Senator Whitehouse in his effort to fight that so that all of us, looking forward, can have a security for our family, for those we love, and for ourselves that we can stay independent, healthy, in our communities throughout our lives.

Thank you very much.

[The prepared statement of Elizabeth Roberts appears in the Appendix on page 42.]

Senator WHITEHOUSE. Thank you, Lieutenant Governor.

And before we switch to Chris Koller, I just want to say that the Affordable Care Act provided very significant tools to States to improve the quality of care and to save money not by cutting people's benefits or taking things away from them, but by improving the quality of care, by coordinating the care better, by eliminating some of the waste and some of the foolishness that is now endemic in our healthcare system.

But we can't do that if there aren't local leaders who are willing to step up and wield those tools and figure out how to make this work in their local communities. And Lieutenant Governor Roberts' leadership on this, recognized by Governor Chafee, is really significant and worthy of note before I turn to our health insurance commissioner, Chris Koller.

Chris, please proceed.

STATEMENT OF CHRISTOPHER F. KOLLER, RHODE ISLAND HEALTH INSURANCE COMMISSIONER

Mr. KOLLER. Great. Thank you very much, Senator Whitehouse and honored guests.

I have to add to the chorus. I want to particularly recognize my colleague Catherine Taylor and all the great work that she and her staff do at the Department of Elderly Affairs.

And Mayor Polisena, I want to note this is a great senior center, and this crowd is a little bit different from one of the last times I was here, which is when we were debating the Affordable Care Act. And what a difference a few years makes is what I would say.

But regardless, it is important to have these community resources where people can come and be informed and engage in discussions as a part of what makes our country what we are. And it is because of, as Lieutenant Governor said, communities that can come together to work on these things.

So in my role, I am responsible for overseeing the actions of commercial health insurance companies, including the rates they charge. And I believe that Senator Whitehouse wanted me to speak to that a little bit and this issue of rising costs. So I am going to take lessons from my religion background and tell you what I am going to say and then say it and then tell you what I said.

The messages are rising medical costs are not unique to Medicare. They are a problem across the entire system. And the reasons for these increases are because of the way we organize and pay for our care.

And the third point is that the Affordable Care Act, as Senator Whitehouse and the Lieutenant Governor said, gives us some great tools to address these costs, and the urgency is only going to increase in the coming years. Because if we get this wrong, then we have no choice but to take the options that are being put forward by other folks around vouchers and things like that. So the onus is on us to use these tools and make them work.

The first part with rising costs, there are lots of ways to state this problem as it goes to Medicare. The Medicare trust fund is scheduled to go bankrupt in 2029. Medicare now consumes a full 15 percent of the budget, and Medicare costs are increasing at two or three times rates of inflation. We can't afford to keep paying taxes—we don't want our taxes to go up two or three times what our Social Security, our wages are going up.

This isn't sustainable for the Federal Government, but this is not unique to Medicare. In Rhode Island, commercial insurance rates, in spite of our office's activities, are rising the last few years at an average of 9 percent a year. Medicaid is the fastest-growing part of the State budget, and that is in spite of the work that Secretary Costantino and his staff continue to do around reducing those costs. And soon, Medicaid is going to be even larger than Medicare nationally.

Now you would think that if we spend 75 percent more per person than any other country that we would get better healthcare as a result, but we don't. Anyone who says that we have the greatest healthcare system in the world I think isn't looking at the numbers that says that we have people who die earlier. We have poor infant mortality. We have more obese people.

We can do better. We don't get a whole lot for all this money that we spend, but it is not a problem that is unique to Medicare.

So where does all this money go? If you look at some of the data, really what we are getting is a lot more services, but particularly, we are paying more people for those services. If you look, compared to other countries, we pay more to our hospitals, to our specialists, to almost every provider at the high end per unit of service.

We actually use less services, I was surprised to find out, than some of the other countries. But we pay more for them. But I want to point out that we don't have to look overseas for solutions. There actually are communities that do better, where costs are 40, 50 percent lower than the averages. It is not just in Medicare. It is across Medicare, commercial, Medicaid. There are communities that get it right.

And the researchers say that those communities that get it right across everybody—Medicare, Medicaid, commercial, uninsured—they have lots of primary care. They have physicians who are organized as groups rather than individuals.

You know, one of our proudest things that we have nationally, and it is sort of one of our best hidden secrets is the Veterans Administration care system, which actually delivers better outcomes and lower costs because the physicians work together as a group. And that is run by the Government. Can you imagine that?

[Laughter.]

These communities have nonprofit hospitals that both compete, but they collaborate. They don't advertise for their latest toy. They advertise for how they are working to reduce costs of care and keep people healthy. These communities have a strong public focus on improving quality, like some of what the Lieutenant Governor has done with flu vaccinations, something that we are very good at in Rhode Island. And they have employers who care and who are willing to go to hospitals and providers and say this is what we want.

So we can become a community like that, through the leadership of Senator Whitehouse, Lieutenant Governor, and other folks working in the State, if we are willing to look at the community as a whole. And how do we put these things together? How do we have lots of good primary care? How do we have medical homes where people can go to get all their services? How do we have community supports that keep people out of hospitals, keep people out of nursing homes unless they have to be there, keep people from being readmitted to the hospitals?

This sort of looking at broader than medical care but thinking about it as healthcare. If we can get our medical providers to work together through things like health information technology and the way that we pay our providers.

So what I want to close with is what the implications are for Medicare because—bring this back down to Medicare. First of all, we have to acknowledge that change is going to have to happen, that the status quo, it is bad for private industry. They can't afford these medical care costs. And it is bad for the Federal Government, as it pays for Medicare.

But we have control over how that change happens, and I think what we are saying is that change can be different than just handing individuals a check and say, "Good luck and God bless, and navigate the system." But the onus is on us.

The second thing is that if we are going to do this, the Federal Government and the State governments have to use the power, the leverage that they have. If you combine Medicare and Medicaid that means $1 out of every $2 that gets spent in this country is spent by public folks. They can pay for what works and not pay for what doesn't work.

And I want to recognize the work that Senator Whitehouse has been doing consistently to try to get Medicare and Medicaid to be better purchasers of things like health information technology, of primary care, the things that we know work, as opposed to paying for things that don't work.

And the last thing I want to say is that the Federal Government has this leverage where it is really on us if we don't want to have the kind of choice that the Lieutenant Governor is talking about is that the Federal Government has to learn how to have the independence to make these sorts of decisions. And I want to call something—it might be really detailed, but it is a good example.

Buried within—and Senator Whitehouse worked hard for this. Buried within the Affordable Care Act was something called the Independent Payment Advisory Board that was a panel of independent experts, not part of Congress, not part of Health and Human Services. They would make recommendations to Medicare and Medicaid to pay for the things that work.

Why is it that we in Rhode Island have more MRIs than in the entire country of Canada? Why is it that children's psychiatrists are scarce as hen's teeth? Well, it is because of the way Medicare pays. And Medicare makes MRIs really, really profitable.

And why does it do that? Because the radiology folks have very good lobbyists who lobby Congress about how MRIs should be paid, and therefore, we are advertising for them in the New England Patriots games. "Come, get your MRI."

[Laughter.]

That isn't going to help keep us healthy, but if we want to change that, we have to make those decisions independently from political interference.

And the Independent Payment Advisory Board was not a death panel. It is not about rationing care. It is about making some decisions about what it—it is frankly doing the kind of things that we are doing here, trying to pay more for primary care, trying not to pay for hospitals to get you sick and then to pay to cure you, which is the way that Medicare pays right now.

So, and if we don't figure out politically how to set up those things, the Senator knows politics is not a bad word. If we don't figure out politically how to set up those things, then we are left with vouchers. We are left with all the Government can do is give you a check and say, "Good luck, navigate out there." And I think we can expect more from ourselves. I think we can expect more from the Government than simply to do that for our seniors, for our parents, for us.

I think it is only through the hard work of people here, the citizens, that we can put this sort of thing together. Because if we don't this is the kind of future that we are talking about. And as I said, I think we can do better.

Thank you very much.

[The prepared statement of Christopher F. Koller appears in the Appendix on page 46.]

Senator WHITEHOUSE. Thank you very much, Chris.

Let me start with a question for Deputy Assistant Secretary Walker. You made an interesting point in your testimony that a great number of seniors are able to remain in their own homes de-

spite meeting the disability requirements for entry into a nursing home.

Now, presumably, that is better for the seniors because they are more independent. Presumably, it is also less expensive for the system.

Before we got underway here, Director Taylor told me that they have information at the Department of Elderly Affairs that seniors who engage with the Department of Elderly Affairs on a regular basis and get involved in their programs actually, on average, last 17 months longer before they end up in a nursing home. They have much longer periods of independence.

So could you talk a little bit about what the things are that seem to be most effective in supporting people to make—first of all, is it a win-win? It looks like it. Is it, in your experience, really a win-win? And if so, how can we get more of it?

Mr. WALKER. Thank you for the question, and the answer is absolutely.

That is really the beauty of the Older Americans Act as the complement to the other systems we have. The mission of the Older Americans Act is very simple. It is to help older people, by giving them supports, do what they want to do, do what they prefer to do, which is to remain independent, to live with dignity, to maintain their health, and to keep them at home and in their own communities for as long as possible.

We clearly understand that, at some point, many seniors will have to go to a nursing facility because they may not have the supports in the community. They may not have family caregivers to provide them support in their own homes. And at that point, the Older Americans Act provides an array of protections to speak on their behalf, to look after their interests, to ensure that the facility is providing the highest quality of care for that older individual.

But our services are low-cost services, nonmedical services that complement the services in a facility, and I have to, again, publicly applaud Rhode Island. What we have done at the Administration on Aging is we have studied what works, what are the things that really are the most effective and the most efficient solutions. And then we have put out discretionary grants—because the Congress has enabled us to do that—encouraging States to try new things, to test new models, to find out what really works within the State and within each community.

And Rhode Island has actively sought those grants, positively competed and won, and has put in place a number of innovative approaches, working with hospitals to reduce readmissions, ensuring that individuals know what the doctor said at the point of discharge, know what supports can be put together within the community so that you avoid having to return to the hospital.

I recently saw a statistic, and I will have to get you the exact figure, but it was startling. It was something like within 30 days of a hospital discharge, 24 percent or 2.6 million of Medicare beneficiaries are readmitted—it was incredible. And the costs are startling—in excess of $2.6 billion each year.

And so, as part of coordinating care, using the Older Americans Act premise of we don't have to fund everything through the Older Americans Act, but the responsibility of a State unit on aging and

an area agency on aging and a tribal organization is to coordinate the services in the community on behalf of the older individual, making it easy for them to access those services, making it effective and efficient.

Senator WHITEHOUSE. So the role of States and particularly of State officials like Lieutenant Governor Roberts and Director Taylor and Commissioner Koller in working together to have a coordinated strategy on this is really central to the success of this program and to allowing seniors these opportunities?

Mr. WALKER. Absolutely. And we look to common sense solutions. The Older Americans Act also has the beauty of ensuring that consumers, older people themselves, are active participants in designing systems, in providing input in terms of what works, what doesn't work well.

You have a number of coordinating councils here in Rhode Island—the Lieutenant Governor is heading those—in terms of how do we constantly look at improving what we have, ensuring that it works well? Living within our means, but making sure that we can do the best we can for the citizens of this State and of this country.

Senator WHITEHOUSE. Let me ask the Lieutenant Governor or the commissioner, both of you used the term "patient-centered medical homes." That is a known piece of terminology in healthcare jargon.

But I think it would be good for the people here in the room and for the record of the hearing, describe that in kind of human terms. What is the experience of a patient who gets into one, and what does it mean in somebody's own life when they have a good operating, patient-centered medical home?

Ms. ROBERTS. Senator, I was going to suggest—I just suggested to the health insurance commissioner that he describe the structure, and then I will actually tell a personal story about how it has worked.

Mr. KOLLER. So if you look at a typical insurer's costs, and the same would be true for Medicare, 5 percent of the people drive 50 percent of the costs in the system. And if you think about who that 5 percent are, they are people with chronic illnesses. They are probably people who are too sick or too disengaged to come to a day like today.

And how do those people get their medical care? They get it all over the place. They go see a foot doctor. They go see a lung doctor. Because they don't have a single disease, they have a bunch of diseases. They have diabetes, and with their diabetes, they are overweight. And that starts to affect their heart. And so, what they are seeing is a bunch of doctors with no one coordinating it.

And the best example is they have got a huge bag of pills, and they don't quite know what to do with it. But every doctor said, "Take this. I think it will be good, and give me a call back in a few weeks and see how it goes."

No one is looking to say, "Well, do those pills interact with one another?" No one is calling up to say, "Did the pills work? Did you finish them?" And chances are they might be sitting on a medicine cabinet or something like that. And it is not just that those pills are expensive. They are. But it is that there is no quarterback.

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So the idea, Senator, you are right. It is kind of jargon. But the idea of a patient-centered medical home is pretty simple. It is to have a medical care provider, a place where you can go who can coordinate your care. And often, it is not the Marcus Welby doctor. It is actually a nurse working for the Marcus Welby doctor.

And the nurse is the one who knows what is going on, who calls you up afterwards and say, "Did you go to your visit? How did it feel? Did it work for you? Let us try something else." And then she goes, or he, and puzzles through with the doc to say what is happening with that, and when should we try something different?

And the problem is that, once again, Medicare, Medicaid, the commercial insurers, they don't pay for that. They don't pay the doc to spend 45 minutes with you or your parent to figure out what is going on and put together a plan, or a nurse. They don't pay for the nurses at all.

They pay for the docs to do a 15-minute visit. Next, next, next, next. Prescribe a pill. Let us go on.

And so, to change that requires public action. Believe me insurers aren't going to do it. The market isn't going to do it. It takes Medicare and the local insurance regulators to sit down and say, hey, you know what? Pay for something different.

If a primary care doc has a nurse care manager, if a primary care doc has an electronic health record, if they work as a team, then we want you to pay for them differently. Pay for them to coordinate that care. That is the principle behind a patient-centered medical home.

Before the Lieutenant Governor talks about it, I have got to say something we are very proud of in Rhode Island. We actually have more of those per capita than any other State in the country because of the really hard work that the primary care docs have been doing for a while with the insurers.

So that is sort of it in theory. But in practice——

Ms. ROBERTS. So it is a little bit of back to the future, I like to say. You know, it is about having an office where they know you, where they have a range of people—because I think about it, you know, most of us take this for granted with our pediatricians.

If your kids are well, I remember even when I was a kid, but with my kids, they would see the nurse for their shots and this and that. I think my children, who are now slightly above the pediatrician, didn't see the pediatrician for the last 5 years because they weren't sick. They just needed somebody to check in, did their physical. And the doctor would see them if they needed to.

But let me tell you a story about my dad. And my dad has a number of chronic illnesses, but my dad has a doctor who he has had for 30 years, who coordinates his care and who also knows him and knows his personality, knows his medical history, and has that information background that helps make a difference.

And my dad had a serious health crisis. Of course, there was a big snowstorm when it happened. So they were having trouble getting to the hospital. His doctor had trouble getting to the hospital. And his doctor came to see him and looked at my dad and said, you know, you are not a candidate for surgery, which, if you were younger, we would do. And I am not going to admit you to the hospital. I am going to send you home.

And we are then going to have people come, and this goes back to that continuum of care, people are going to come and help care for you at home. And he said to my dad, honestly, I can't tell you you are going to live. You may not live. But he knew my dad to know to send him home because I don't think my dad would have lived if he had stayed in the hospital.

So my dad went home. He is living with my brother because he is a widower, and they coordinated hospice services. And you know what? It is a year and half later. My dad is living with my brother, doing quite well. You know, he has still got chronic conditions, but it is what the potential is on a very practical level, on a personal level.

And when you think about it and you are not his daughter, you also think about the fact that that just saved Medicare tens of thousands of dollars and did the right thing for my father.

So medical homes have the ability to know you, know your living situation, have a range of providers integrated in. If you maybe need some mental health counseling as part of recovering, they have access to those services. It helps you navigate.

And for those of us who are children of people who are ill, that bag of pills and that list of 10 doctors is just as overwhelming, and how do we help our seniors and all of us navigate this complex system? That medical home can be our partner and a very powerful partner.

Senator WHITEHOUSE. Let me ask one final question before we go on to the second panel. We have talked about the so-called medical home, which is really something as simple and human and practical as a go-to person who knows you and who knows what care you are receiving and can help you organize what is going on, understand what is going on, and navigate your way through the system. That is the most kind of low-tech possible thing.

At the other end is the high-tech aspect of health information technology. And when I first started looking into this, I was astounded to read that there had been fortunes saved in retail, in banking, in financial services, and all these different American industries, but it hadn't really penetrated into healthcare in any significant way. Indeed, the article said that the healthcare industry had about as much information technology going on in it as the mining industry.

And then I ran into—the human stories started to come out. I remember a person I know whose daughter was so ill that she had to be basically medically evacuated up to a Boston hospital. And in the rush to get her into the ambulance and up to the Boston hospital where the specialists were waiting to treat her, her paper records got left behind at the Rhode Island hospital.

And so, they got up there, and they didn't know what to do. And they couldn't go the way you could go in every other aspect of your lives and find it electronically. They had to send a car, take a call down there, and send a car up with the records.

In the meantime, she was in real extremis, and they started needing to redo the tests that had already been done on her so they could know what to do up there while the car was racing up with the records, put her life at risk, cost an absolute fortune in unnecessary tests.

And you can imagine the fear of the father with his daughter going through all this. "You are kidding me. You forgot the records, and there is no way to—"

So could you just comment for a bit, Lieutenant Governor and then Commissioner, on what you think the value is down the road if we can get a really robust health information infrastructure going here in Rhode Island?

Ms. ROBERTS. Well, this is a great example of where reform does exactly what it should. It improves quality and lowers cost and lowers inefficiency.

It is amazing that we don't even have to go to Boston. I work at the State House. So if you think about it, if I fell down the stairs at the State House and really badly hurt myself, I would probably go to the Miriam Hospital emergency room—it is sort of the closest one—to get whatever care I needed.

And if I then went home, and I live about 4 miles from there in Cranston, and things weren't going right and I ended up at Kent Hospital, they would have no idea what had happened. And heaven forbid I was ill enough that I couldn't tell them. I didn't have my husband with me who could tell them about me. They have to start from scratch.

And it is amazing to me that I can go anywhere in the world and look at every single banking transaction in the last 12 months of my Citizens Bank account here in Rhode Island, but I can't go into a doctor's office that is not my doctor's office and have them know anything about me. It just makes sense in terms of quality, in terms of cost, in terms of simplifying.

Like that human navigator we want to have help us with the system, to have our information travel through the system—our history, our medications, all of those things—so that people aren't duplicating services, but they also know quickly about your medical history.

For those of you who don't know—and I am going to give Senator Whitehouse, we will have a little mutual admiration society here—we are really leading the country in many respects in this effort. And there have been big Federal grant opportunities to help us invest in this system and creating that network so that medical information can be privately and safely shared between our different physicians and a hospital if we walk in the door.

We have benefited from all three of the—we are a three-for-three State in terms of Federal investment here. And you now have the opportunity to sign up as an individual in what is called currentcare, where your medical information, your lab reports—think about it, MRIs. How many people—as the head of health purchasing for IBM said, "My goal in buying health insurance for my employees is never to pay for an MRI twice in one day."

And how many people have had a problem and had a test duplicated because you went someplace else because they sent you somewhere else or they couldn't get access to your past? It is really an exciting thing. It is a great opportunity, and we have to do it.

Now when Senator Whitehouse says we were behind, it was partly because so much of healthcare we have been struggling with each other. We fight with our health insurance company. Our

health insurance companies fight with the doctors and physician offices. We haven't been on the same page.

And in order to make investments like that, which sometimes benefit one group financially and sometimes another, you don't want to invest. It is like, "Oh, it is his benefit. He needs to pay for it." We need to be focused on the common good of the health of our community, and then we invest.

And I really give a lot of credit to our Federal leaders for giving us the resources to move this issue forward in our State, and we need to really make it work well for the broad community.

Mr. KOLLER. You took all my lines.

[Laughter.]

I think I would just add a couple of things. One, most of the research indicates that 20 to 30 percent of medical care is duplicative, just of absolutely no value. And the best example is what happens when someone goes to the emergency room. The emergency room is kind of like our symbol for everything that is messed up in our healthcare system because we are asking highly trained docs to take care of kids with earaches, as well as trauma victims.

It makes no sense, and they have no information. It is like they are being asked to fly an airplane with the shades down over it because they have to invent everything all over again because they have no information on you when you come in.

What I want to—and the other point I would make is after Hurricane Katrina, the patients who were evacuated, the citizens who were evacuated, the ones who were the most medically secure were the veterans because they could land at any place, walk into any VA facility, and someone would look and say, "Oh, here is your problem list."

Imagine having to recreate that if you were coming out of Katrina or someplace. The last thing you are going to pick up is your chart on your way out. And yet, for the VA, it was all there.

So what I would—so making this real is real hard in Rhode Island. Money helps, but it is also kind of personal change. So I would encourage every one of you to have a conversation with your primary care physician, your medical home, to say how do I sign up for currentcare? To ask yourself what would it take for me to feel comfortable signing in for this?

And if you are not comfortable because you are concerned about security of information, if you are concerned about someone having access to it, then you have to tell us what it would take to make you comfortable. Because until each of us makes that commitment to change, to be part of the system or to say what it is going to take for them to do it, then we are going to be left with ER docs who are giving us tons of tests and two MRIs a day.

And so, that is how we move from talking about it in theory to getting the money to making it actually happen so that we have got—our clinicians have the information so they can make the right decisions for us at each point.

Senator WHITEHOUSE. It is a little bit out of the traditional order for an official Senate hearing. But this is Rhode Island. So I get to do it my way, not the Washington way.

And what I would like to do is to ask for our Lieutenant Governor, for Assistant Secretary Walker, and for our healthcare com-

missioner a round of applause for their wonderful testimony, for the great work that they do.

[Applause.]

And we will take just a moment while we call up the second panel. So if you want to stretch for a second?

[Pause.]

Alright. The hearing will come back to order.

I hope that the first panel helped demonstrate how important and how realistic some of the practical alternatives are to simply throwing people off of Medicare or throwing people off of Social Security because of cost issues. Whether it was Deputy Assistant Secretary Walker talking about the ways you can keep seniors at home longer by working with the Department of Elderly Affairs and with Director Taylor and save money that way or whether you are talking about having a medical home that coordinates your care with a nurse who knows who you are and what you are doing, what your situation is, to having an electronic record that follows you wherever you go, there are things that can be done that can improve our system and make it less expensive.

And we now have witnesses who can talk a little bit about the personal cost and the problems that can ensue if we don't choose to go that way, but instead choose just to cut and take things away from people.

And first, we will hear from Kathleen Connell. She is the senior State director of AARP Rhode Island. Kathy joined AARP Rhode Island in 2001, following a long and distinguished career in public service, education, and healthcare. Her career in public service included three terms as Rhode Island Secretary of State, a term in the Rhode Island Senate, and 16 years elected to local town offices in Middletown.

During that time, she was also a leader in numerous education and healthcare issues and in issues affecting women. She currently serves on the board of directors of Quality Partners of Rhode Island. Kathleen holds a master's degree in international relations and a bachelor's degree in nursing, both from Salve Regina University in Newport, Rhode Island.

Our final witness will be Audrey Brett, who is a senior living in Middletown, Rhode Island, where she has retired after a career in State and local government in nearby Connecticut. She currently receives Social Security and Medicare benefits. She has two sons, seven grandchildren, and two great-granddaughters.

We will begin with Kathy Connell.

STATEMENT OF KATHLEEN CONNELL, SENIOR STATE DIRECTOR, AARP RHODE ISLAND

Ms. CONNELL. Thank you, Senator, and it is a pleasure and an honor to be here and a challenge to follow the previous panel.

All of them have shown and I am sure, Deputy Assistant Secretary Walker, that you observe that Rhode Island has a tradition of leadership in healthcare that exists today more strongly than ever. It is a tradition that we take great pride in, beginning with our Congressmen Fogarty and Forand and the OAA and Medicare. And we are pleased, more than pleased, that our Senator is taking a leadership role in the challenges in this particular area.

I am here today as the State director of AARP. And as I said, it is a challenge to follow that panel. In fact, Audrey said as we were called up, "Okay, we are the also-rans."

[Laughter.]

So she clearly has a sense of humor about this, and I am looking forward to hearing her testimony, too.

But it is as a representative of AARP that I am here, and let me address that. AARP is a nonprofit, nonpartisan, social mission organization representing some 37 million members age 50 and older across the country. Here in Rhode Island, we serve some 135,000 members, which is a significant number in a State this size.

This morning, AARP Rhode Island had an executive council meeting scheduled, but when the Senator's office called, the executive council agreed that there is nothing more important on our plates than the issues we discuss today. So we changed the meeting, and the executive council are here with us today. Would you people all raise your hands, please?

And these are dedicated individuals that are out there, working on the issues AARP takes positions on and backs up with research and efforts in the field.

Our members are Democrats, Republicans, moderates, independents, people who align with other parties, and some who aren't sure where they stand politically. But what they have in common is that they seek a healthy, secure future, a life of independence, dignity, and purpose. In short, the American dream. Among the ways AARP helps to fulfill this expectation here in Rhode Island and across the country is through education and information, advocacy, and community service.

So let me begin by addressing concerns about Social Security. Seniors, along with just about everyone else, are nervous about potential changes in Social Security and what the debate in Congress holds for their future. I want to assure you that AARP on both the national and State levels will be a strong and tireless participant in this watershed discussion, and we know you will be, too.

First, let me tell you where we stand. Social Security must be protected for current beneficiaries and strengthened so future generations get the benefits they have earned. But Social Security changes should only be considered if these changes make retirement more secure, not less. And it is important to understand some key points.

Social Security is strong and can pay Americans 100 percent of the benefits they have earned for the next 25 years and approximately 75 percent of promised benefits thereafter without any changes at all. But to make sure the program will be strong for future generations, we need to make gradual, modest changes sooner rather than later.

Social Security is not only a lifeline for the most vulnerable. It is a critical source of income for the middle class. Do not let it be turned into a welfare program. In other words, if Social Security is fundamentally altered so that it is no longer an earned benefit for all who contribute, then the long-term result will be many middle-class wage earners retiring without the critical income support provided by Social Security. For most middle-income earners, Social Security remains their largest source of income in retirement.

Americans have earned their Social Security benefits by paying into the system their whole working lives. Social Security is earned by the money you contribute from your paycheck and what your employer contributes on your behalf.

Social Security has not contributed to the Nation's debt and should not be used to balance the budget. Instead of putting our children and grandchildren's retirement in jeopardy, Congress should find ways to solve our Nation's budget problems without making damaging cuts to Social Security.

We believe Social Security is a guarantee. When you pay in, you get the benefit you earned when you retire. Social Security benefits should keep up with inflation so seniors, many of whom are kept out of poverty by Social Security, can continue to afford basic necessities when costs rise. We believe that Social Security benefits were always intended to be there in both good times and bad.

It is also important to note that the next generation has paid into Social Security for decades and deserves to get the retirement benefits they have already earned. With shrinking pensions, dwindling savings, diminished assets, and longer life expectancies, future generations will depend on Social Security even more. It goes without saying your urgent attention to strengthening Social Security for the long term is necessary and greatly appreciated.

Let me next mention the Medicare program and some recent proposals being considered by Congress. Medicare was created in 1965 and plays a vital role in ensuring health and retirement security of older Americans and people with disabilities in current and future generations.

Medicare covers persons age 65 and older, regardless of their income or medical history, and now covers 47 million Americans, helping individuals pay for needed healthcare services. Nearly half of all people on Medicare, 47 percent, live on incomes below $21,600 as individuals and $29,140 for couples.

According to the most recent data available, Medicare beneficiaries spent a median of $3,103 a year of their own money on healthcare in 2006. Ten percent of beneficiaries, more than 4 million people, spent more than $8,300 a year. The oldest and poorest beneficiaries spent about one-quarter of their incomes on healthcare.

As you know, AARP supported the Affordable Care Act last year because it will improve and strengthen Medicare and provide Americans who currently lack health insurance access to affordable comprehensive health insurance. President Obama recently suggested that the Independent Payment Advisory Board, IPAB, established under the new law, be expanded. AARP agrees with many of the Independent Payment Advisory Board's original goals, that being extending Medicare solvency, slowing cost growth, and improving quality without reducing benefits or increasing cost sharing for people in Medicare.

However, we remain concerned about the spending targets the IPAB must meet in its second 10 years and the unintended impact these savings targets might have on beneficiaries' access to or quality of care. We have strong concerns with expanding the role of this unelected, unaccountable board. We will carefully monitor how

these proposals move forward to ensure that Medicare is protected and strengthened for the millions of people who depend on it.

Other proposals being considered in Congress that would greatly expand the cost sharing on beneficiaries, significantly increasing their out-of-pocket cost for Medicare, we do not believe the answer is to simply shift costs onto Medicare beneficiaries and increase the health and economic insecurity of millions of Americans. Increasing the out-of-pocket costs for people on Medicare would especially penalize the sick.

The House-passed Fiscal Year 2012 budget resolution. Before it left for recess, the House passed this resolution, which, among other things, would eliminate the current Medicare program for those turning 65 in the year 2022 and after and replace it with a defined contribution premium support program, with the Government's contribution growing each year by the rate of inflation. We find the direction of this House-passed budget disturbing and in some cases misguided.

First, we are concerned that a premium support system would dramatically increase costs for Medicare beneficiaries while removing the promise of secure health coverage, a guarantee that future seniors have contributed to through a lifetime of hard work. Under this proposal, premium payments to private plans would be sharply reduced, capped at levels well below medical inflation.

Therefore, Medicare beneficiaries would bear a larger and larger share of the high cost of medical inflation. According to the calculations based on the Congressional Budget Office analysis, the House-passed budget would more than double the beneficiary costs in 2022 from about $5,500 to $12,500, an increase of roughly $7,000 per year in beneficiary premiums and coinsurance.

The legislation would also increase the age of Medicare eligibility from 65 to 67 by 2033. Those who enter Medicare before 2022 would continue under the current program, with the option to switch to the new program. AARP opposes raising the age of eligibility for the Medicare program because, according to research, it would increase the cost burden for 65- to 66-year-olds; increase premiums and cost sharing for Medicare enrollees; raise costs for States, employers, and for people under 67 purchasing coverage; and produce relatively little in savings to the Federal Government.

And the House-passed budget repeals key improvements in the Affordable Care Act. The two I would like to speak to today are closure of the coverage gap or donut hole in Medicare Part D and eliminating the Community Living Assistance Services and Supports, CLASS, program.

AARP fought to close the donut hole because it provides millions of seniors with access to lower out-of-pocket costs for their prescription drugs. Repealing the donut hole provision would immediately increase the prescription drug costs for nearly 4 million Medicare beneficiaries.

The CLASS program is a national voluntary insurance program to help individuals pay for some of the costs of services and supports to help them live in their homes and communities. It has the potential to provide savings in Medicaid, support family caregivers in their caregiving roles, and help to give eligible consumers choice and control and a flexible benefit to help them meet their needs.

Abandoning relief from the donut hole and taking away an option to help people live in their homes does not bode well for older adults. The added burden of higher health costs would put more seniors at risk, especially those who are most vulnerable.

As for Medicaid, under the House-passed budget resolution, all Federal Medicaid payments to States would be converted to a block grant, beginning in 2013, with constrained annual growth. Now Rhode Island is operating in a special environment when it comes to Medicaid because we have what is known as the global waiver that puts more money to work here, creating some flexibility in how the State allocates Federal funds and, we hope, helping us to rebalance the health and long-term services and support system toward more community-based care, which research shows over and over again is the preference of the people who use it.

We are watching this closely because oversight is absolutely critical and because it remains to be seen what happens down the road when we are apt to see a reduction in the original Federal contribution. What we do know is that the notion of replacing Medicaid as it is presently constituted with a block grant system is a move in the wrong direction.

There are limited financing options currently available to pay for long-term services and supports, and individuals typically exhaust their own assets before turning to Medicaid. Block granting Medicaid would put both current and future seniors in need of these services at risk. For those who are already in nursing homes or receiving home- and community-based services, cutbacks could lead to reduced access and inadequate care.

For those who do not yet need long-term services and supports or can still pay for those services themselves, if the time comes and they have exhausted their savings, may be turned away or offered insufficient care that neither meets their needs nor maintains their dignity.

While AARP appreciates that the budget resolution recognizes the importance of Social Security to older Americans, we remain concerned that across-the-board cuts to Medicare, Medicaid, and other critical Federal programs could also have a detrimental impact to the lives of many seniors who depend on these programs for their health and retirement security. We urge you to consider the impact of these proposed cuts on real people here in Rhode Island and across the country and to look to less draconian ways to achieve savings.

Across-the-board cuts could include reductions in Medicare and Medicaid and other healthcare spending. The House-passed budget resolution proposes enacting this hard spending cap as a law, and it could not be waived regardless of need or economic circumstances, even by a supermajority of votes in Congress.

The budget contemplates enacting this spending cap as part of the debt ceiling debate that will begin when you return to Congress next week. This is a frightening scenario for everyone.

The Older Americans Act provides essential programs, information, and services to meet the needs of a growing older population. These programs provide vital support for those older adults who are at significant risk of losing their ability to remain in their own

homes and communities who need support and protection in long-term care facilities.

Pending formal legislative language, our interest is to ensure that the act maintains critical service and information roles and promotes greater responsiveness to the needs of mature and older Americans. In this period of economic downturn, AARP is most concerned that programs, authorities, and partnerships that have already proven effective in meeting the needs of vulnerable older Americans be maintained and strengthened.

We believe that the most important legislative objective to better serve older persons is to promote and improve efficiency in the delivery of core services. Better coordination of existing OAA programs with other Federal programs holds great promise and merits the support of the Administration and Congress.

AARP's 135,000 members in Rhode Island hope that the Special Committee on Aging is listening. We hope you will not turn away from the great needs of a generation that has made America great and millions of others who have paid into a system based on the promise of greater health and financial security in retirement.

We know that creative solutions are necessary. All we ask is that you carefully measure the human consequences of your decisions and that you remember the greatest wealth of this Nation is the way we show the world the respect we have for our older citizens.

Thank you.

[The prepared statement of Kathleen Connell appears in the Appendix on page 50.]

Senator WHITEHOUSE. Thank you very much, Kathy, and thank you to AARP.

And now we will turn to our final witness, Audrey Brett. Please proceed.

STATEMENT OF AUDREY BRETT

Ms. BRETT. Hi. I don't know how to use this. Is this right? Okay.

I really don't know why I am here. I feel very flattered, and I thank you for having me. I am not of the caliber of the professional people who are speaking. I am just an old Yankee tobacco farmer from Connecticut.

[Laughter.]

But us Yankees have pretty good logic, I want you to know that. Also, speaking last, I don't have to speak long, and I can be comic relief.

[Laughter.]

It delights me to hear all this talk about 65-year-olds. I have a son that age. He is very old for my age.

[Laughter.]

As a young woman, I worked full time. And during my years, I paid payroll taxes, and when I retired, I applied for Social Security. Women's wages at that time were a small percentage of what men earned, another one of my women's rights things. And so, my Social Security check was quite minimal.

And I never thought much about it until my husband died and my check stopped. His was transferred to me, and that was really a godsend. He died suddenly. I not only lost him, I lost one check, the supplemental income he brought in as a manufacturer's rep.

I still had the same rent, maintenance, medical costs, car maintenance, food, and no income except for the Social Security check, which enabled me to go on living simply, but adequately, and without being a burden on my sons and losing my dignity as well. Like me, many friends are experiencing the same Social Security that has succeeded in keeping millions of widows, senior citizens, children, and disabled out of poverty.

I am reminded of an old political saying, as I listen and read a lot. Because I spent all of my adult years in Connecticut in the political arena and 50 years in the vineyard, I learned a lot of good stuff. And one thing I learned was, "Figures don't lie, but liars figure."

The Preamble of our Constitution describes that document as providing for the common defense and promoting the general welfare. We go all the way back to that. And I am disturbed and troubled that there are those who would destroy our basic democratic principles for their own political aggrandizement. I worry for me. I worry for my children.

That grand old lady standing in New York Harbor who welcomed all of those who came to this country, the land of the free, where all men are created equal, to find a good life, she stands in the harbor and weeps.

When I crossed the border into Rhode Island, one of the first things I did was to establish myself with a medical provider. That is my old Girl Scout training, "Be prepared." I quickly learned that although Medicare is always accepted, certain Medigap insurances are not. I have never had a complaint with Medicare. It has always been available and always delivers what it has committed to do.

In the privatized area, however, actions are very different. In the private sector, companies have used the process known as rescission for many years. It is well documented that tens of thousands of Americans lose their health insurance after being diagnosed with life-threatening, expensive medical conditions. And once you lose it and have an existing condition, you can't get insurance.

Again, political expediency, I greatly fear the change for Medicare to privatization. The Federal Medicare program has changed the lives of millions of Americans, but our roots of Medicare go back to our Nation's early efforts to achieve health coverage for its elderly and poor citizens.

For all those Americans who worked, paid their taxes, added to the betterment of this country, served in the military and civil service, we cannot let them live and die in poverty. We owe them the final days of security and dignity.

If I had to move out of Connecticut, I think I am glad I came to Rhode Island because I am impressed with the gentleman of intelligence, understanding, and caring who represents this State in the Senate. And Senator Whitehouse, for your tireless efforts in resisting the actions that threaten the good and welfare of your constituents in the Nation, I thank you very much.

[The prepared statement of Audrey Brett appears in the Appendix on page 57.]

Senator WHITEHOUSE. Thank you, Audrey, very much.

It is always good to have some testimony that keeps it real, and you have more than accomplished that goal. And I really appreciate that you testified here today.

I want to note one thing in Audrey's testimony that I thought was particularly significant, and it is a very touching phrase that she used. And that was, "My Social Security check enabled me to go on living simply, but adequately without being a burden on my sons." And it reminds me of the statement that President Johnson made way back when Medicare was founded.

He said, "No longer will young families see their own incomes and their own hopes eaten away simply because they are carrying out their deep moral obligations to their parents." And I think that testimony helps remind us that Medicare and Social Security is not just about the seniors who are the immediate beneficiaries.

Franklin Roosevelt talked about freedom from want, freedom from fear, and the freedom from want and fear that these programs provide, knowing that people can have a secure and dignified old age, isn't just a freedom that seniors enjoy. It is a freedom that all Americans enjoy. It is a worry that regular working families out there now, going to the second or third job, Americans have a lot to worry about.

And knowing that they are not going to be—what was President Johnson's phrase here? They are not going to see their own incomes and their own hopes eaten away because of their moral obligation to their parents, that they are not going to have to prepare to take on that burden, that risk, that chance that something terrible goes wrong in their parents' healthcare, and suddenly, they have to stop everything. Suddenly, they have to lose everything in order to support them. That is an important freedom that allows our children to pursue their own dreams, to travel if necessary to where jobs are for them, to have a sense of what—I mean, that is really part of what America has been about.

And I think that was a very important point that you made. I just wanted to recognize that.

The other thing I would like to do is to ask Kathy Connell about the question of the prescription costs in Medicare and Medicaid. We had testimony from the earlier panel about the buying power that Medicare and Medicaid have, that $1 out of every $2 goes through those systems.

As you know, when the prescription drug Part D plan was put together, a group of people, I assume driven by the interests of the pharmaceutical industry, insisted on a requirement in the bill that the Federal Government is not allowed to negotiate for the price of the pharmaceuticals that it pays for through these programs. And we have all heard the stories about the drugs that are $88 in the United States, and you go up over the Canadian border, and there they are for $22.

We have all seen the difference between what the VA can buy drugs for because they are not limited by that restriction. They can use the lesser buying power that they have. What is the position of AARP on trying to particularly in an environment in which potentially slashing Medicare benefits, giving it up as a benefits program and having it just be a voucher that goes to an insurance industry, and as for the rest, "You are on your own, pal."

In that context, does it make it even more important that we fight to try to make sure that the buying power of Medicare and Medicaid are brought to bear on the increasing costs of prescription drugs? What is AARP's position here?

Ms. CONNELL. Our position is to do whatever is necessary to help to contain costs, and we did support buying power for the negotiation in Medicare for cost of drugs. That part of the issue has not been on the front burner recently that I have noticed, but it certainly is one that warrants the attention of those who want to make sure that this program does serve.

We know that the costs of drugs have been increasing far beyond the rate of inflation. And oftentimes, there are new and wonderful drugs coming on the market, but there are also old ones that have been kicking around forever whose costs have gone up exponentially.

So that is a whole area that needs to be carefully looked at and addressed. And hopefully, that is part of what will happen as they seek to get these costs under control.

Senator WHITEHOUSE. Well, let me thank both of you for your testimony, and let me thank everyone for staying through this hearing. I want to particularly acknowledge again Mayor Polisena, who, despite the very, very busy schedule of a Mayor in a Rhode Island city, has taken the time to stay through the entire hearing and to hear all the testimony.

As I said, I have never met anybody in Rhode Island government or politics who is a stronger fighter for seniors, particularly for his Johnston seniors, than Mayor Polisena. And that is shown in the quality of this wonderful senior center that we are here.

[Applause.]

It is shown in the wonderful work of Tony Zompa and the staff who are here. And I appreciate it very much.

I think the witnesses have been very helpful and instructive. And if there is a single point that I think we can take away from this hearing, it is that there is a terrible cost to real Rhode Islanders and to real Americans if we degrade Social Security and Medicare, if we change them from being cornerstones of what it means to be an American and to have that security and dignity and hand it over to, in particular in Medicare's case, the insurance industry. But in the Social Security case, if we are going to go back to privatizing that as was tried a few years ago, hand that over to Wall Street.

So there are powerful interests here, and there are real harms that could take place. But what was important to me in today's hearing was to hear so many different solutions that can be brought to hear in a win-win way to improve these programs, to lower the costs, particularly in healthcare, in ways that actually improve our experience of the healthcare system, how well the healthcare system serves us, our safety while we are in the hands of the healthcare system, and the results that we, as a society, get from our healthcare system.

And I will do one last recognition. She probably doesn't want me to do it, but I see in the back of the room a friend and former State senator who served in public life with great distinction for many

years, Catherine Graziano. And so, I want to make sure I recognize her as well.

[Applause.]

So do we keep the hearing open for a week? Okay. So under the Senate rules, the record of this hearing can stay open for 2 weeks, if anybody wishes to add any further testimony. So we will keep it open for the full 2 weeks. If anybody has any additional comment or testimony that they would like to add, then that will go into the official Senate record of this hearing.

And I will thank again the wonderful panel of witnesses who came out. The wonderful panels, both panels of witnesses were really extraordinary, and thank all of you for attending.

And let you know that we are at the beginning of a very long and active discussion about these programs, but I think it is pretty clear where I stand, and I can assure you that the entire Rhode Island congressional delegation stands with me in this area.

So, again, thanks to those who are here, recognition again to our Department of Elderly Affairs director Catherine Taylor, and thank you all so very much.

The hearing will be adjourned.

[Whereupon, at 11:36 a.m., the hearing was adjourned.]

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APPENDIX

Statement of Senator Sheldon Whitehouse
A Member of the Senate Special Committee on Aging
"Protecting the Promise to Our Seniors"
April 27, 2011

The hearing will come to order. Before we begin, I would like to thank everyone in attendance today. I want to extend my sincerest gratitude to staff of the Johnston Senior Center for agreeing to host this event. I would also like to thank Deputy Assistant Secretary Edwin Walker for rearranging his busy schedule and flying up to Rhode Island to be with us here today. We appreciate your effort, and look forward to your testimony as well as that of the other witnesses here today. Thank you all for participating.

It is hard to imagine, but there was a time within the last century that half of our nation's seniors were living below the poverty level. It is an astounding statistic and a sobering reminder of the challenges that seniors faced in our country's not-so-distant past. We should be proud of how far we've come. Today, the poverty rate among seniors is lower than any other age group. This is due in no small part to the promise we have kept to make the wellbeing of our seniors a national priority.
That promise began in earnest with the passage of the Social Security Act in 1935, the most successful domestic government program in our nation's history, and a critical safety net for seniors through good times and bad. Over 200,000 Rhode Islanders rely on Social Security to help them make ends meet, and I am committed to ensuring that they can count on those benefits.

The enactment of Medicare, in 1965, built upon the promise begun by Social Security. At the time, President Johnson said, "No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents…"

That is a promise that Medicare has kept and one that we have fought to protect and strengthen. Most recently, under the new health care reform law, seniors can receive life-saving preventive care services, like screenings for colon cancer, diabetes, and breast cancer, with no copayment. In addition, the Affordable Care Act fulfills a promise that I made during my campaign in 2006 by moving to close the Medicare prescription drug "doughnut hole," completely, by 2020 – finally bringing full prescription drug coverage to Medicare recipients. This year, seniors who fall into the coverage gap will receive a 50 percent discount on brand name drugs. Since the beginning of the year, this new discount has saved nearly 48,800 Medicare beneficiaries $38 million – an average of $800 per person. For the thousands of Rhode Islanders who hit the doughnut hole each year, these improvements will allow them a little more peace of mind.

In July 1965, the same month that Medicare was created, Congress also passed the Older Americans Act. Less well-known than Medicare, the OAA has nonetheless supported a wealth of services that improve quality of life for seniors: health and wellness programs, transportation services, or Meals on Wheels and other nutrition programs – like the ones provided right here at

the Johnston Senior Center. In Rhode Island, the Department of Elderly Affairs, directed by Catherine Taylor, has done a great job leveraging federal funding to provide services that so many of our state's seniors have come to rely on. I want to acknowledge Catherine who is here with us today and thank her and her staff for the important work they are doing in the Rhode Island community.

For all the gains that Social Security, Medicare, and the Older Americans Act have made in protecting seniors, each of these critical programs is at a crossroads.

The Older Americans Act is set to expire later this year. From my position on the Senate Aging Committee and on the Health, Education, Labor, and Pensions Committee, I will work hard to make sure that the OAA is reauthorized and the services it supports for seniors will continue.

As many of you know, Social Security has been a frequent target of attack. In recent weeks, there has been talk about the need to change Social Security, or even to cut benefits, in order to reduce our debt. Let me be clear: Social Security has paid out every dime owed to all eligible Americans without contributing a penny to the federal deficit or debt. It is fully solvent today, and is projected to remain so for another quarter-century. If changes are desired to strengthen Social Security, those changes should be considered independently from work to reduce the deficit. As a member of the Defending Social Security Caucus, I intend to work to maintain Social Security as America's cornerstone of retirement security.

Medicare is just as critical. The House of Representatives recently passed a Republican Budget, which proposes privatizing Medicare and requiring seniors to pay the majority of their health expenses with their own money. In fact, estimates suggest that this proposal would end up forcing a typical, 65 year-old senior to pay on average $12,500 each year in out-of-pocket expenses starting in 2022; more than double what a senior is estimated to pay under Medicare. Here in Rhode Island, where the average senior only gets about $14,200 per year from Social Security, that would be an exercise in poverty creation.

Under the Republican Budget, seniors would lose the new benefits provided by the health care reform law: those preventive services I mentioned earlier. The Republican Budget would also reopen the Medicare prescription drug doughnut hole, affecting nearly 17,000 Rhode Islanders who, in 2012, would pay an additional $9.5 million for their prescriptions under the House plan.

The attack on Medicare overlooks the basic fact of health care that ALL health care costs are skyrocketing, irrespective of who the insurer is. There is a problem in health care – but attacking Medicare misdiagnoses the problem.

As we get today's hearing under way, I hope my message is clear: We will protect our promises to our seniors. I look forward to the testimony today and working with you to protect these important programs.

With that, it's my pleasure to begin the introductions for the first panel of witnesses.

Our first witness is Edwin Walker, the Deputy Assistant Secretary for Program Operations at the Department of Health and Human Services Administration on Aging. In this role, he promotes the development of home and community-based long-term care programs, policies and services designed to improve the quality of life for older people and improve effectiveness for caregivers. Edwin is recognized as an expert on the Older Americans Act legislation and he serves as the primary liaison for the Administration on Aging on legislation related to aging services and programs. He has over 25 years of experience with aging services and programs, previously serving as director of the Missouri Division on Aging.

After Edwin, we will hear from Elizabeth Roberts, the Lieutenant Governor of the State of Rhode Island. Prior to taking office, Lieutenant Governor Roberts spent over a decade distinguishing herself as an advocate for quality, affordable health care for every family and built a statewide reputation as a tireless leader on health and medical issues. Lt. Gov. Roberts serves as the chair of the Long Term Care Coordinating Council, where she is pushing to expand community-based care for seniors and people with disabilities. In addition, she formed and headed the Healthy Rhode Island Implementation Task Force and serves as chair of the Rhode Island Healthcare Reform Commission, where she leads the state's health reform efforts. Lt. Gov. Roberts served in the Rhode Island State Senate from 1997 to 2007. She is a graduate of Brown University and earned an MBA in health care management from Boston University.

The first panel will end with testimony from Chris Koller, Rhode Island's first Health Insurance Commissioner. He took over this role in 2005. The Office of the Health Insurance Commissioner is responsible for health insurance consumer protection, the financial solvency of RI's health insurers and directing policies that improve the accessibility, affordability and quality of Rhode Island's health care system. The Office is nationally recognized for its rate review process and its efforts at improving the primary care infrastructure in the state and the readability of health insurance contracts. Prior to this position, Mr. Koller was the CEO of Neighborhood Health Plan of Rhode Island, a nationally recognized community health center-based Medicaid health plan. In this role he was the founding Chair of the Association of Community Affiliated Plans. Mr. Koller has a bachelor's degree from Dartmouth College and Master's degrees in Management and Religion from Yale University.

[PANEL I TESTIMONY AND QUESTIONS]

On the second panel, we'll hear from Kathleen Connell, the Senior State Director of AARP-RI. Kathy joined AARP-RI in 2001, following a long career in public service, education, and health care. Her career in public service included three terms as the Secretary of State in Rhode Island, a term in the Rhode Island Senate, and sixteen years elected to local town offices in Middletown. During that time she was also a leader in numerous education and health care issues, and in issues affecting women. She currently serves on the Board of Directors of Quality Partners of Rhode Island. Kathleen holds a Masters Degree in International Relations and Bachelor's Degree in Nursing, both from Salve Regina University in Newport, R.I.

Our final witness is Audrey Brett, a senior living in Middletown, Rhode Island, where she has retired after a career in state and local government in nearby Connecticut. She currently receives

Social Security and Medicare benefits. Audrey has two sons, seven grandchildren, and two great granddaughters.

[PANEL II TESTIMONY AND QUESTIONS]

Testimony of

Edwin Walker

Deputy Assistant Secretary for Program Operations
Administration on Aging

U.S. Department of Health and Human Services

Before the

Senate Special Committee on Aging

on

Reauthorization of the Older Americans Act

Field Hearing

Johnston, Rhode Island

April 27, 2011

Thank you, Senator Whitehouse, for the opportunity to testify before this Senate Special Committee on Aging hearing on the upcoming reauthorization of the Older Americans Act (OAA). Over the past year, the Administration on Aging (AoA) has conducted the most open process for seeking input on the reauthorization of the OAA in its history. I am pleased to discuss the input we have received from across the country, and to learn more about the perspectives from Rhode Island on this important legislation that provides vital home and community-based services to older adults and their caregivers.

At the outset, I would like to commend you, Senator Whitehouse, for your leadership as a member of the Senate Special Committee on Aging, and also as member of the Senate Committee on Health, Education, Labor and Pensions, the Budget Committee, and the Judiciary Committee, all of which have jurisdiction over important seniors issues, including the HELP committee which has jurisdiction over the OAA programs themselves. We are grateful for the support you have provided to these programs that play such a vital role in helping to maintain the health and well-being of millions of older Americans, as well as for your strong leadership in improving the quality of care for families, for protecting against consumer fraud, and supporting elder rights.

I am impressed by the level of commitment and dedication of Rhode Island's aging services network and by the interest and enthusiasm of your older citizens and their families. I would like to commend Catherine Taylor, Director of the Rhode Island Department of Elderly Affairs, for the excellent work that she and her agency provide so that elderly individuals are better able to maintain their health and independence in their

homes and communities. I also want to express my appreciation for the great work that the Narragansett Indian Tribe, and other providers of supportive services, delivers on a daily basis so that tens of thousands of seniors can maintain their independence.

Rhode Island has one of the highest per capita populations of seniors in the country, and plays a large role as a leader in many aspects related to the health and well-being of seniors and soon-to-be seniors. More than 10,000 of Rhode Island's residents over the age of 60 receive nutrition assistance in congregate settings or through meals delivered to their homes each year, and thousands more receive other vital community supports through the OAA that help them remain in their homes. By applying for and winning a number of competitive Federal grant awards, the Rhode Island Department of Elderly Affairs has taken full advantage of opportunities which seek to more efficiently support the needs of frail seniors and their families. I would like to highlight just a few:

- Testing innovative interventions for facilitating the safe discharge of elderly hospital patients and nursing facility residents to their homes in the community;
- Establishing caregiver services for persons with dementia which can better help them live with independence and dignity;
- Developing person-centered, self-management programs that provide older adults with the information and tools they need to help them cope with chronic diseases such as diabetes, heart disease, lung disease or arthritis; and
- Having a long history of educating and informing seniors through the Senior Medicare Patrol program so that they are better able to help prevent and combat waste, fraud and abuse in Medicare and Medicaid.

We have much to learn from the insights and perspectives of your citizens. I am honored to be here today.

On July 14, 1965, President Johnson signed the Older Americans Act into law. Sixteen days later, on July 30, he signed legislation creating Medicare and Medicaid. These three programs, along with Social Security enacted in 1935, have served as the foundation for economic, health and social support for millions of seniors, individuals with disabilities and their families. Because of these programs, millions of older Americans have lived more secure, healthier and meaningful lives.

For more than 45 years, the Older Americans Act has quietly but effectively provided nutrition and community support to millions of people across the nation, and in Rhode Island. It has also protected the rights of seniors, and in many cases, has been the key to their independence. The programs supported by the OAA provide community-based supports that assist families caring for their loved ones and help seniors stay in their homes for as long as possible. Over the past year, nearly 11 million older Americans and their family caregivers have been supported through the OAA's comprehensive home and community-based system. These services complement medical and health care systems, help to prevent hospital readmissions, provide transport to doctor appointments, and support some of life's most basic functions, such as assistance to elders in their homes by delivering or preparing meals, or helping them with bathing. This assistance is especially critical for the nearly three million seniors who receive intensive in-home services, half a

million of whom meet the disability criteria for nursing home admission but are able to remain in their homes, in part, due to these community supports.

What is more, the need for this support is growing rapidly. Every day, more than 9,000 baby boomers turn 65, equivalent to the population of a small town. In just four years, the population aged 60 and older will increase by 15 percent, from 57 million to 65.7 million. During this period, the number of seniors with severe disabilities who are at greatest risk of nursing home admission and Medicaid eligibility will increase by more than 13 percent.

The reauthorization of the Older Americans Act provides us with the opportunity to strengthen and build upon a long record of success in serving our families and communities, and to help meet the growing need. To support this discussion, over the past year the Administration on Aging received reports from more than 60 reauthorization listening sessions held throughout the country, and received online input from interested individuals and organizations, as well as from seniors and their caregivers. This input represented the interests of thousands of consumers of the OAA's services. We continue to encourage ongoing input and discussions.

During this process, we heard a number of themes:

Improve program outcomes by:

- Embedding evidence-based interventions in disease prevention programs;

- Encouraging broader partnerships and alliances that result in comprehensive, person-centered approaches;
- Providing flexibility to respond to local nutrition needs; and
- Increasing efforts to fight fraud and abuse in Medicare and Medicaid.

Remove barriers and enhancing access by:

- Enhancing caregiver supports to parents caring for their adult children with disabilities;
- Providing ombudsman services to all nursing facility residents, not just older residents; and
- Utilizing Aging and Disability Resource Centers as single access points for long-term care information and to public and private services;

The following are some examples of areas that we would like to discuss with the Congress as you consider legislation:

- **Ensuring that the best evidence-based interventions for helping older individuals manage chronic diseases are utilized**. A number of evidence-based programs have shown to be effective in helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits.

- **Improving the Senior Community Service Employment Program (SCSEP) by integrating it with other seniors programs.** The President's 2012 budget

proposes to move this program from the Department of Labor to the Administration on Aging within HHS. The goal of this move is to better integrate this program with other senior services provided by AoA. We would like to discuss adopting new models of community service for this program, including programs that engage seniors in providing community service by assisting other seniors so they can remain independent in their homes.

- **Combating fraud and abuse in Medicare and Medicaid by converting the Senior Medicare Patrol Program (SMP) as an ongoing consumer-based fraud prevention and detection program.** The SMP program serves a unique role in the Department's fight to identify and prevent healthcare fraud by using the skills of retired professionals as volunteers to conduct community outreach and education so that seniors and families are better able to recognize and report suspected cases of Medicare and Medicaid fraud and abuse.

The Older Americans Act has historically enjoyed widespread, bipartisan support. Based in part upon this extensive public input process, we think that reauthorization can strengthen the Older Americans Act and put it on a solid footing to meet the challenges of a growing population of seniors and continue to carry out its important mission of helping elderly individuals maintain their health and independence in their homes and communities.

Thank you again, Senator Whitehouse, for your leadership on these important issues and for the invitation to testify here today. I would be happy to answer any questions.

Talking Points for Hearing on "Protecting the Promise to Our Seniors: Social Security, Medicare, and the Older Americans Act" with Senator Whitehouse
Wednesday, April 27, 2011 at 10:00 am
Johnston Senior Center, 1291 Hartford Avenue, Johnston

- Good morning. I am here today in my capacity as Chair of both the Rhode Island Healthcare Reform Commission and the Long Term Care Coordinating Council. These are forums for Rhode Islanders to actively participate in health policy, and to have a real impact on issues that will profoundly affect seniors, those who are nearing retirement, and indeed all of us.

- As changes to vital programs like Medicare, Medicaid, and Social Security are being discussed at the national level, it is important that Rhode Islanders contribute to this dialogue too, and I thank Senator Whitehouse for providing us with that opportunity today.

- There has been a lot of misinformation about the health reform law and its impact on Medicare and seniors, and I want to take this opportunity to set the record straight.

- First of all, health reform does NOT cut benefits. In fact, it actually improves benefits.

    - The dreaded donut hole will be gradually filled in over time so that seniors can afford their medications.
    - Seniors can now get free annual wellness visits.
    - And they no longer have to pay deductibles, copayments or other costs for recommended preventive care.

- These reforms are part of an effort to focus on keeping people healthy, instead of waiting until they get sick – which is more expensive. The health reform law also provides incentives for health care providers to work together to improve the quality of care and reduce costs.

- There is no doubt that we need to reduce health care costs so that the government can afford its promises to seniors, as well as investments in other priorities like education. But we now face a stark choice as to how to do that, which will have a profound effect on seniors and our health care system.

- Do we reform the way we pay for health care, to encourage better care instead of more care? Or do we radically restructure programs to simply make seniors pay more out of their pockets?

- As Chair of the Rhode Island Healthcare Reform Commission, I can assure you that we are working hard to reform the way we pay for and deliver health care in this state.

    - For example, Rhode Island has been a national leader in improving the care of chronic disease by developing patient-centered medical homes – primary care providers that coordinate care.
    - As we move forward in implementing the health reform law, I want to continue to encourage all Rhode Islanders to participate in the dialogue, because we

know that real change cannot happen unless everyone – doctors, hospitals, nurses, businesses, and patients – is involved.

- My other role is Chair of the long term care coordinating council – a group of policymakers and providers of services to the elderly and persons with disabilities.

- Meet monthly to discuss state policies as well as the impact of federal programs.

- A small change in how Medicare pays for certain services can have a large impact on the providers and potentially on the Rhode Islanders it serves.

- One of the most important reasons for us all to work together to safeguard and strengthen the Medicare program is that some of the most important cost and quality reforms will be possible through the significant purchasing power of Medicare. Medicare is one avenue for significant payment reforms and is a powerful tool for policymakers focused on containing cost and sustaining quality.

- The value of the long term care council is that it represents an open forum of some of the most well-informed and knowledgeable participants in the long term care arena. It is a forum where all facets of the long-term care system are at the same table, discussing common areas of interest and concern.

- In fact, almost all of today's witnesses are regular attendees of council meetings.

- This coordinated approach allows for thoughtful dialogue and creates an environment that fosters the use of best practices and information sharing.

Testimony – Field Hearing, April 27, 2011
Christopher Koller
Health Care Costs

Thank you Senator Whitehouse and honored guests for the opportunity to speak with you on the important topic of rising Medical Costs. My name is Christopher F. Koller and I am the Health Insurance Commissioner for the State of Rhode Island. In this role I am responsible for overseeing the actions of commercial health insurance companies in the states, including the rates they charge.

My three messages for the panel are the following:

- Rising medical care costs are not unique to Medicare, but are a problem across the entire health care system.
- The reasons for these increases have to do with the way we seek, organize, and pay for medical care. But we have examples that work well too.
- While the Affordable Care Act gives us some powerful tools to address these costs, the urgency will only increase in the coming years and will involve some fundamental choices we have to make.

1. Rising Medical Care Costs

This panel is being organized to discuss, in part, Medicare's rising costs. There are any number of ways to state the problem - the Medicare trust fund will go completely bankrupt in 2029, Medicare now consumes 15% of the federal budget, Medicare costs are increasing at a rate of two or three times the national inflation rate. However you state it, this is not sustainable for the federal government and for tax payers.

The first point I wish to make is that this problem is not unique to Medicare. Here in Rhode Island, commercial insurance rate increases have averaged nine percent per year for the past three years, even with aggressive rate oversight. Medicaid is the fastest growing portion of the state budget, in spite of aggressive cost cutting by state officials. Medicaid will soon overtake Medicare as the largest federal health care program.

Therefore any solution to the Federal Government's Medicare budget problem must take into account the systemic problems in medical care and must pose systemic solutions.

2. The Reasons for Rising Costs

So where does all this money go? To more – more of everything. Studies by the Commonwealth Fund show that compared to other countries we pay more for services – more for our physicians, more for our drugs and more for our administrative services. We

are also using more services all the time – as technologies are added – but we actually use fewer hospital and physician services than most other countries.

Even though our medical care costs almost twice as much as other countries and we get poorer outcomes. We don't have to look overseas for solutions. There are communities here that are cheaper – that deliver lower costs and better health. Places like Portland Maine, Asheville North Carolina and Grand Junction, Co can be up to 20 or 30% cheaper overall than national average – even when you take into account the cost of living.

So what do they have that makes them successful? Researchers are still working on it but it seems low cost, high health communities have some combination of the following:

- Lots of primary care
- Well organized, integrated physician groups, usually with health information technology.
- Nonprofit hospitals that both compete and collaborate.
- A public focus on improving quality measures.
- Employers who care and hold the system accountable

These all speak to a strong community culture that emphasizes health, prevention and cooperation. It seems lower costs and better health care is not about having lots of competing insurers, specialists, and high technology gadgets. It is not even about having lots of medical care. It is about how medical care providers work with each other, how patients and purchasers see their role and how decisions get made about the medical care that is provided.

3. The Implications for Medicare

I would like to focus on three implications for Medicare as Federal policy makers responds to the problem of rising costs.

A. Change

The status quo in Medicare is going to bankrupt the country. That means that beneficiaries must accept some changes in their Medicare benefits. It could mean changes in costs, or services or choice of providers. It should be graduated over time – so my Medicare benefit in the future may look different from my father's now. But it is not honest to pretend that Medicare can continue the way it is now and to look for someone else to change but not me. Each of us is going to have to accept some responsibility for the costs of our care.

B. Leverage

One out of every four dollars that gets spent in health care is spent by Medicare. It goes up to one out every two if you include Medicaid. That is an enormous ability to make change

in the medical care system – to pay for what works and stop by paying for what doesn't. The Affordable Care Act recognized that in creating the Center for Medicare and Medicaid Innovation. The goal of the Center is to advance new models of paying providers to help create the kind of collaborative, coordinating culture found in our best performing communities. Rhode Island has already been the beneficiary of this work – being one of 8 innovating states recognized by Medicare for its work in improving Primary Care with a Medicare Advanced Primary Care project designation. Sen. Whitehouse should also be commended for his tireless work with using Medicare and Medicaid to advance the adoption of Health Information technology. Rhode Island has also been the beneficiary here as well with the work of the Rhode Island Quality Institute.

For better or for ill, Medicare and Medicaid policies –what is covered, how it is paid, and how beneficiaries act with the system – largely shape our health care system. That is an enormous responsibility and opportunity.

C. Independence

When you spend one of every two dollars in health care in the US, you have a lot of people who want to be your friend. And to benefit from your choices. This makes these decisions ripe for interference and influence. It might also explain why - if the literature is clear that no good health care system succeeds without lots of high quality primary care physicians – they are the most poorly paid physician group. And why – if integrated medical groups are the lowest cost, highest quality way to get medical care – patients are discouraged from selecting them? And why we pay more for private health insurance companies to administer Medicare than it costs the federal government. Each of these situations has to do with interference in the Medicare administration by people seeking special treatment and to preserve the status quo.

For Medicare to be sustainable and to retain its original promise of fairness to all older Americans, the Government must set up ways for Medicare and Medicaid to be accountable to the Congress but independent from interference. The current fight over the future of the Independent Payment Advisory Board – an expert panel meant to make payment decisions for Medicare and Medicaid based on science – is the most recent example of how challenging this task is.

But if we cannot set up ways for making these decisions independently – where campaign contributions do not buy special consideration – than our hopes for Medicare must be diminished, and we may be forced to consider voucher programs which leave seniors to buy only the health insurance they can afford from private companies.

I think we can do better than that for our seniors and our community. But it will require the kind of change and leadership envisioned by the Affordable Care Act and more in the future.

Thank you

Testimony Before the

Special Committee on Aging

United States Senate

on

Protecting the Promise to Our Seniors: Social Security, Medicare,

and the Older Americans Act

April 27, 2011

Johnston Senior Center
1291 Hartford Avenue
Johnston, RI 02919-7121

Witness: Kathleen Connell
Senior State Director
AARP Rhode Island

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

Good morning, Senator Whitehouse, and thank you for including AARP in this very important discussion. One of AARP's many roles is to encourage community conversations about vital issues concerning the 50-plus population across the country and right here in the great state of Rhode Island.

AARP is a non-profit, non-partisan, social mission organization representing some 37 million members age 50 and older across the country. Here in Rhode Island, we serve some 135,000 members.

Our members are Democrats, Republicans, Moderates, Independents, people who align with other parties and some who aren't so sure where they stand politically. What they have in common is that they all seek a healthy and secure future – a life of independence, dignity and purpose. In short, the American Dream. Among the ways AARP helps fulfill this expectation here in Rhode Island, and across the country, is through education and information, advocacy and community service.

So, today, we are here to share our point of view on these matters of interest to the Special Committee on Aging.

SOCIAL SECURITY

Let me begin by addressing concerns about Social Security.

Seniors, along with just about everyone else, are nervous about potential changes in Social Security and what the debate in Congress holds for their future. I want to assure you that AARP on both the national and state levels will be a strong and tireless participant in this watershed discussion. And you should be, too.

First, let me tell you where we stand. Social Security must be protected for current beneficiaries and strengthened so future generations get the benefits they've earned. But, Social Security changes should only be considered if these changes make retirement more secure, not less. It's important to understand some key points.

- Social Security is strong and can pay Americans 100 percent of the benefits they've earned for the next 25 years, and approximately 75 percent of promised benefits thereafter – and that's without any changes at all. But, to make sure the program will be strong for future generations, we need to make gradual, modest changes sooner rather than later.

- Social Security is not only a lifeline for the most vulnerable; it is a critical source of income for the middle class. Don't turn it into a welfare program. In other words, if Social Security is fundamentally altered so that it is no longer an earned benefit for all who contribute – then the long-term result will be many middle-class wage earners retiring without the critical income support provided by Social Security. For most

middle income earners, Social Security remains their largest source of income in retirement.

- Americans have earned their Social Security benefits by paying into the system their whole working lives. Social Security is earned by the money you contribute from your paycheck and what your employer contributes on your behalf.

- Social Security hasn't contributed to the nation's debt and shouldn't be cut to balance the budget. Instead of putting our children and grandchildren's retirement in jeopardy, Congress should find ways to solve our nation's budget problems without making damaging cuts to Social Security.

We believe Social Security is a guarantee that when you pay in, you get the benefit you've earned when you retire. Social Security benefits should keep up with inflation so seniors – many of whom are kept out of poverty by Social Security – can continue to afford basic necessities when costs rise.

We believe that Social Security benefits were always intended to be there in both good times and bad. It also is important to note that the next generation has paid into Social Security for decades and deserves to get the retirement benefits they have already earned. With shrinking pensions, dwindling savings, diminished assets and longer life expectancies, future generations will depend on Social Security even more.

Senator, it goes without saying, your urgent attention to strengthening Social Security for the long term is necessary and greatly appreciated.

MEDICARE

Let me turn next to the Medicare program and some recent proposals being considered by Congress. Medicare was created in 1965 and plays a vital role in ensuring the health and retirement security of older Americans and people with disabilities in current and future generations. Medicare covers persons age 65 and older, regardless of their income or medical history, and now covers 47 million Americans, helping individuals pay for needed health care services. Nearly half of all people on Medicare (47%) live on incomes below $21,660 for an individual and $29,140 for couples. About 29 percent of all people on Medicare have a cognitive/mental impairment and about the same percent report being in fair or poor health. According to the most recent data available, Medicare beneficiaries spent a median of $3,103 a year of their own money on health care in 2006. Ten percent of beneficiaries – more than 4 million people – spent more than $8,300 a year. The oldest and poorest beneficiaries spent about one-quarter of their incomes on health care.

Independent Payment Advisory Board

As you know, AARP supported the Affordable Care Act last year because it will improve and strengthen Medicare and provide Americans who currently lack health insurance access to affordable, comprehensive health insurance.

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

Other proposals are being considered in Congress that would greatly expand the cost-sharing on beneficiaries, significantly increasing their out-of-pockets costs for Medicare. We do not believe the answer is to simply shift costs onto Medicare beneficiaries and increase the health and economic insecurity of millions of Americans. Increasing the out-of-pocket costs for people on Medicare would especially penalize the sick.

House-Passed Fiscal Year 2012 Budget Resolution

Before it left for recess, the House passed the Fiscal Year 2012 House Concurrent Budget Resolution (H. Con. Res. 34), which, among other things, would eliminate the current Medicare program for those turning 65 in the year 2022 and after, and replace it with a defined contribution, "premium support" program, with the government's contribution growing each year by the rate of inflation.

AARP finds the direction of this House-passed budget disturbing and in some cases misguided. First, we are concerned that a premium support system would dramatically increase costs for Medicare beneficiaries while removing Medicare's promise of secure health coverage – a guarantee that future seniors have contributed to through a lifetime of hard work. Under this proposal, premium payments to private plans would be sharply reduced, capped at levels well below medical inflation. Therefore, Medicare beneficiaries would bear a larger and larger share of the high cost of medical inflation, as increased costs will be shifted to them – making it harder and harder for them to pay for other household expenses. According to an calculations based on the Congressional Budget Office analysis, the House-passed budget would more than double beneficiary costs in 2022, from about $5,500 to $12,500 – an increase of roughly $7,000 per year in beneficiary premiums and co-insurance.

The legislation would also increase the age of Medicare eligibility from 65 to 67 by 2033. Those who enter Medicare before 2022 would continue under the current Medicare

program, with the option to switch to the new program. AARP opposes raising the age of eligibility for the Medicare program because, according to research, it would:

- increase the cost burden for 65 – 66 year olds who no longer have access to Medicare,
- increase premiums and cost sharing for Medicare enrollees,
- raise costs for states, employers and for people under 67 purchasing coverage on the individual market, and
- produce relatively little in savings to the federal government.

Finally, the House-passed budget repeals key improvements in the Affordable Care Act, but the two I would like to speak to today are the closure of the "coverage gap", or the doughnut hole, in Medicare Part D and eliminating the Community Living Assistance Services and Supports (CLASS) program.

AARP fought to close the doughnut hole because it provides millions of seniors with access to lower out-of-pocket costs for their prescription drugs. Repealing the doughnut hole provision would immediately increase the prescription drug costs for nearly 4 million Medicare beneficiaries.

The CLASS program is a national voluntary insurance program to help individuals pay for some of the costs of services and supports to help them live in their homes and communities. It has the potential to: provide savings to Medicaid; support family caregivers in their care giving roles; and help to give eligible consumers choice and control and a flexible benefit to help them meet their needs.

Senator, abandoning relief from the doughnut hole and taking away an option to help people live in their homes by repealing the CLASS Program does not bode well for older adults. The added burden of higher health costs will put more seniors at risk, especially those who are most vulnerable.

MEDICAID

As for Medicaid, under the House-passed budget resolution, all federal Medicaid payments to states would be converted to a block grant beginning in 2013, with constrained annual growth.

Rhode Island is operating in a special environment when it comes to Medicaid because of the Global Waiver that put more money to work here, creating some flexibility in how the state allocates federal funds and – we hope – helping us rebalance the health and long-term services and supports system more toward community-based care.

We are watching this closely because oversight is absolutely critical and because it remains to be seen what happens down the road when we are apt to see a reduction in the original federal contribution.

What we know is that the notion of replacing Medicaid as it is presently constituted with a block grant system is a move in the wrong direction. Medicaid funding should not be limited to a block grant, which could lead to millions losing needed health and long-term services and supports coverage, especially in bad economic times.

The House-passed budget resolution could lead to cuts for millions of older adults and people with disabilities who get long-term care, including services to help them live in their own homes, through Medicaid.

There are limited financing options currently available to pay for long-term services and supports and individuals typically exhaust their own assets before turning to Medicaid. Block granting Medicaid would put both current and future seniors in need of these services at risk. For those who are already in nursing homes or receiving home and community-based services, Medicaid cut-backs could lead to reduced access and inadequate care. For individuals who do not yet need long-term services and supports or can still pay for these services themselves, if the time comes and they have exhausted their savings, they may likely be turned away or offered insufficient care that neither meets their needs nor maintains their dignity.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)

Also under the proposal, SNAP – the Supplemental Nutrition Assistance Program -- is ended as an entitlement to individuals and is converted into a block grant to the states. SNAP eligibility would be made contingent on work or job training, and there would be lifetime limits on SNAP.

Today, 2.5 million older Americans receive SNAP. Block granting SNAP will diminish its ability to provide assistance in economic downturns. Typically, states have reduced benefits or created waiting lists for other block grant programs during tough economic times.

Nearly a third of SNAP recipients today are older or people with disabilities. Unless clear exemptions from work requirement were provided for the elderly and people with disabilities, the policy assumptions made in this budget would bar older adults and Americans with disabilities from receiving SNAP benefits.

ACROSS-THE-BOARD CUTS

While AARP appreciates that the budget resolution recognizes the importance of Social Security to older Americans, we remain concerned that across-the-board cuts to Medicare, Medicaid and other critical federal programs could also have a detrimental impact to the lives of many seniors who depend on these programs for their health and retirement security. We urge you to consider the impact of these proposed cuts on real people, here in Rhode Island and across the country, and to look at less draconian ways to achieve savings.

Across-the-board cuts would include reductions in Medicare, Medicaid and all other health care spending. The House-passed budget resolution proposes enacting this hard spending cap as a law and it could not be waived – regardless of need or economic circumstances – even by a super-majority of votes in Congress.

The budget contemplates enacting this spending cap as part of the debt ceiling debate that will begin when you return to Congress next week.

This is a frightening scenario to everyone.

OLDER AMERICANS ACT

The Older Americans Act (OAA) provides essential programs, information and services to meet the needs of a growing older population. Programs supported through the OAA include home-delivered and congregate nutrition services, in-home supportive services, transportation, caregiver support, community service employment, the long-term care ombudsman program, services to prevent the abuse, neglect, and exploitation of older persons, and other supportive services. These programs provide vital support for those older adults who are at significant risk of losing their ability to remain in their own homes and communities, or who need support and protection in long-term care facilities.

Pending formal legislative language, our interest is to ensure that the Act maintains critical service and information roles, and promotes greater responsiveness to the needs of mature and older Americans. In this period of economic downturn, AARP is most concerned that programs, authorities and partnerships that have already proven effective in meeting the needs of vulnerable older Americans be maintained and strengthened. We believe that the most important legislative objective to better serve older persons is to promote and improve efficiency in the delivery of core services. Better coordination of existing OAA programs with other federal programs holds great promise and merits the support of the Administration and Congress.

CONCLUSION

AARP's 135,000 members in Rhode Island hope that the Special Committee on Aging is listening. We hope that you will not turn away from the great needs of a generation that has made America great and millions of others who have paid into a system based on the promise of greater health and financial security in retirement.

We know that creative solutions are necessary. All we ask is that you carefully measure the human consequences of your decisions. And that you remember the greatest wealth of this nation is the way we show the world the respect we have for our citizens.

Testimony of Audrey Brett
Before the U.S. Senate Special Committee on Aging
"Protecting the Promise to Our Seniors"
April 27, 2011

Good morning. My name is Audrey Brett. I am a transplant from another "country" called Connecticut, and I currently live in Middletown, Rhode Island.

As a young woman I worked full time. During my working years, I paid payroll taxes and when I retired I applied for Social Security. Women's wages being a small percentage of what men earned - my SS check was quite minimal. I never thought much about it until my husband died and my check stopped and his was transferred to me. What a godsend! That kept my head above water.

Jerry died suddenly - not only I lost him, I lost one check and the supplemental income he brought in as a manufacturer's rep. I had rent, maintenance, food, medical costs, car maintenance and many unexpected expenses - and NO income except for his Social Security check which enabled me to go on living - simply but adequately without being a burden on my sons and losing my dignity as well. As I said - a godsend

Like me, my many friends are experiencing the same security provided by Social Security that has succeeded in keeping millions of widows, senior citizens, children and disabled out of poverty. I have read that the SS retirement fund has a surplus and is constantly receiving monies from payroll taxes allowing it to do exactly what it was designed to do. So why is it being described as a budget problem?

I am reminded of an old political saying: "Figures don't lie - but liars figure." The preamble of our Constitution describes that document as "providing for the common defense and promoting the GENERAL WELFARE...." I am disturbed and troubled that there are those who would destroy our basic democratic principles for their own political aggrandizement. I worry for me - I worry for my children. The grand lady standing in NY harbor weeps!

When I crossed the border into Rhode Island, one of the first things I did was look to establish myself with a medical provider (my old Girl Scout teaching ""Be prepared" is always with me!). I quickly learned that although Medicare is always accepted, certain Medigap insurances are not! I have never had a complaint with Medicare - it is always available to me and always delivers what it is committed to do.

In the "privatized" area, however, actions are VERY different. In the private sector, insurance companies have used the process known as "rescission" for years. It is well documented that tens of thousands of Americans lost their health

insurance after being diagnosed with life threatening, expensive medical conditions.

Again - political expediency? I greatly fear the change from Medicare to "privatization." The federal Medicare program has changed the lives of millions of Americans. But the roots of Medicare go back to our nation's early efforts to achieve health coverage for its elderly and poor citizens. For all those Americans who worked, paid their taxes, added to the betterment of the country, served in military and civil service - we cannot let them live and die in poverty. We owe them their final days of security and dignity.

Rhode Island is most fortunate to have a man of intelligence, understanding and CARING representing them in the Senate.

I thank you, Senator Whitehouse, for your tireless efforts in resisting the actions that threaten the good and welfare of your constituents - and the nation.