AARP[SM]

INDUSTRY, BUSINESS, AND LABOR COMMITTEE
MARCH 18, 2010

Chairman Keiser and members of the Industry, Business, and Labor Committee, my name is Linda Johnson Wurtz, I am Associate State Director for Advocacy for AARP North Dakota.

According to the North Dakota State Data Center, by 2020 nearly 25% of North Dakota's population will be 65+. I know you have heard me say that many times. When I started working for AARP, I tacked a reminder at the top of my bulletin board. It reads: "In 2010, 5,000 people per day will turn 65." It seemed like a long way off when I tacked it there in 2001. Now it is 2010 and 5,000 people per day are turning 65 in our country. I begin with that because the importance of living in a state with an older population colors everything I do. The last time I checked we were tied with Iowa as the 5th oldest per capita state in the nation. Because health care and health insurance becomes more important to us as we age, I'm grateful to be able to participate in this conversation about health care reform.

I have watched the discussion in this committee and you have uncovered a lot of good information. However, several times I have heard members wonder just what is in health care reform for North Dakota. I'd like to point out a few possibilities. Since we are still uncertain of the outcome, you understand if I stay away from specifics.

This committee has heard from several presenters about the uninsured and under-insured…and yes you can access care in North Dakota even if you do not have insurance. But there is a cost for that, a hidden cost, and we have also heard about that…it's commonly referred to as uncompensated care. We have heard about bankruptcies related to health care expenses, and how the uninsured go without preventative care and often have a critical condition before seeking care…which all adds to the difficulty of treatment, the uncertainty of the

outcomes, and cost of care. So, the affordability pieces that have been discussed as part of health care reform should be of interest to all of us. Items like premium subsidies for low-income families, options for small businesses so that they can afford to offer health care to their employees, premium tax credits for some families, preventative care that is covered for seniors, significantly reducing the doughnut hole by covering 50% of the cost of prescription drugs for Medicare beneficiaries who reach the gap in their Part D coverage, and eliminating annual and lifetime coverage caps. These are all things that could give people more economic security and ultimately strengthen the state's economy. Some projections indicate that streamlining the health care system and reducing the burden of uncompensated care could reduce the burden of rising premiums for state and local governments. People who have adequate and affordable health insurance coverage are more secure, more stable, and continue to be productive members of our state. Some sources say that a good predictor of future bankruptcy is being uninsured for two years. The best case scenario would be that every person in North Dakota has adequate health insurance, and every alternative that lowers the number of uninsured helps all of us who in some way are paying for the largely unseen costs.

The Insurance Department informed us that insurance providers in North Dakota can charge older beneficiaries with independent policies up to 5 times the premium of a younger beneficiary…in small group coverage the age rating is 4:1. One issue that I'd like to touch on in regard to age rating has to do with older workers. Our age rating in North Dakota makes older workers more expensive for employers. In a state with a higher than average aging population, we are finding it beneficial in terms of the "brain drain" to have workers stay in the workforce past their traditional retirement years. The economy has forced some of our people to work longer. However, studies show that workers past the age of 50 who have in some way been separated from their employment, are usually out of work for longer periods of time. It's possible that the increased cost of health insurance could cause an unintended bias in hiring. In addition to more even distribution of risk and the fairness issue, the reduction of the age rating to 3:1 could benefit older workers who are trying to get back into the workforce.

In that same affordability vein there are some things that will go toward strengthening Medicare, and of course we don't deal with Medicare on a state level, but it is the health insurance coverage for over a hundred thousand of our citizens and contributes to their financial security.

One issue that has been discussed is hospital readmissions. Because more than 20% of older Americans suffer from five or more chronic conditions, our health issues sometimes require several doctors with different specialties and several drugs from those different specialists. Patients discharged from the hospital frequently report difficulty remembering clinical instruction and confusion over correct use of medications. Hospital readmissions have been reported to be a significant issue for Medicare. The transitional care benefit being discussed as part of health care reform would provide the medical guidance needed, home visits to coordinate complex care with multiple clinicians, teaching self-care, and promote access to long-term services and supports as needed. Clinical trials of transitional care programs showed a 45% reduction in hospital readmissions. Transitional care could provide an immediate benefit to Medicare, and a model that we can use in other areas of health care to promote better health outcomes.

Other promising practices that could strengthen Medicare for our citizens is the attention to reducing waste and eliminating abuse, including increased funding for enforcement, savings in Medicare Advantage, and moving toward use of comparative effectiveness research.

Comparative effectiveness research evaluates the effectiveness of two or more medical treatments. The research can be used by the medical community to provide better care, resulting in better outcomes and lower health care costs. We have had conversations in North Dakota about the benefits of using this research. Pharmacy programs from private insurance to state medical assistance use comparative effectiveness and evidence-based research to inform their prior authorization determinations and prescription drug lists. Not only will this help to

strengthen Medicare, it moves us in the direction of paying for quality of care rather than quantity of care.

Another issue area that is familiar to our legislature is transparency of pharmacy benefit managers (PBM) …and that is another factor that will be gradually introduced as a cost containment factor in Medicare. This committee has heard testimony regarding the practice of PBMs in negotiating price discounts through bulk purchasing. Some states are testing the transparency of these practices in holding down the costs of prescription drugs, and although North Dakota has not implemented those policies, we have discussed them.

AARP worked very hard to see that attention was given to long term services and supports in health care reform. There are several issues around long term care that have been discussed as part of health care reform. Spousal impoverishment protections…some of which we have done on a state level, continued funding for Aging and Disability Resource Centers and Money Follows the Person…both are demonstration programs that we are taking advantage of in North Dakota, opportunities for an enhanced FMAP (federal medical assistance percentage) for states that increase access to home and community based services, and the Community Living Assistance Services and Supports (CLASS) insurance plan.

Many legislators over the years have talked to me about the benefits of long term care insurance, both to our citizens and our state. The CLASS plan is a voluntary insurance plan meant to complement private long-term care insurance or Medicaid and help people help themselves. It helps individuals plan ahead so they can afford to pay for some of the services they need to help them live independently in their homes and communities. Individuals can choose to pay into the CLASS plan and after 5 years, or whenever they need it, receive a monthly amount that will help them pay for long term services and supports.

There are also provisions for staying healthy, like workplace wellness programs and preventative care. Although we need to be cautious that wellness provisions are not used in a punitive fashion or to cherry pick beneficiaries, they are an

important part of the overall picture. There are proposals for consumer protections, for example prohibiting the need for prior authorization for emergency services…and eliminating the requirement for a referral to see an ob-gyn.

And finally, I'll mention a couple of things about workforce. We don't have a nursing or health care workforce shortage in North Dakota at this time…we do have some issues with geographic distribution. Seventeen counties have less than the national average of RNs per 1,000 people. As residents of a state with a higher than average aging population we need to look toward the future. 25% of North Dakota's RNs plan to retire by 2016; 25% of LPNs plan to retire by 2017. Well over half of the staff members in nursing homes, assisted living, and basic care are over 40 years of age. Many of us have already been in discussions about improving the pipeline and recruitment methods for replacing and increasing these valuable workers in North Dakota.

Part of health care reform addresses health care workforce needs, provides for demonstration projects for nursing education, provides funding for geriatric education and training, and grants for residency and employment of nurse practitioners.

My overall message today is that we've had some pretty good conversations, both here in this committee and on a national level, about the health care system. There are some good ideas being discussed along with some valid concerns. Whatever happens, we should continue to develop what is good into policies that will work for the people of North Dakota.

Immediate Benefits in Health Insurance Reform for Americans 50+

Since the beginning of the health care reform debate, AARP has been fighting to protect guaranteed Medicare benefits; lower prescription drug costs for seniors; crack down on insurance company abuses; make sure you can continue to see your doctors, prevent anyone from coming between you and your doctor and give you and your loved ones more options to live independently at home as you age.

Although all the elements of health care reform that will benefit you won't go into effect overnight, here are critical improvements that will be felt right away.

Strengthening Medicare: Health care reform will strengthen and improve Medicare so today's seniors and future generations have the health care they need by:

- ✓ **Protecting guaranteed Medicare benefits:** You will continue to receive all of Medicare's guaranteed benefits, including doctor and hospital visits and rehabilitation services.
- ✓ **Closing the Medicare Part D coverage gap or "doughnut hole":** In 2010, if you reach the doughnut hole, you will receive a rebate for $250 to help you pay for prescriptions. Beginning in 2011, if you reach the doughnut hole, you will receive a 50 percent discount on your drugs. The doughnut hole will be fully closed over the next 10 years.
- ✓ **Providing preventive care, such as screenings for cancer and diabetes, free of charge:** You will no longer have to pay out of pocket for preventive care services. You will also be able to work with your doctor to develop your own plan to keep you as healthy as possible.
- ✓ **Improving access to primary care doctors:** Your primary care doctor will receive bonuses for treating people in Medicare, so you can get higher quality and better coordinated care.

Making Insurance Affordable: Health care reform will make insurance more affordable for older Americans and hold down overall health care costs by:

- ✓ **Protecting Retirees:** If you have retiree health coverage through your employer and are between 55 and 64, new Federal funds will encourage your employer to continue offering you health benefits.
- ✓ **Covering the Sick:** If you can't find affordable coverage because of your medical history, you will have access to temporary insurance coverage.
- ✓ **Providing Preventive Care:** Your insurance company will be required to provide you with preventive care, such as immunizations and screenings for cancer or diabetes, free of charge.
- ✓ **Helping Young Adults:** If your young adult son or daughter needs health insurance, you can cover them on your insurance policy until they are 26 years old.
- ✓ **Promoting Healthy Living:** You will be able to make healthier choices because chain restaurants and vending machines will be required to disclose nutrition content.
- ✓ **Helping Small Businesses:** If you work for a small business, your employer may be eligible for tax credits that would cover up to 50 percent of your premiums.

Holding Insurers Accountable: Health care reform will stop insurance company abuses and discrimination by:

- ✓ **Preventing annual or lifetime limits:** Insurance companies will be prevented from imposing lifetime limits or arbitrary annual limits on coverage, which will give you the peace of mind of knowing that your benefits won't run out just when you need them most.
- ✓ **Limiting insurance company profits:** New consumer protections will make sure insurance companies spend the bulk of their revenues paying for your medical care—not insurance companies' overhead—and provide rebates to you if they don't.
- ✓ **Preventing insurance companies from dropping the sick:** Insurance companies will no longer be able to deny you affordable coverage when you get sick.

Living Independently: Health reform will give you and your loved ones more choices to live independently at home as you age:

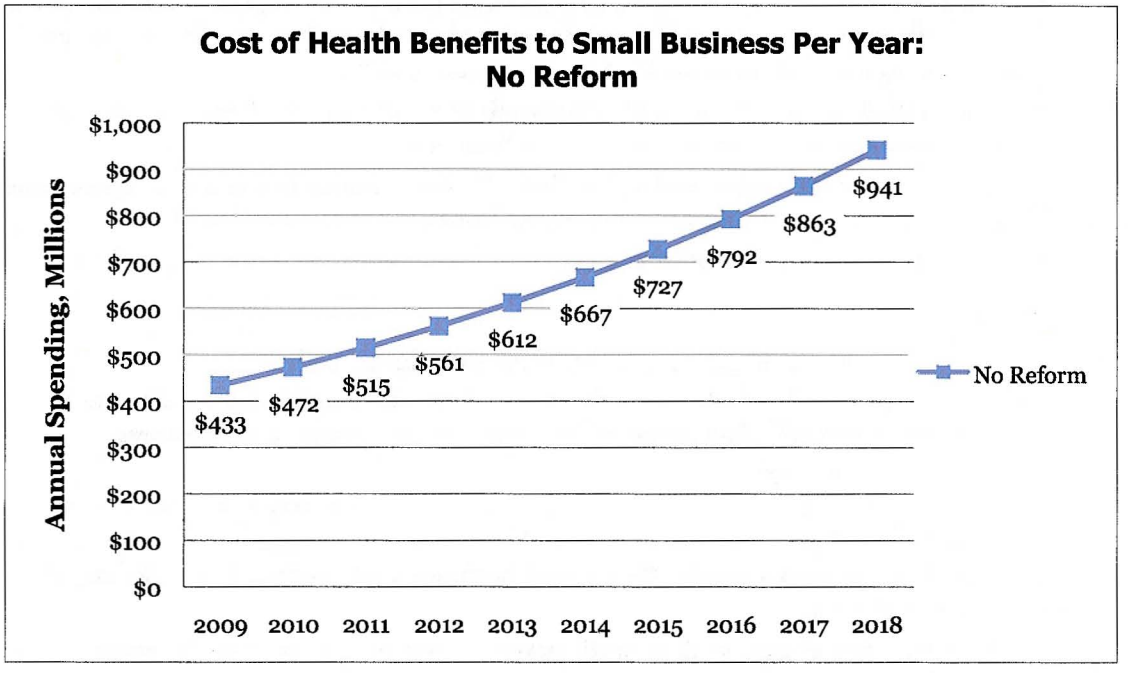
- ✓ **Expanding access to home and community-based services:** Your state will receive new financial incentives to provide more access to the services and supports you need to live independently in your home and community.
- ✓ **Making informed choices about long-term care:** Finding information on long-term care can be overwhelming. This legislation provides funding for "one-stop shops" to make it easier to get the information you need.
- ✓ **Providing better information and accountability for nursing home care:** There will be a better process for you to file complaints about quality of care at a nursing home, and more information about complaints that have been filed. You will also get more information on nursing home quality and consumer rights. There will be improved training to help health professionals care for people with dementia and to help nursing homes prevent abuse.
- ✓ **Improving criminal background checks for long-care:** The legislation expands a successful program that runs criminal background checks on employees of long-term care providers to help prevent potential abuse of older adults and people with disabilities needing long-term care.

SMALL BUSINESS MAJORITY

Healthcare Reform Will Help North Dakota Small Businesses

Without change, health insurance premiums will continue to skyrocket.

North Dakota's small businesses and self-employed entrepreneurs spent $397 million in healthcare premiums in 2008. According to projections based on research by MIT economist Jonathan Gruber,[1] that number will rise to $941 million by 2018 without relief from comprehensive reform.[2]



Small businesses in North Dakota are burdened by high premiums.

Small businesses in North Dakota support healthcare reform to relieve them from rising and unpredictable health insurance rates, according to results of a telephone survey conducted in May 2009 and sponsored by Small Business Majority.[3] The survey of 200 small business owners found:

- Just 48% of North Dakota's small business owners reported paying for health insurance for their employees. Of those, 66% say they're really struggling to do so.
- Of the 52% who don't provide insurance, more than three-quarters say they can't afford it.
- The number one concern for North Dakota's small business owners regarding healthcare reform is controlling costs, followed by providing coverage for everyone and assuring high-quality standard minimum benefits.

[1] "The Economic Impact of Healthcare Reform on Small Business," Small Business Majority, June 2009.

[2] Small Business Majority projections based on microsimulation modeling by Jonathan Gruber.

[3] Small Business Majority survey of North Dakota's small business owners, May 2009.

North Dakota's small businesses pay higher rates because of insurance market consolidation.

- The top insurer maintains 91% of the market share.[4]
- The average family premium among companies with fewer than 50 employees is $7,920 per year.[5]
- Insurance rates are volatile for small businesses and vary substantially from year to year. The variance in premiums among businesses with 10 or fewer employees is so great that one might pay up to four times as much as another, similar firm of the same size.[6]

North Dakota's small businesses need reform to make healthcare affordable.

- A well-designed health insurance exchange would create a marketplace that is fair, efficient and predictable, relieving small business owners from the tedious and time-consuming task of shopping for health insurance in today's chaotic conditions.
- Insurance reform would ensure that thousands of North Dakota citizens with histories of health problems would get coverage they've been denied.
- Tax credits and individual subsidies, included in the proposals now before Congress, would help businesses afford coverage for their employees.
- Long-term cost containment would reduce rates by eliminating waste and inefficiency.

Facts about small business in North Dakota

- North Dakota had 16,797 small employers in 2006, representing 94% of the state's employers and 44% of its private-sector employment. (2006 County Business Patterns, US Census)
- 46,892 self-employed entrepreneurs make up 14% of North Dakota employment and fuel North Dakota's economy in every industry. (Internal Revenue Service, 2005) These entrepreneurs and the state's small business employees together make up 52% of the workforce.
- Small businesses created all of North Dakota's net new jobs from 2004 to 2005. (Small Business Administration Office of Advocacy, North Dakota Small Business Profile)
- Of the uninsured adults in North Dakota, 73% have jobs. (Center for American Progress from US Census data)
- Just 36% of firms with fewer than 50 employees in North Dakota offer health insurance. (Kaiser Family Foundation, State Health Facts)

Small Business Majority conducts extensive scientific polling and research to determine small business owners' perspectives on healthcare reform and brings a nonpartisan voice to policy discussions nationwide. Based in Sausalito, CA, with offices in Washington, DC, and New York City, the organization works with small business owners, healthcare policy experts and elected officials nationwide. For more information about Small Business Majority and the research in this fact sheet, visit our website at www.smallbusinessmajority.org.

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[4] "Competition in health insurance: A comprehensive study of U.S. markets, 2007 update," American Medical Association.
[5] "Small Group Health Insurance in 2008" America's Health Insurance Plans, March 2009
[6] Ibid.

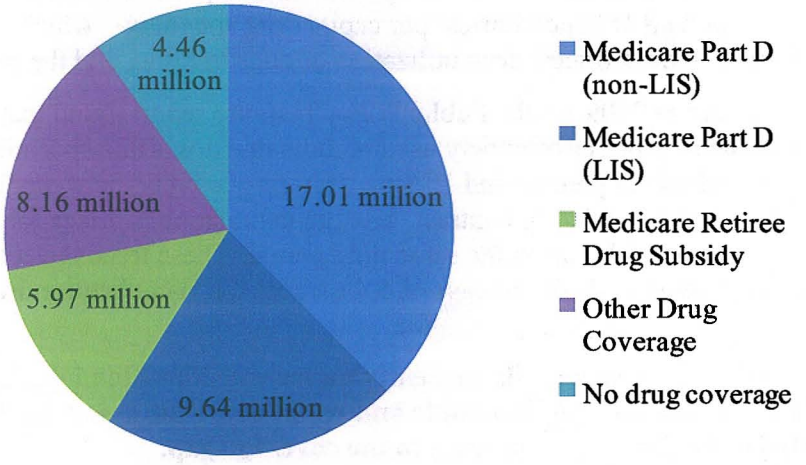
Fact Sheet

Closing the "Doughnut Hole" Will Help Protect Over One-Third of Medicare Beneficiaries from High Drug Costs

➢ **Over one-third (17 million) of the nation's 45 million Medicare beneficiaries would benefit from eliminating the "doughnut hole"—the gap in Part D drug coverage where they have to pay the full cost of their prescription drugs.**

- Approximately 26 million Medicare beneficiaries have Part D coverage. Of these, more than 9 million receive low-income subsidies to cover drug costs, leaving 17 million with no real protection from the doughnut hole.
- Eliminating the doughnut hole would affect beneficiaries in every state. For example, we estimate that close to 2 million Medicare beneficiaries are currently at risk of falling into to the coverage gap in California; more than a million in Florida; and nearly a million in New York, Texas and Pennsylvania. (See attached chart for state breakouts.)

Total Medicare Beneficiaries with Prescription Drug Coverage, 2009



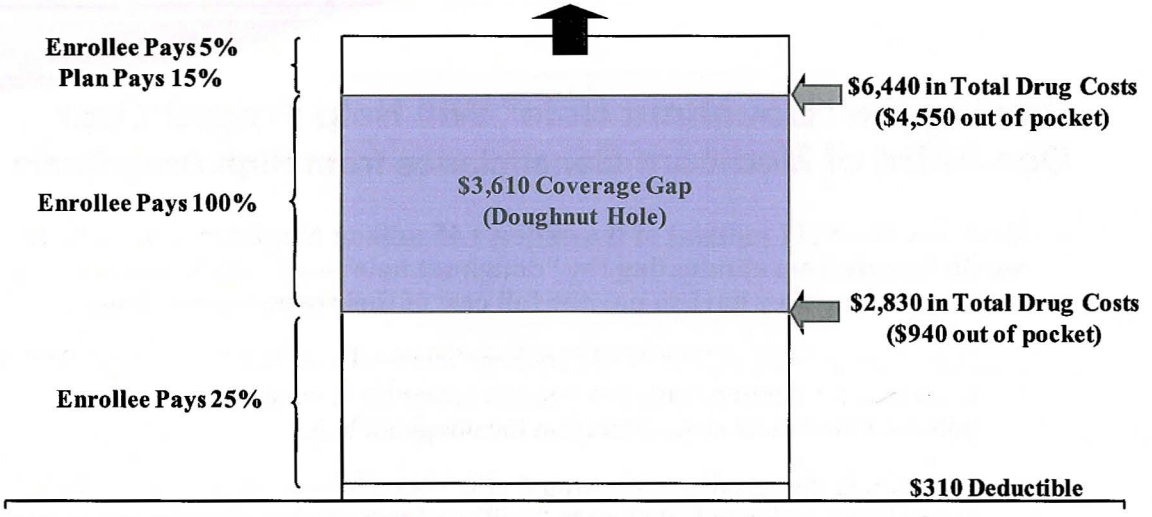
Note: Enrollment data are as of February 1, 2009. "Other drug coverage" includes multiple source of creditable coverage, including TRICARE retiree coverage, FEHB retiree coverage, and Veterans Affairs coverage.
Source: AARP Public Policy Institute analysis based on data from the Centers for Medicaid and Medicare Services. Available online at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

➢ **Medicare beneficiaries in the doughnut hole pay the full cost of their prescription drugs—as well as their premiums.**

- The standard benefit under Part D has an annual deductible; an initial coverage period where beneficiaries pay 25 percent of their drug costs; and catastrophic coverage that limits beneficiaries' spending to roughly five percent of their drug costs. The doughnut hole is between the initial coverage period and catastrophic coverage; closing it would entail raising the initial coverage level until it met the catastrophic coverage level. Enrollees would then be responsible for 25 percent of their drug costs until they reached catastrophic coverage.

AARP

STANDARD MEDICARE PART D DRUG BENEFIT, 2010



- **In 2010, the size of the doughnut hole stands at $3,610. By 2016, it is projected to almost double, to more than $6,000, with potentially significant impact on the health and financial security of many enrollees.**
  - The size of the doughnut hole is updated annually and indexed to reflect growth in Medicare Part D beneficiaries' per capita drug spending—which is affected by changes in drug prices, drug utilization or consumption, and the mix of therapy.
  - A November 2009 AARP Public Policy Institute report found that the manufacturer prices of widely used brand name drugs and specialty drugs increased by 9.3 percent and 10.3 percent, respectively, between October 2008 and September 2009. In contrast, average manufacturer prices for widely used generic drugs fell during the same time period. These trends resulted in an average annual rate of increase of 5.4 percent for manufacturer drug prices despite a negative rate of general inflation.
- **The health care reform bills currently under consideration in Congress move towards closing the doughnut hole and could help millions of Medicare beneficiaries limit their exposure to the coverage gap.**
  - The Affordable Health Care for America Act (House bill, H.R. 3962) completely eliminates the Medicare Part D doughnut hole by 2019. It also provides a one-time decrease in the size of the doughnut hole and requires drug manufacturers to provide 50 percent discounts on brand name drugs and authorized generics for Part D enrollees while they are in the doughnut hole.
  - In contrast, the Patient Protection and Affordable Care Act (Senate bill, H.R. 3590) provides a one-time decrease in the size of the doughnut hole and 50 percent discounts similar to what is found in H.R. 3962, but does not close the doughnut hole entirely. However, Senate leadership has publicly committed to closing the doughnut hole in the final health care reform bill.

Estimates of Medicare Part D enrollees who face the full cost of the doughnut hole, 2009

	# of Medicare Part D enrollees facing the full cost of the doughnut hole	% of Medicare Part D enrollees facing the full cost of the doughnut hole
Alabama	251,391	52.6%
Alaska	9,729	40.4%
Arizona	378,374	70.6%
Arkansas	174,660	56.5%
California	1,934,464	61.9%
Colorado	248,261	72.4%
Connecticut	198,658	65.9%
Delaware	45,998	64.9%
District of Columbia	13,732	39.1%
Florida	1,302,719	67.9%
Georgia	397,113	57.3%
Hawaii	92,179	71.9%
Idaho	87,509	70.8%
Illinois	636,984	64.6%
Indiana	356,082	67.2%
Iowa	251,914	75.1%
Kansas	186,897	72.9%
Kentucky	215,857	52.5%
Louisiana	213,439	52.5%
Maine	70,133	44.9%
Maryland	202,434	61.9%
Massachusetts	336,087	57.3%
Michigan	564,548	67.0%
Minnesota	380,839	74.7%
Mississippi	148,440	47.8%
Missouri	401,770	66.9%
Montana	66,449	71.9%
Nebraska	131,037	74.7%
Nevada	136,811	73.8%
New Hampshire	62,645	65.7%
New Jersey	445,380	66.4%
New Mexico	114,654	62.4%
New York	949,903	56.4%
North Carolina	489,736	58.6%
North Dakota	57,465	76.9%
Ohio	611,046	65.1%
Oklahoma	221,846	64.0%
Oregon	278,875	74.0%
Pennsylvania	982,421	70.7%

	# of Medicare Part D enrollees facing the full cost of the doughnut hole	% of Medicare Part D enrollees facing the full cost of the doughnut hole
Rhode Island	77,691	65.2%
South Carolina	220,670	56.1%
South Dakota	64,833	74.7%
Tennessee	354,079	55.0%
Texas	903,167	56.3%
Utah	111,889	76.1%
Vermont	31,858	54.3%
Virginia	357,695	63.7%
Washington	322,250	67.6%
West Virginia	135,799	60.4%
Wisconsin	318,951	69.2%
Wyoming	30,642	73.5%
U.S.	**17,007,316**	**63.8%**

Note: Calculations do not include LIS beneficiaries who do not experience the Medicare Part D coverage gap. U.S. calculations include beneficiaries in the territories and whose address information is being updated.
Source: AARP Public Policy Institute analysis based on enrollment data from the CMS Management Information Integrated Repository (MIIR), February 1, 2009; Office of Personnel Management; Department of Defense; Department of Veterans Affairs; Indian Health Service; CMS Coordination of Benefits Database (COB). Available online at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

Fact Sheet

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